Banner Plans & Networks

Heart Failure Toolkit for PCPs

(Revised May 2025)

Updated 5/7/2025

Contents

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Introduction Letter

Dear Providers:

Banner Plans & Networks (BPN) providers continue to make strides in impacting the quality of care for our members, and as part of the ongoing work our Cardiology Clinical Strategy Committee has devised clinical best practices and a toolkit for PCPs to improve outcomes for patients with heart failure.

Within BPN's Medicare & Medicare Advantage populations, around 18% of members have a heart failure diagnosis, which is above the national average. Additionally, heart failure is often mis- or under-diagnosed, leading to members not getting appropriate care early in their disease state[1].

BPN's heart failure patients have an average annual medical spend about $17,400 more than those without diagnosed heart failure. Hospital readmission and emergency department visits are twice as likely to happen with this patient population and they are 5 times more likely to have an inpatient hospital stay.

To help us better manage patients with heart failure, we have included these tools:

- NEW - Heart Failure Provider One Pager
- Heart Failure Best Practices
- Heart Failure Medication Guidelines (Updated)
- NEW - Heart Failure Action Plan
- NEW – Heart Failure Co-Morbid Conditions
- NEW – Palliative Care and Heart Failure
- Heart Failure Coding and Clinical Documentation Resource (Updated)
- NEW – Direct Test Ordering Guide
- Heart Failure Patient Resources (Updated)

In addition to the resources provided in the toolkit, this video series from American Journal of Managed Care, offers helpful insights for treatment of heart failure in primary care.

https://www.ajmc.com/view/identifying-key-risk-factors-for-heart-failure

Thank you for taking the time to review these materials. We hope these resources assist you in your practice. Thank you for your ongoing work to help BPN make health care easier, so life can be better. Please consult your Care Transformation Consultant with questions.

Sincerely,

Dr. Ed Clarke, MD

VP, CMO Banner Plans & Networks

Heart Failure (HF) Care Guidelines

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Heart Failure (HF) - Provider One Pager

POP
Provider One Pager

Primary care providers (PCPs) play a crucial role play in early identification, treatment, and ongoing care of patients with heart failure.

Early Identification

Many individuals have multiple risk factors, significantly increasing their risk of developing heart failure.[1] Screening high-risk individuals allows for early diagnosis and treatment, preventing further damage to the heart and minimizing complications, leading to better long-term outcomes.

Risk Factors
• Coronary Artery Disease (CAD) • History of Myocardial Infarction (MI) • Hypertension (HTN) • Diabetes • Age 65 years or older • Obesity • Sedentary lifestyle • Smoking/tobacco use • Alcohol or drug abuse

Signs & Symptoms
• Dyspnea and/or orthopnea • Edema in feet, ankles, legs or abdomen • Sudden weight gain • Frequent coughing or wheezing • Unexplained fatigue • Lack of appetite or nausea • Confusion or impaired thinking • Rapid or irregular heartbeat • New onset chest pain

Diagnostic Tools

No single test definitively diagnoses heart failure; a comprehensive evaluation is necessary using both physical examinations and diagnostic tests.

- **ECHO (Echocardiography)** to evaluate ejection fraction and structural abnormalities of the heart.
- **BNP (B-type natriuretic peptide) or NT-proBNP** to check for markers of heart failure.
- **Chest X-ray** to check for pulmonary congestion or pleural effusion.
- **ECG (Electrocardiogram)** to assess for arrhythmias or signs of ischemia.
- **Exercise Stress Test** to measure the heart's function and blood flow under pressure.

Heart Failure Management by PCPs

PCPs are equipped to manage and treat heart failure without a specialist cardiology consult.

Direct Test Ordering

Diagnostic tools such as ECHOs and exercise stress tests are available for **Direct Test Ordering** from one of our preferred cardiology providers.

