

PRESENTED BY HIGHMARK RISK ADJUSTMENT ACCURACY MANAGEMENT

Arrhythmias



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Agenda

1. Overview of the condition
 2. Coding & documentation considerations
 3. Documentation example
 4. Additional resources
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Arrhythmias

An arrhythmia is an abnormal heart rhythm where electrical signal disruptions cause the heart to beat too fast (tachycardia), too slow (bradycardia), or irregularly.

Symptoms:

While some patients are asymptomatic, others may experience palpitations, dizziness, fainting, shortness of breath, chest discomfort, or fatigue.

Complications:

Unmanaged arrhythmias can lead to stroke (especially with Afib), heart failure, or cardiac arrest/sudden death.

Treatment:

Treatment aims to control heart rate and reduce risks, often involving:

- Medications: For rate/rhythm control and blood thinning
- Procedures: Catheter ablation, electrical cardioversion, pacemakers, or defibrillators
- Lifestyle Changes: Quitting smoking, stress reduction, reduced alcohol/caffeine, weight management.



Types of Arrhythmias

Tachycardia

- Fast heartbeat, greater than 100 bpm

Atrial fibrillation

- Chaotic atrial impulses

Atrial flutter

- Organized, rapid atrial rhythm

Bradycardia

- Slow heartbeat, less than 60 bpm

Premature Contractions

- Extra beats

Coding Considerations



Arrhythmia ICD-10 codes

I44. –	Atrioventricular and left bundle-branch block
I47. –	Paroxysmal tachycardia
I48. –	Atrial fibrillation and flutter
I49. –	Other cardiac arrhythmias

Refer to the current version of the ICD-10-CM Official Guidelines for Coding and Reporting, the ICD-10-CM Index to Diseases and Injuries, and the Tabular List of Diseases for a list of all ICD-10-CM codes and coding instructions.

All arrhythmias, including AFib, require explicit clinician interpretation in progress notes; coding from ECG reports alone is not permitted.

Pacemaker-controlled arrhythmias (e.g., sick sinus syndrome, complete heart block) require ongoing documentation post-implantation.

Note the presence of a cardiac pacemaker and assign ICD-10 code Z95.0 Presence of cardiac pacemaker.

If the documentation notes, the arrhythmia has resolved after cardioversion/ablation and no longer requires treatment, assign ICD-10 code: Z86.79 Personal History of other diseases of the circulatory system

Documentation Considerations

Thorough and accurate documentation of arrhythmias enables timely interventions, enhances patient care and satisfaction and ensures appropriate coding and reimbursement.

Specify the type:

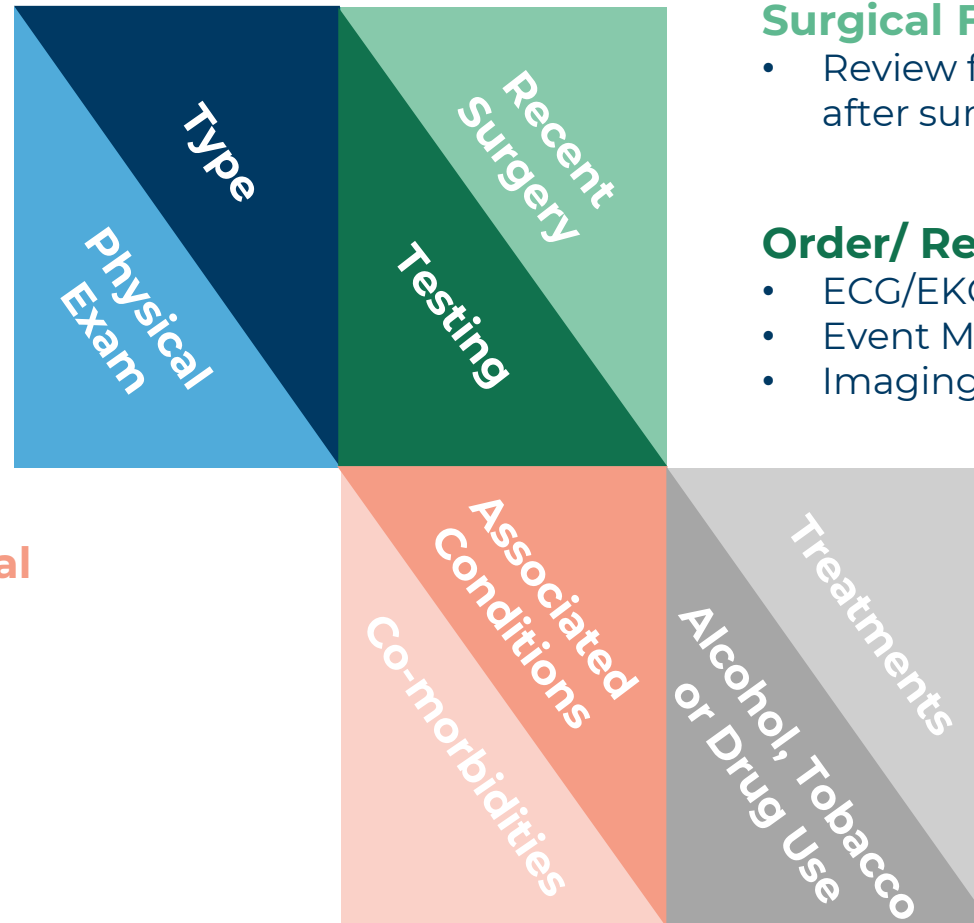
- Typical atrial flutter
- Permanent atrial fibrillation
- Sick sinus syndrome
- Complete atrioventricular block

