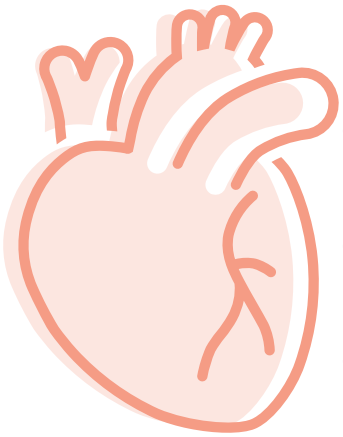
Cardiomyopathy & Heart Failure

Cardiomyopathy, a frequently misreported heart condition, involves weakened or thickened heart muscle impairing blood circulation. It can be inherited or acquired through infections, diseases, or chemotherapy side effects. This condition often leads to heart failure, a state where the heart struggles to pump enough blood to meet the body's needs. Heart failure risk factors include unhealthy lifestyle choices (smoking, alcohol, obesity, inactivity), hypertension, diabetes, and pre-existing heart problems. The severity of heart failure is staged using the NYHA system, categorizing patients based on their physical activity limitations and symptoms like shortness of breath and chest pain. Diagnoses cannot be assumed from medication lists, physician orders, problem lists, or medical history; accurate diagnosis and management are critical to prevent serious complications.

Best Documentation Practices



Avoid general terms	Instead of using general terms like "cardiomyopathy" and "heart failure", specify the precise type using all available descriptive details. *(E.g. Dilated cardiomyopathy or acute on chronic diastolic congestive heart failure)*
State the cause	Specify the cause, if known, using terminology that clearly establishes causality, such as "associated with," "due to," or "secondary to".
Include the current status	Describe the status as “stable”, “worsening”, “improved”, “compensated”, or “decompensated”, avoiding the term "history of" as it implies a past, resolved condition.
Record signs & symptoms	Record all present and absent signs and symptoms related to the patient's condition during the visit. *(E.g. Has shortness of breath or no swelling of lower legs)*

Remember to link all medications, note any referrals or consultations, and include test results.

M.E.A.T. the Condition

Proper documentation requires at least one of these four elements be present in the documentation for each condition

M
Monitor

How is the patient doing?

Document signs, symptoms, disease progression/regression or ongoing surveillance

E
Evaluate

What is the current state of the condition?

Document current state, test results, medication effectiveness or response to treatment

A
Address/Assess

How will the condition be evaluated?

Document discussion, review of records, counseling, or ordering further tests

T
Treatment

What is being done to help the condition?

Document care, prescribed medications, referral to specialist or other modalities

CMS requires **annual coding and reporting of all chronic conditions**. A condition is not considered present in a given year unless it is appropriately documented and coded in that year.

Cardiomyopathy & Heart Failure ICD-10 Category Reference Guide

This partial list of Risk Adjustment condition categories and ICD-10 codes (showing only partial codes for some) is not exhaustive. **For complete codes and all applicable coding instructions, refer to the current ICD-10-CM Alphabetic Index and Tabular List.**

Cardiomyopathy	
I42.X	Cardiomyopathy
Heart Failure	
I50.XX	Heart failure
Use additional code to identify, if applicable	
Z94.1	Heart transplant status

Coding Examples

Example 1	
Documentation	**Reason for Visit:** F/U for dilated cardiomyopathy secondary to hypertension. **Subjective:** Reports improved symptoms, decrease in SOB, less fatigued. Denies CP **PE:** Lower extremity +1 pitting edema bilaterally **Assessment & Plan:** Dilated Cardiomyopathy, stable. Continue BP control, current medication regimen, heart healthy low Na diet. Monitor weight daily and call if 2–3 lbs. in a day or more than 5 lbs. in a week.
ICD-10 Code(s)	I42.0 Dilated cardiomyopathy
Rationale	The provider specifically addressed the type of cardiomyopathy, documented a cause and current symptoms, and reported a stable status in the assessment.

Example 2	
Documentation	**Reason for Visit:** Medication Management **Subjective:** Patient started Entresto 3 months ago, no issues reported **Assessment & Plan:** HFrEF, chronic; No issues with Entresto will continue at current dose, ECHO scheduled in 3 months.
ICD-10 Code(s)	I50.22 Chronic systolic (congestive) heart failure
Rationale	The assessment and plan address the patient's heart failure with reduced ejection fraction (systolic heart failure), noting its current status. The provider reviewed the patient's medications for heart failure management and scheduled further testing.

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