Provider CQDocumentation Guide

PREMIER

Congestive Heart Failure (CHF)

Documentation and code assignment requires reporting the acuity, type and underlying conditions, when applicable, to fully capture the specificity of the condition. Cardiomyopathy, if applicable, requires a separate code for reporting.

Documentation Requirements	
Acuity:	Acute, Chronic, Acute on chronic
Type:	Diastolic, Systolic, Combined Diastolic and Systolic
Underlying Conditions:	Coronary Artery Disease, Hypertension, Cardiomyopathy, Valve Disease, Congenital Heart Disease, Diabetes, Genetics, etc.
Cardiomyopathy:	Ischemic, dilated, restrictive, obstructive, hypertrophic, alcoholic, etc. (Requires a separate code for reporting)
Best Practice:	Document and code also End Stage Heart Failure, if applicable

EMR Diagnosis Key Search Term	
Diagnosis Etiology	**Diagnosis Complication**
Key Search Term: Key Search Term:	Key Search Term: Key Search Term:

Documentation and Reporting Guidelines

Combination code requirements for CHF

Report one of the codes below, in addition to the code for CHF, when applicable:

- Heart failure due to hypertension
- Heart failure due to hypertension with chronic kidney disease
- Post-Procedural Heart Failure (following cardiac surgery; following other surgery)
- Rheumatic heart failure
- Heart failure complicating abortion, ectopic or molar pregnancy
- Heart failure following obstetric surgery and procedure

Chronic Diseases

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

Conditions that Co-exist at the time of the encounter

- Code all documented conditions that coexist at the time of the encounter and requires or affects patient care treatment or management.
- Do not code conditions that were previously treated and no longer exist.
- History codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.