



Cardiovascular Diseases Best Practice Documentation

Click on the desired Diagnoses link or press Enter to view all information.

Diagnoses:

- [Acute Myocardial Infarction \(AMI\)](#)
- [Acute Coronary Syndrome/ Type II MI](#)
- [Coronary Artery Disease/Angina](#)
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Acute Myocardial Infarction

- ST elevation (STEMI)
 - Require site and specific artery:
 - Anterior Wall
 - Left main coronary artery
 - Left anterior descending artery
 - Other coronary artery of anterior wall
 - Inferior Wall
 - Right coronary artery
 - Other coronary artery of inferior wall
 - Other
 - Left circumflex coronary artery
 - Other Specified
- Non-ST elevation MI (NSTEMI)
 - No specific site requirements
- Type II MI
 - Requires the above Specificity of STEMI or NSTEMI
 - Best Practice Documentation when patient did not have an AMI
 - “Acute subendocardial ischemia without AMI”
- Time Element of Infarction is Required
- All STEMI and NSTEMI's Require documentation of timing of the infarction in relation to the visit:
 - Document date of any recent acute MIs within 28 days of admission
 - Document whether or not the current MI has occurred within 28 days of a previous MI
 - If the patient has a history of an MI (older than 28 days)



AMI

Documentation Example

Insufficient Documentation

- Patient with history of tobacco abuse, diabetes and hypertension presents to the ED with chest pain which started around 4:00 pm. EKG shows 0.5-1 mm ST elevation in inferior leads as well as 0.5-1 mm ST depression in I and aVL. Transfer to cath lab for acute ST elevation MI.

Best Practice Documentation

- Patient with history of tobacco abuse, **continues to smoke cigarettes daily, diabetes ,type II controlled**, and hypertension presents to the ED with chest pain which started around 4:00 pm. EKG shows 0.5-1 mm ST elevation in inferior leads as well as 0.5-1 mm ST depression in I and aVL. Transfer to cath lab for acute ST elevation MI.
- DX: **Inferior STEMI, RCA culprit lesion.**



Acute Coronary Syndrome (ACS) and Angina

- ACS is an umbrella term for situations where the blood supplied to the heart muscle is suddenly blocked, it lacks clinical specificity
- ACS in terms of ICD-10 translates to Acute Ischemic Heart Disease
- Best Practice Documentation – do not use the term ACS - describe the actual clinical condition you are treating, examples include:
 - NSTEMI, initial episode of care
 - Angina
 - with Coronary Atherosclerosis (unstable or with documented spasm)
 - Unstable
 - Angiospastic
 - Following MI (specify type of MI and onset)



ACS

Documentation Example

Insufficient Documentation

- Patient with ACS. History of CAD, DM, HTN, HLD.

- Type II MI due to demand ischemia

Best Practice Documentation

- Patient admitted with **unstable angina**, positive troponin and EKG changes. Patient ruled in for **NSTEMI**. Past medical history of **native artery CAD, DM 2, HTN** and **HLD**.

- **NSTEMI** due to demand ischemia



Coronary Artery Disease

- Best practice documentation is to specify all three of these key elements when documenting CAD:
- Specify artery
 - Native
 - Bypass graft
- With or without Angina, further defining the type of Angina
 - with Coronary Atherosclerosis (unstable or with documented spasm)
 - Unstable
 - Angiospastic
 - Following MI (specify type of MI and onset)
- Due to
 - Lipid rich plaque
 - Calcified coronary lesion



Angina Documentation Example

Insufficient Documentation

- Patient with chest pain.

Best Practice Documentation

- Patient admitted with **unstable angina**. Troponin sent, for cardiac catheterization this morning.



Cardiomyopathy

Cardiomyopathy can have a host of underlying causes. Best practice documentation is to specify the cause of the cardiomyopathy.

- Ischemic
- Primary
- Dilated
- Obstructive hypertrophic
- Nonobstructive hypertrophic
- Endomyocardial
- Takotsubo (clarify with or without MI)
- Restrictive or Constrictive
- Alcoholic
- Due to drug or other external agent
- Associate with other disease – specify disease (such as amyloidosis, etc.)



Cardiomyopathy Documentation Example

Insufficient Documentation

- History of CM/CHF.

Best Practice Documentation

- Patient with history of **nonischemic cardiomyopathy** and **chronic diastolic CHF**.



