

Identifying and Documenting Heart Failure, Chronic Obstructive Pulmonary Disease and Chronic Kidney Disease

Early detection and monitoring of chronic conditions are vital to delaying the onset of disease and keeping patients out of the hospital. The goal of Peoples Health is to improve the health outcomes of our plan members by engaging providers to assist with the screening, diagnosis and documentation of the following prevalent conditions.

When evaluating patients, we ask that you code to the highest level of specificity, complexity (comorbidities) and accuracy possible for all applicable diagnoses. As always, for adequate documentation, each diagnosis requires the four elements of a SOAP note—subjective, objective, assessment and plan (even when the plan is observation or no treatment). CMS requires active diagnoses to be documented and coded annually, even for permanent diagnoses or those that do not require ongoing treatment, to show that associated conditions are being assessed and managed. Document the presence, assessment and plan of care for any of the conditions.

As always, adhere to CMS guidelines for appropriate coding and documentation.

CONDITIONS

1. Heart failure

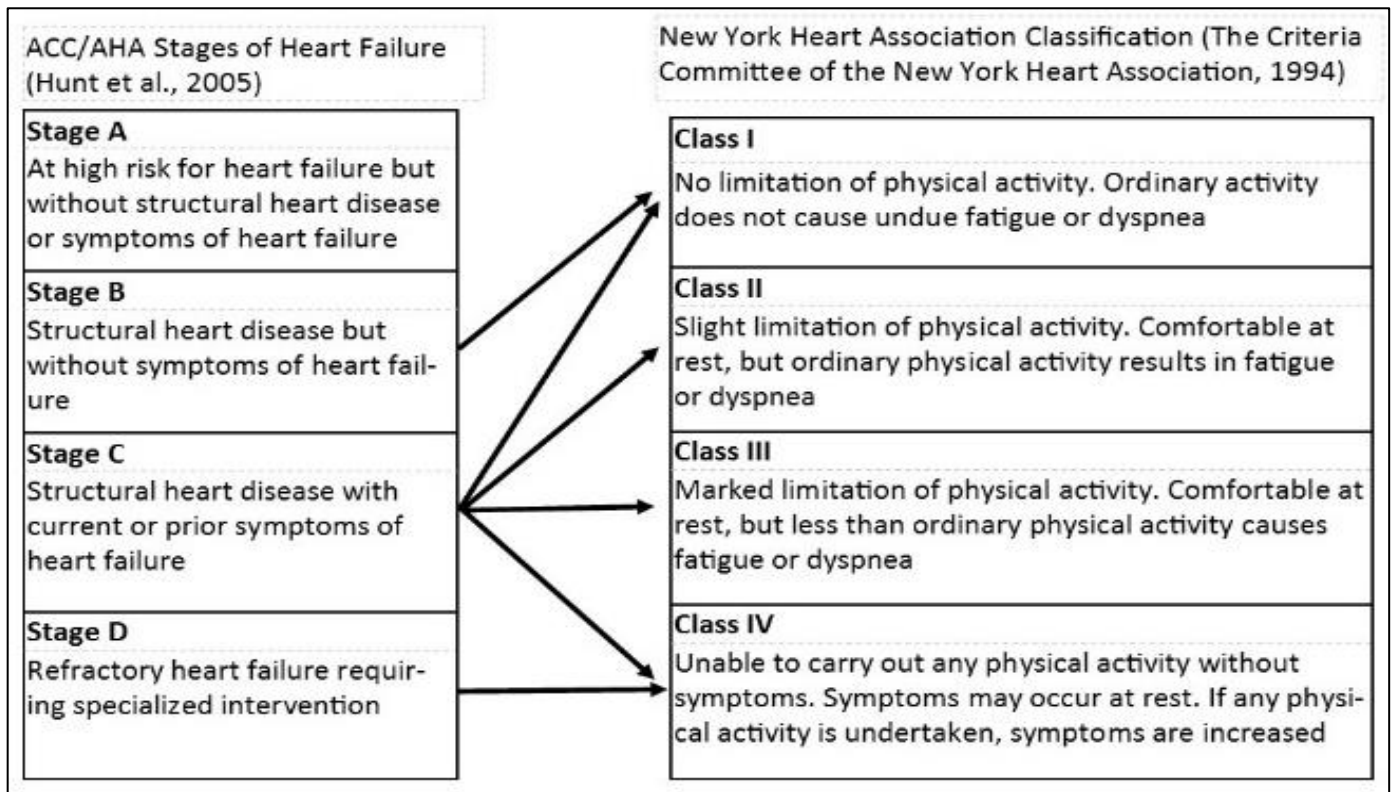
Heart failure (HF) is a complex clinical syndrome resulting from a structural or functional impairment of ventricular filling or ejection of blood.