Provide patient education and a **Heart Failure Action Plan**

Heart Failure Action Plan	
• Educate patients and caregivers about their condition and treatment plan. • Emphasis the importance of medication adherence and daily self-monitoring.	• Ensure patients recognize early signs of worsening heart failure (e.g., sudden weight gain, increased shortness of breath, swelling) that indicate when to seek medical attention.

Recommend Lifestyle Modifications

✓ Recommend a low-sodium, heart-healthy diet and fluid restriction in patients with fluid overload
✓ Promote regular aerobic exercise as tolerated
✓ Encourage weight management
✓ Urge smoking cessation and alcohol reduction

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Guideline-Directed Medical Therapy (GDMT)

Once diagnosis is confirmed, accurate **HF classification and staging** helps guide therapy and prognosis. Follow **GDMT** which is considered the cornerstone of managing heart failure, and has been shown to improve cardiac function, quality of life, and functional status, and to decrease risks of hospitalization and mortality.[2]

Primary Heart Failure Pharmacological Therapy

Optimize medications such as ACE inhibitors, ARBs, beta-blockers, MRAs, and SGLT2 inhibitors based on HF classification and comorbid conditions. In patients with chronic symptomatic HFrEF NYHA II or III who tolerate an ACEi or ARB, replacement by an ARNI is recommended to further reduce morbidity and mortality.

Management to Slow Disease Progression

Monitoring and Follow-up	
• **Frequent Visits**	Schedule Annual Wellness Visits (AWV) and ensure regular follow-up to assess symptom progression, adjust medications, and monitor for side effects.
• **Regular Monitoring**	Keep track of weight, blood pressure, and renal function (especially in patients on diuretics and ACE inhibitors).
• **Heart Rate & Rhythm**	Monitor for arrhythmias, especially atrial fibrillation, which can exacerbate symptoms.
• **Manage Comorbid Conditions**	Managing comorbid conditions in heart failure is a critical component of care, as comorbidities can significantly affect the progression of the disease, its symptoms, and overall prognosis.

Proper Coding

Providers should document the etiology, type, and acuity of heart failure whenever possible. Also include any causative factors, such as alcohol, diabetes, HTN, ischemia, CKD, rheumatic, etc.

Type of Heart Failure	
• Systolic, Diastolic or Combination	• Congestive
• Reduced or preserved ejection fraction	• Left or right side
	• Pre-heart failure
	• End-stage

Acuity/Status of Condition
• Acute (decompensated)
• Chronic (compensated)
• Acute on chronic
• Historical condition only

Indications for Cardiology Co-Management

Heart failure patients should be referred to a cardiologist when newly diagnosed, experiencing severe (NYHA Class III-IV) symptoms, showing rapid deterioration despite treatment, having unclear etiology, requiring advanced therapies/devices, or having recurrent hospitalizations.

Additional Resources

Support Teams & Services		
Care Management Services include: Community resources Disease & lifestyle education Post discharge assistance CM Referral Form	**Mobile Providers** Services include: Home NP/PCP visits Mobile Labs/X-ray Same-day urgent care Home Care Providers	**Palliative Care** Services include: Patient centered treatment goals & condition management Coordination with PCP office Palliative Care Providers