Note the exam findings

- Assess heart rate & rhythm
- Signs & symptoms (dizziness, fatigue, chest pain, palpitations)

Identify any associated medical conditions or co-morbidities:

- Heart Failure
- Hypertension
- Sleep Apnea
- Diabetes
- COPD
- Hyperthyroidism
- Viral Infections



Surgical Follow up:

- Review for compliance with anticoagulants after surgery

Order/ Review/ Interpret Tests:

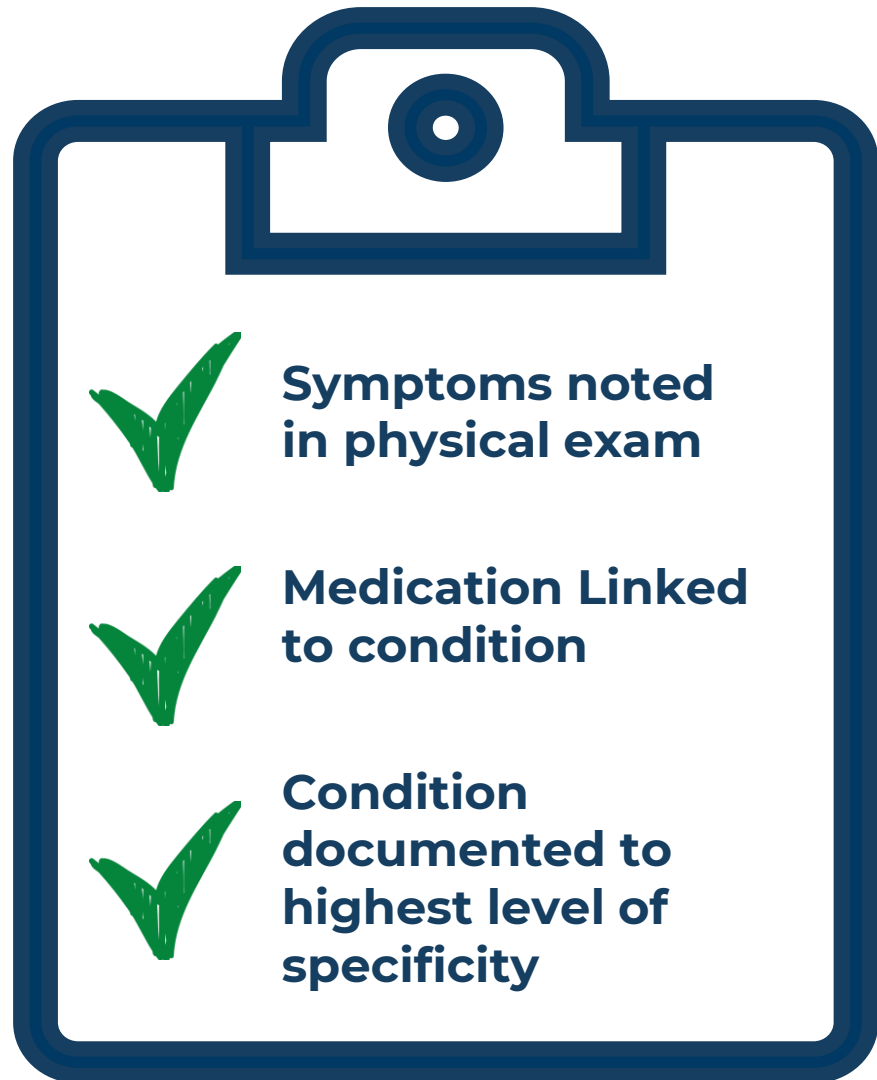
- ECG/EKG
- Event Monitor
- Imaging & Blood tests

Document Treatment Plan:

- Medications (including dosage)
- Procedures
- Lifestyle changes

Document any related alcohol, drug or tobacco use

Atrial Fibrillation Documentation Example



History of Illness:

Patient here for follow up of chronic conditions. The patient reports **occasional palpitations**. He takes **Sotalol and Eliquis**. Cardioversion had been discussed in the past, but patient declined.