The cardinal manifestations of HF are:

- Dyspnea and fatigue, which may limit exercise tolerance
- Fluid retention, which may lead to pulmonary and/or splenic congestion and/or peripheral edema

Some patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea or fatigue. Because some patients present without signs or symptoms of volume overload, the term “heart failure” is preferred over “congestive heart failure.”

The American College of Cardiology and American Heart Association (ACC/AHA) stages of HF and the New York Heart Association (NYHA) functional classification provide useful and complementary information about the presence and severity of HF. The ACC/AHA stages of HF emphasize the development and progression of disease and can be used to describe individuals and populations, whereas the NYHA classes focus on exercise capacity and the symptomatic status of the disease.



There are many contributing factors for HF.

Common comorbidities:*

- Hypertension (may be the single most important modifiable risk factor)
- Diabetes mellitus
- Metabolic syndrome
- Atherosclerotic disease
- Cardiomyopathies
- History of myocardial infarction

*Not a comprehensive list

Factors for Diagnosis

There is no single diagnostic test for HF because it is largely a clinical diagnosis based on medical history and physical examination. The following factors identified during a physical exam could indicate HF: dyspnea, neck vein distention, S3 gallop, cardiomegaly and paroxysmal nocturnal dyspnea. These symptoms may indicate the need for an echocardiogram.

Common labs:

- Complete blood count
- Comprehensive metabolic panel
- B-type natriuretic peptide test
- Thyroid function test
- Lipid panel

Common diagnostic tests:

- Echocardiogram
- EKG
- Nuclear stress test
- Exercise stress test
- Stress echocardiogram
- Chest X-ray

ICD-10 codes:

Refer to ICD-10 resources to select the most appropriate code for the diagnosis and extension. Example codes and extensions for HF conditions are provided below. For others, refer to coding resources.

- I11.0 – Hypertensive heart disease with heart failure
- I50.9 – Heart failure, unspecified
- I27.20 – Pulmonary hypertension, unspecified
- I130 – HTN heart & CKD w/HF & CKD stage 1-4 or UNS CKD
- I50.20 – Unspecified systolic congestive heart failure
- I50.22 – Chronic systolic congestive heart failure
- I50.30 – Unspecific diastolic congestive heart failure
- I50.32 – Chronic diastolic congestive heart failure
- I50.42 – Chronic combined systolic and diastolic congestive heart failure

Rx Indicators: ACE-I/ARB agents, diuretics, beta blockers, positive inotropes, alternative vasodilators, aldosterone receptor antagonists

2. Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD), a common, preventable and treatable disease, is characterized by persistent airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response to noxious particles or gases in the airways and the lungs. Exacerbations and comorbidities contribute to the overall severity in individual patients.

Symptoms:

A diagnosis of COPD should be considered in patients older than age 35 who have a risk factor (generally smoking) and who present with one or more of the following symptoms:

- Dyspnea – cardinal symptom of COPD
- Chronic cough
- Regular sputum production
- Frequent winter "bronchitis"
- Wheeze and chest tightness

Additional features in severe disease:

- Fatigue
- Weight loss
- Anorexia
- Effort intolerance
- Waking at night
- Ankle swelling
- Occupational hazards
- Chest pain
- Hemoptysis

Common comorbidities:

- Cardiovascular diseases
- Osteoporosis
- Respiratory infections
- Anxiety and depression
- Diabetes
- Lung cancer
- Bronchiectasis

Factors for Diagnosis

Factors for diagnosis may include but are not limited to history and physical exam, imaging (chest X-ray, CT chest scan), PFTs or spirometry.

The easiest way to make a functional diagnosis of COPD is with the use of a spirometry. A common method of classification is the GOLD criteria. A score of 0 to 2 is low risk, and a score of 3 to 6 indicates the need for spirometry.

Use of the CAPTURE (COPD Assessment in Primary Care To Identify Undiagnosed Respiratory Disease and Exacerbation Risk) questionnaire can aid in identifying patients with undiagnosed COPD.

Please answer each question	No	Yes	
1. Have you ever lived or worked in a place with dirty or polluted air, smoke, second-hand smoke, or dust?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your breathing change with seasons, weather, or air quality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your breathing make it difficult to do things such as carry heavy loads, shovel dirt or snow, jog, play tennis, or swim?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Compared to others your age, do you tire easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please answer the question			
	0	1	2 or more
5. In the past 12 months, how many times did you miss work, school, or other activities due to a cold, bronchitis, or pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The distinction between COPD and asthma is that asthma has reversible obstruction, whereas COPD does not. The onset of asthma is generally prior to age 20 and accompanied by a family history or allergic conditions, and symptoms may vary over time. COPD onset is generally after age 40, results from heavy exposure to risk factors, and symptoms and impaired lung function are persistent.