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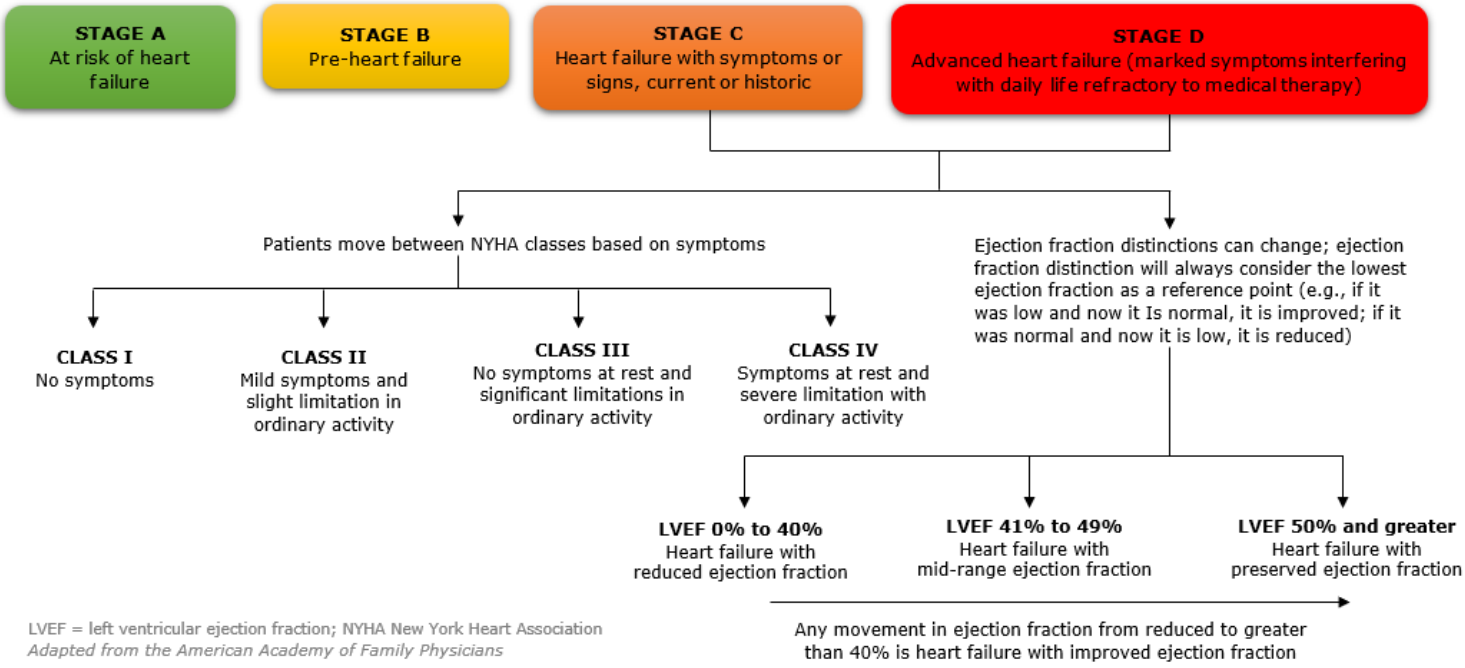
Care Guidelines: Heart Failure (HF)

Heart failure is one of the most common causes of heart-related illness and death in the United States. In fact, it is one of the most common reasons people aged 65 and older go into the hospital. Therapy should be individualized based on comorbid conditions, overall clinical status, tolerance to, and possible contraindications to guideline-directed medical therapy (GDMT).

HF Classification (1)



LVEF = left ventricular ejection fraction; NYHA New York Heart Association
Adapted from the American Academy of Family Physicians

Non-Pharmacologic Heart Failure Management

Regular Clinical Re-Evaluation & Care	• Frequency is dependent on the severity of HF symptoms and comorbid conditions • Early post-discharge provider follow-up (within 7 days) • Annual Wellness Visit (AWV)
Lifestyle Modification	• Diet • Exercise • Weight loss • Smoking cessation • Alcohol use counselling (<2 standard drinks/day for men; <1 standard drink/day for women) • Substance use disorder (SUD) management
Comprehensive Self-Care Education	• Include education on HF Action Plan
Psychosocial Care: **Address potential barriers to self-care**	• Screen for depression, social isolation, frailty, low health literacy, and SUD • Screen for Social Determinants of Health (SDOH) and refer to appropriate resource
Coordinated Care: **Multi-disciplinary care team approach**	To include: • PCP • Consider Cardiology co-management. • Care Management team (RN, SW, Pharmacy, RD, etc.)
Exercise Training/Cardiac Rehabilitation	• Consider in compensated NYHA class II-III
Timely Palliative or Hospice Care Discussions	• Patients with advanced HF refractory to optimum GDMT • Recommend palliative care early for symptom management
Complete Vaccination Evaluation	• Influenza, Covid-19, Pneumococcal, RSV, etc.

