Accurate Heart Failure Documentation

1. Document to the Highest Specificity

Specify **Acuity** – acute, chronic, acute on chronic

Document **Type** of Failure – right, left, systolic, diastolic, CHF, etc.

Specify **Chamber** – left ventricular, right ventricular, biventricular, right heart failure due to left heart failure

2. Document all co-existing diagnoses

Diabetes, Hypertension, CAD, CKD (note the stage), Cancer, Obesity, etc

Linking co-morbidities to Heart Failure may increase the Risk Score

3. Documentation of "History of" or "H/O"

"History of – H/O" means the patient no longer has the condition!

Medical Note States	CMS Interpretation…
H/O CHF	CHF has resolved

4. Documentation must demonstrate the diagnosis was Monitored, Evaluated, Assessed, AND/OR Treated

M	E	A	T
Monitor	Evaluate	Assess	Treat
Signs Symptoms Disease regression Disease progression	Lab results Radiology results Response to treatment Medication effectiveness	Discussion Ordering tests Review consults Counseling	Referrals Therapies Modify medications Start/Stop medication

5. Patient followed by a different provider – make it count!

Supporting documentation would be a simple notation to that effect.

Ex: "Congestive Heart Failure (CHF), followed by Dr. Smith, cardiologist."