Consider:

- Long-standing, usually inadequately treated asthma can become an obstructive process
- The difference between obstructive asthma and non-obstructive asthma, where a patient wheezes during an attack but returns to normal breathing once the attack subsides
- Chronic obstructive asthma when a patient is on chronic therapy to relieve obstructive symptoms:
 - Chronic long-acting beta agonists (LABAs)
 - Chronic inhaled steroids
 - Chronic use of antimuscarinic bronchodilators

ICD-10 codes:

Refer to ICD-10 resources to select the most appropriate code for the diagnosis and extension. Example codes and extensions for respiratory conditions are provided below. For others, refer to coding resources.

COPD

- J41.0 – Simple chronic bronchitis or smoker’s cough
- J43.2 – Centrilobular emphysema
- J43.9 – Emphysema, unspecified
- J44.1 – Chronic obstructive pulmonary disease w/exacerbation
- J44.9 – Chronic obstructive pulmonary disease, unspecified; or chronic obstructive asthma
- J84.9 – Interstitial pulmonary disease, unspecified
- J84.10 – Pulmonary fibrosis, unspecified

Severe persistent asthma

- J45.50 – Severe persistent asthma, uncomplicated
- J45.51 – Severe persistent asthma w/acute exacerbation
- J45.52 – Severe persistent asthma w/status asthmaticus

3. Chronic kidney disease (CKD)

Chronic kidney disease (CKD) is defined by KDIGO 2012 guidelines as abnormalities of kidney structure or function, present for more than 3 months, with implications for health. CKD is classified based on cause, GFR category and albuminuria category.

Symptoms:

According to the Centers for Disease Control and Prevention, CKD is prevalent in 15% of U.S. adults (37 million people), and although CKD results in progressive loss of kidney function, it is often asymptomatic until the late stages of the disease. In fact, 40% of people with severely reduced kidney function who are not on dialysis are unaware of having CKD. What’s more, approximately 1 in 3 adults with diabetes may have chronic kidney disease.

Comorbidities:

- Diabetes – leading cause of CKD
- Hypertension
- Heart disease
- Stroke

Causes:

- Polycystic kidney disease
- Prolonged obstruction of the urinary tract
- Pyelonephritis
- Glomerulonephritis

Factors for Diagnosis

Clinical practice guidelines from the American Diabetes Association and the National Kidney Foundation recommend screening patients with diabetes for kidney disease every year. Together, the following tests provide key information about kidney health, including the stage of CKD and the risk of progression.

eGFR	Blood test to assess kidney function	serum creatinine (mg/dL) with equation (mL/min/1.73m ²)
uACR	Urine test to assess kidney damage	urine albumin (mg/dL)
		urine creatinine (g/dL)

ICD-10 codes and CKD stages:

Sample codes provided below; refer to ICD-10 resources to select the most appropriate code for the diagnosis and extension.

- E10.22 – Type 1, diabetes mellitus with diabetic CKD
- E11.22 – Type 2, diabetes mellitus with diabetic CKD
- N18.1 – **CKD Stage G1**, GFR ≥ 90 (normal or high)
- N18.2 – **CKD Stage G2**, GFR 60–89 (mildly decreased)
- N18.3x – **CKD Stage G3a**, GFR 45–59 (mildly to moderately decreased); **CKD Stage G3b**, GFR 30–44 (moderately to severely decreased)
- N18.4 – **CKD Stage 4**, GFR 15–29 (severely decreased)
- N18.5 – **CKD Stage 5**, GFR <15 (kidney failure)
- N18.6 – End-stage renal disease

This is a summary of information from clinical resources and should not be used for the diagnosis or treatment of medical conditions. Peoples Health has used all reasonable care in compiling the information but makes no warranty as to its accuracy for individual patient care. Clinical judgment and knowledge of patient’s individual health should be used in determining conditions and care plan.

Sources:

- Peoples Health Evidence-Based Practice Guideline, Diagnosis and Management of Chronic Heart Failure in the Adult
- Peoples Health Provider Education Series PowerPoint (Cardiology), 2017
- Peoples Health Evidence-Based Practice Guideline, Chronic Obstructive Pulmonary Disease
- Primary Care Plus Regional Meeting, Education Series PowerPoint (Pulmonary), 2017
- Peoples Health Evidence-Based Practice Guideline, Diagnosis and Management of Adults With Chronic Kidney Disease
- NCQA, Let’s Talk About Diabetes and Kidney Health: Ready – Set – Test flyer, March 2021
- <https://www.cdc.gov/kidneydisease/basics.html>, Chronic Kidney Disease Initiative page