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Primary Guideline-Directed Medical Therapy (GDMT) (1)(2)

Stage	LVEF	NYHA Functional Classification	Management Recommendations
A	NA	NA	Control comorbidities Consider SGLT-2i in diabetics
B	>40%	NA	Control comorbidities Consider SGLT-2i in diabetics
	≤40%	Class I	Control comorbidities ACEi (preferred) or ARB Consider Heart failure-specific beta blockers Consider SGLT-2i in diabetics
C and D	≥50% (HFpEF)	Class I	Control comorbidities Consider SGLT-2i in diabetics
		Class II-IV	Control comorbidities Loop diuretics, if congested Consider SGLT-2i Consider (based on lower end LVEFs and comorbidity): • ARNi (preferred) or ACEi or ARB • Heart failure-specific beta blockers • MRA
	41%-49% (HFmrEF)	Class I	Control comorbidities
		Class II-IV	Control comorbidities Loop diuretics, if congested SGLT-2i Consider: • ARNi (preferred) or ACEi or ARB • Heart failure-specific beta blockers • MRA
	≤40% (HFrEF)	Class I	Control comorbidities ACEi or ARBs Heart failure-specific beta blockers
		Class II-III	Control comorbidities ARNi (preferred) or ACEi or ARB Heart failure-specific beta blockers MRA Loop diuretics, if congested SGLT-2i
		Class IV	Control comorbidities Heart failure-specific beta blockers Loop diuretics, if congested MRA SGLT-2i
	Improved from ≤40% (HFimpEF)	All classes	Continue GDMT based on lowest previous EF even in asymptomatic patients to prevent relapse.

Indications For Cardiology Co-Management Referral (3)

- Persistent NYHA Functional class III-IV symptoms while on optimum GDMT
- Systolic BP ≤90 mmHg or symptomatic hypotension
- Creatinine ≥1.8 or BUN ≥43 MG/DL
- Presence of the following history:
  - Atrial Fibrillation
  - Ventricular Arrhythmias
  - Repetitive ICD shocks
- ≥2 ED visits or hospitalizations for worsening HF in prior 12 months
- Persistently reduced LVEF ≤35% despite ≥3 months on optimum GDMT (for consideration of device therapy if no previous use of ICD or CRT)

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Medication Guidelines: Heart Failure (HF)

Primary Heart Failure Pharmacological Therapy

Select one: ARNi, ACEi, or ARB.
Allow a 36-hour washout period when switching from an ACEi to ARNi to minimize potential for angioedema. No washout period is necessary for patients previously on an ARB.

Drug Class	Use/Indication	Drug Options	Starting Dose	Target Dose
Angiotensin II receptor blocker, neprilysin inhibitor (ARNi)	In HFrEF and NYHA II-III, the use of ARNi is recommended to reduce morbidity and mortality. In select HFpEF patients with persistent symptoms and uncontrolled BP despite SGLT2i and MRA optimal therapy, ARNi may be considered to reduce hospitalizations especially in those with lower end of the spectrum LVEF.	Sacubitril/ valsartan	24/26mg-49/51mg BID	97/103mg BID
Ace-inhibitor (ACEi)	Used as second line therapy if ARNi is not tolerated or is not affordable. The use of ACEi is beneficial in reducing morbidity and mortality.	Captopril Enalapril Fosinopril Lisinopril Perindopril Quinapril Ramipril Trandolapril	6.25mg TID 2.5mg BID 5-10mg QDay 2.5-5mg QDay 2mg QDay 5mg BID 1.25-2.5mg QDay 1mg QDay	50mg TID 10-20mg BID 40mg QDay 20-40mg QDay 8-16mg QDay 20mg BID 10mg QDay 4g QDay
Angiotensin II receptor blocker (ARB)	In patients with previous or current symptoms of chronic HFrEF who are intolerant to ACEi because of cough or angioedema and when the use of ARNi is not feasible, the use of ARB is recommended to reduce morbidity and mortality.	Candesartan Losartan Valsartan	4-8mg QDay 25-50mg QDay 20-40mg QDay	32mg QDay 50-150mg QDay 160mg BID
Heart Failure Beta Blocker	Indicated in HFrEF and HFmrEF. Considered in HFpEF if comorbidity warrants. Can also be considered in HFpEF at lower end of LVEF range. The use of one of the three HF beta blockers is recommended to reduce mortality and hospitalizations.	Bisoprolol Carvedilol Carvedilol CR Metoprolol (CR/XL)	1.25mg QDay 3.125mg BID 10mg QDay 12.5-25mg QDay	10mg QDay 25-50mg BID 80mg QDay 200mg QDay