Congestive Heart Failure

- Acuity
 - Acute
 - Chronic
 - Acute on chronic
- Type
 - Systolic
 - Diastolic
 - Combined systolic and Diastolic
 - Rheumatic
- Due to or associated with
 - Cardiac or other surgery
 - Hypertension
 - Valvular disease
 - Rheumatic heart disease
 - Endocarditis (valvulitis)
 - Pericarditis
 - Myocarditis



Chronic Heart Failure Documentation Example

Insufficient Documentation

- Patient admitted with CHF. History of CRI, HTN, HLD. Will carefully diurese.
- Patient admitted for treatment of fluid overload due to dialysis noncompliance. Past medical history: CHF, Kidney failure

Best Practice Documentation

- Patient admitted with **acute on chronic systolic and diastolic CHF**. History of **HLD, hypertensive heart disease** and **CKD 2**. Will carefully diurese.
- Patient with **ESRD** is admitted for treatment of fluid overload due to dialysis noncompliance, Patient has history of **chronic systolic heart failure shows no signs of decompensation at this time**.



Conduction Disorders & Dysrhythmias

- Atrioventricular block
 - First degree
 - Second degree
 - Complete
- Bundle-branch block
 - Right
 - Left
 - Bifascicular
- Fascicular
 - Left anterior
 - Left posterior
 - Right
 - Bifascicular
 - Trifascicular



Cardiac Dysrhythmias

- Atrial Fibrillation
 - Paroxysmal
 - Persistent
 - Permanent or Chronic
 - Post op

- Atrial Flutter
 - Typical or Type I
 - Atypical or Type II

- Tachycardia - If paroxysmal, further specify
 - Re-entry ventricular
 - Supraventricular
 - Ventricular
 - Unspecified



Cardiac Arrest / Sudden Cardiac Death

- Identify cardiac arrest as due to or most probably due to:
 - Underlying cardiac condition – specify condition
 - Other underlying condition – specify condition
 - Unspecified cause – document unknown reason



Cardiac Arrest Documentation Example

Insufficient Documentation

- Patient admitted s/p witnessed arrest at home.

Best Practice Documentation

- Patient admitted s/p witnessed cardiac arrest at home. Patient taken to cath lab and received DES to the LAD. **Cardiac arrest due to anterior wall MI.** Patient now stable s/p successful stenting.



Valve Disorders

- Clearly identify the valve(s)
 - Aortic
 - Mitral
 - Pulmonary
 - Tricuspid
- Further define the condition
 - Insufficiency or regurgitation
 - Prolapse
 - Stenosis with or without insufficiency
- Provide the etiology if known:
 - Rheumatic
 - Non-rheumatic
 - Congenital



Heart Valve Documentation Example

Insufficient Documentation

- Pt with severe stenosis, will need valve.

Best Practice Documentation

- Patient presented with **non-rheumatic severe aortic stenosis** and **regurgitation**. AVR scheduled for Thursday.



Postop Hematoma

When a patient undergoes a procedure, such as a cardiac cath, there are times a small hematoma is noted that may or may not be clinically significant.

To provide a clear clinical picture providers should document:

- Site of the hematoma (upper arm, thigh, etc)
- Depth
 - ❑ Skin
 - ❑ Subcutaneous tissue
 - ❑ Muscle
- The clinical significance of the hematoma
 - ❑ Intraoperative complication
 - ❑ Postoperative complication
 - ❑ Expected outcome
 - ❑ Unrelated to the procedure



Key Documentation Concepts

- Identify cause-and-effect relationships (i.e., hypertensive heart disease, unstable angina due to CAD)
- AMI's:
 - Identify:
 - episode of care (initial, subsequent (new AMI occurring within 4 weeks of initial AMI)
 - Type (NSTEMI, STEMI)
 - Site of STEMI
- Specify acute, chronic or acute on chronic when appropriate.
- Specify rheumatic, non-rheumatic, congenital when appropriate
- Be consistent!



Take the Extra Step!

Below are some additional key documentation tips for optimal representation of severity and services.

Document:

- ALL chronic conditions – present and stable but managed.
- Significance of abnormal tests (i.e.: UTI, electrolytes, echo)
- Clarify whether diagnoses are ruled in or ruled out
- Establish cause-and-effect relationships (i.e. PICC line infection)
- Laterality, if applicable
- Explain the “why” and “because” to support medical necessity
- Any tobacco use, abuse, dependence, history of smoke exposure (e.g., second hand, occupational, etc.)