Physical Exam:

Cardiac: **Irregularly Irregular**

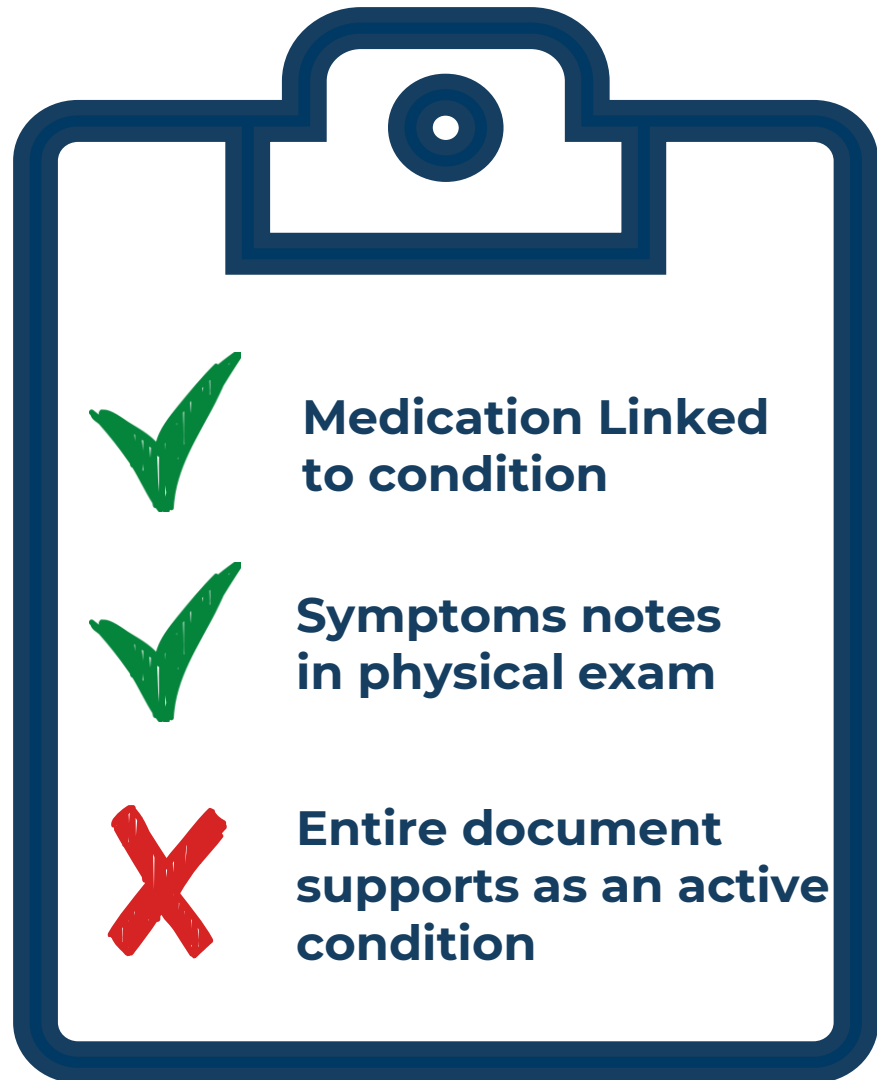
Assessment & Plan:

Long Standing Persistent Atrial Fibrillation (I48.11)

Patient taking meds as prescribed. To follow up with Cardiology in two weeks. Recommended he consider cardioversion due to his risk of stroke.

The clinician's documentation throughout the encounter supports the active Afib diagnosis. The documentation includes specifics on the type, signs, and symptoms, as well as a clear treatment plan with further recommendations for cardioversion to avoid complications.

Atrial Fibrillation Example



History of Illness:

Patient here for follow up of chronic conditions. **Afib has been a constant issue.** The patient reports as having intermittent chest tightness. **Patient takes Sotalol and Eliquis** and a cardioversion had been discussed, but patient declined.

Physical Exam:

Cardio: **Rhythm is irregularly irregular**

Assessment & Plan:

History of atrial fibrillation

Patient is stable on medications. To follow up with Cardiology in two weeks.

The clinician documented the atrial fibrillation as an active condition in the HPI and indicated current treatment with medication; however, the condition was documented as a “history of” in the assessment & plan. Avoid using the term “history of” unless the condition has resolved and no longer requires treatment/management.

Additional Resources

Documentation Best Practice Checklist



Annually assess all chronic conditions and document a plan for each one



Link medications to help establish ongoing treatment especially if the medication is used to treat multiple conditions.



Use the term “History of” before a condition if it no longer exists or has resolved



Validate patient reported findings



Code and document all coexisting conditions that require or affect patient care, treatment or management



Avoid using uncertain terms when a diagnosis has been confirmed for a patient



Choose the highest level of specificity when selecting an ICD-10 code



Keep problem list up to date by removing acute and one-time conditions

Highmark Provider Resource Center

KNOWLEDGE COLLEGE

15-minute on-demand courses on risk adjustment coding and documentation to help clinicians comply with CMS standards and ICD-10-CM guidelines

1. Log into Availity.
2. Navigate to the Provider Resource Center.
3. Locate “Resources and Education” in the menu bar and navigate to “Clinical Quality & Education”.
4. Select “Coding Education/HCC University”.

RISK ADJUSTMENT OVERVIEW

Review the foundations of what risk adjustment is, hierarchical condition categories, common errors, best practices and impacts to patient care



CODING & DOCUMENTATION CARDS

Reference cards to assist with documentation and coding according to CMS documentation standards and ICD-10-CM coding requirements



Have questions about risk adjustment?

**Want to share feedback or suggest topics
for future presentations?**

Email:

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