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Drug Class	Use/Indication	Drug Options	Starting Dose	Target Dose
SGLT2-inhibitor	SGLT2-inhibitors are recommended to reduce hospitalization for HF and cardiovascular mortality irrespective of the presence of type 2 diabetes. Caution initiating with impaired renal function. Avoid use in Type 1 diabetics and in diabetics with history of, or predisposition to, DKAs.	Dapagliflozin Empagliflozin	10mg QDay 10mg QDay	10mg QDay 10mg QDay
Mineralocorticoid Receptor Antagonist (MRA)	MRA can be used in both HFrEF and HFpEF with evidence of weaker efficacy in HFpEF than in HFrEF. MRA can be used if eGFR >30mL/min/1.73m^2 and serum potassium is <5.0 mEq/L. Careful monitoring of potassium, renal function, and diuretic dosing should be performed at initiation and closely monitored according to clinical status (approximately 1 week, then 4 weeks, then every 6 months afterward) to minimize risk of hyperkalemia and renal insufficiency.	Spironolactone Eplerenone	12.5-25mg QDay 25mg QDay	25-50mg QDay 50mg QDay
Vasodilators	Recommended in African-American patients in NYHA III-IV	Hydralazine/ isosorbide dinitrate	37.5mg/20mg TID	75mg/40mg TID

Medications to Avoid with Heart Failure (not-all inclusive)

Medication Class	Rationale	Alternatives to consider
Thiazolidinediones (in HFrEF)[1-3] (i.e. Pioglitazone)	Increases risk of HF decompensation/hospitalizations	Metformin (in stable heart failure) or SGLT2 inhibitor if appropriate
Non-dihydropyridine calcium channel blockers (in HFrEF)[1][4-6] (i.e. Diltiazem)	Higher risk of recurrent HF symptoms	Amlodipine
NSAIDs [1][7-8] (i.e. Ibuprofen/Naprosyn)	Increases morbidity and mortality	Acetaminophen
DDP-4 (Saxagliptin and Alogliptin only)[1][9]	Concern for increased risk of HF hospitalizations	Metformin (in stable heart failure) or SGLT2 inhibitor if appropriate

ACEi/ARBs should not be used with a history of angioedema/other allergic reactions. Caution utilizing ARNIs with hypotension, advanced kidney disease, or hyperkalemia.[1] These situations may require ARNI temporary discontinuation, lower dosing, or switching between classes. True contraindications to goal directed medication therapy are rare, such as advanced degree atrioventricular block and the use of beta blockers in the absence of pacemakers, or cardiogenic shock that has not resolved.

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Heart Failure (HF) Action Plan

A heart failure action plan is crucial for managing and improving outcomes for patients with heart failure and should be based on the type of heart failure, severity of the condition, as well as the patient's age and comorbidities. Taking a proactive approach is a vital to:

- Preventing hospitalizations and readmissions
- Slowing disease progression
- Improving quality of life

Heart Failure Action Plan/Self Check Plan

Every patient with heart failure should have a personalized **Heart Failure Action Plan** or **Self Check Plan** and should be encouraged to keep a written copy where it is easy to locate. This plan can help empower patients and their caregivers to manage their condition by:

- Daily monitoring and medication adherence
- Recognizing early warning signs of worsening symptoms
- Understanding when to contact their provider or seek emergency care

Refer to the **Heart Failure Action Plan Zones Chart** below for corresponding symptoms:

Green Zone (Stable)	**No changes needed, continue:** ✓ Daily weight checks ✓ Eat low salt/sodium food ✓ Take medications as directed ✓ Monitor symptoms ✓ Balance activity and rest ✓ Follow-up visits with providers
Yellow Zone (Caution)	**Contact doctor or health care team** • Symptoms may indicate that an adjustment in lifestyle or medications is needed
Red Zone (Emergency)	**See a doctor or heath care professional right away** • Call 911 or go to ER immediately

Heart Failure Action Plan Zones

Green Zone: Stable Continue Self-Management	
• Symptoms are under control • No new or worsening shortness of breath • No swelling in feet, ankles, legs or abdomen	• Weight is stable • No chest pain • Physical activity is normal

⚠ **Heart Failure Warning Zones**	
Yellow Zone: CAUTION Contact Health Care Team	**Red Zone: EMERGENCY Seek Immediate Medical Care!**
• Chronic dry, hacking cough • Worsening shortness of breath with activity or while lying flat • Increased swelling in legs, ankles, feet or abdomen • Sudden weight gain of >2-3lbs in 24-hour period (or 5 lbs. within a week) • Increased fatigue/ tiredness	• Frequent dry, hacking cough • Struggling to breath/ unrelieved shortness of breath even at rest • Severe swelling in legs, ankles, feet or abdomen • New or worsening dizziness or confusion • New onset chest pain • Loss of appetite

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Heart Failure (HF) Comorbid Conditions

Managing comorbid conditions in heart failure (HF) is a critical component of care, as comorbidities can significantly affect the progression of the disease, its symptoms, and overall prognosis. The role of primary care providers (PCPs) is essential in managing these comorbidities alongside heart failure treatment.

Condition and Impact on Heart Failure	Management
Chronic Obstructive Pulmonary Disease (COPD) Often coexists with HF, particularly in older adults, and managing both conditions is essential.	**Medications:** Continue COPD management with bronchodilators (beta-agonists, anticholinergics) and corticosteroids as indicated. Be cautious with beta-blockers as they can exacerbate bronchospasm, though they are often necessary for HF. **Oxygen therapy:** For patients with hypoxia or advanced COPD. **Pulmonary rehabilitation:** Encourage participation to improve functional capacity.
Hypertension Is a major risk factor for the development and progression of HF, particularly HF with preserved ejection fraction (HFpEF).	**Medications:** ACE inhibitors, ARBs, beta-blockers, and calcium channel blockers are used to control blood pressure. **Lifestyle modifications:** Encourage weight management, low-sodium diet, exercise, and alcohol reduction. **Regular monitoring:** Regular BP checks to adjust medications and ensure target levels (generally <130/80 mm Hg) are achieved.
Diabetes Mellitus Increases the risk of HF, worsens prognosis, and can complicate management due to medication interactions and the effects of hyperglycemia on heart function.	**Glycemic control:** Target A1c of 7% or lower, but individualized. **Medications:** Metformin is often first-line unless contraindicated (e.g., renal insufficiency). SGLT2 inhibitors (like empagliflozin or dapagliflozin) are recommended for HF with reduced ejection fraction (HFrEF), as they improve outcomes. **Lifestyle**: Encourage diet modification, regular exercise, and weight management.
Chronic Kidney Disease (CKD) Often coexists with HF and can worsen both conditions, leading t"cardiorenal syndrome."	**Medications**: Adjust doses of HF medications (e.g., ACE inhibitors, ARBs, diuretics) based on kidney function. Use SGLT2 inhibitors carefully, as they are beneficial in both HF and diabetes but require renal monitoring. **Monitor kidney function**: Regular monitoring of creatinine and GFR. Avoid nephrotoxic agents where possible. **Fluid management**: Cautious use of diuretics to prevent volume overload without worsening kidney function.
Atrial Fibrillation Is common in patients with HF and can worsen symptoms and increase the risk of stroke.	**Rate control**: Beta-blockers, calcium channel blockers (verapamil or diltiazem), or digoxin. **Rhythm control**: Antiarrhythmic drugs (e.g., amiodarone, flecainide) may be considered. **Anticoagulation**: Use anticoagulation for stroke prevention based on CHA2DS2-VASc score (commonly apixaban, rivaroxaban, or warfarin). **Close monitoring**: Regular ECGs to assess rhythm and adjust therapy as needed.

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Condition and Impact on Heart Failure	Management
Anemia Can worsen HF symptoms by decreasing oxygen delivery to tissues.	**Screening:** Regular hemoglobin and hematocrit measurements. **Iron supplementation:** For iron deficiency anemia (oral or IV iron). **Erythropoiesis-stimulating agents:** May be considered in severe anemia, especially in CKD.
Hyperlipidemia Is a risk factor for the development of coronary artery disease, which can contribute to heart failure.	**Statins:** Use statins for cardiovascular disease prevention unless contraindicated (e.g., in advanced HF with very low ejection fraction, where the benefit may be less clear). **Lifestyle:** Diet modification (low-fat, heart-healthy diet), exercise, and weight loss.
Depression and Anxiety Are common in HF patients and can negatively affect quality of life and adherence to treatment.	**Screening:** Use screening tools such as the PHQ-9 for depression and GAD-7 for anxiety. **Treatment:** Antidepressants (SSRIs/SNRIs) or referral to counseling and psychotherapy (cognitive-behavioral therapy) if necessary. **Support:** Encourage participation in support groups or other mental health resources.
Obstructive Sleep Apnea (OSA) Is common in HF and can worsen both HF symptoms and outcomes.	**Screening:** Ask about symptoms of sleep apnea (e.g., loud snoring, daytime sleepiness). **Treatment:** CPAP (continuous positive airway pressure) therapy for patients diagnosed with OSA or Inspire therapy, a minimally invasive, FDA-approved treatment for OSA that uses an implanted device to keep the airway open during sleep. **Weight loss:** Encourage weight management, as it can improve sleep apnea severity.
Obesity Contributes to the development and worsening of HF, particularly HFpEF, and can complicate medication adherence.	**Lifestyle interventions:** Diet modifications (low-sodium, Mediterranean diet), weight loss programs, and regular exercise (such as walking, swimming). **Psychosocial support:** Refer to weight management programs and counselors if needed. **Consider bariatric surgery:** In severe cases of obesity, if other methods fail.

Palliative Care in Heart Failure (HF)

Palliative care is team based supportive care and plays a crucial role in improving the quality of life for individuals living with heart failure (HF), particularly those with advanced or end-stage heart disease. It is important to remember that palliative care is appropriate at any stage of the disease journey, not just at the end of life and can work alongside other treatments aimed at improving heart function or managing acute symptoms.

Palliative care is NOT synonymous with hospice care

While heart failure is a chronic and progressive condition, palliative care focuses on symptom management, emotional support for patients and their caregivers, and helping guide decision-making at different stages of the disease.

Components	Approach and Interventions
Multidisciplinary Team Based-Care & Coordination of Care	• **Team Based-Care:** Palliative care providers collaborate with primary care, cardiologists, social workers, dietitians, spiritual care providers, and other specialists to ensure seamless communication amongst the care teams to provide coordinated, holistic care. • **Care Coordination:** Help patients and families navigate complex healthcare needs and systems, ensuring continuity of care, and preventing unnecessary hospitalizations.
Symptom Management	• **Dyspnea:** One of the most common and distressing symptoms in advanced heart failure. Palliative care can provide medications like opioids to ease breathlessness or use non-pharmacological interventions like supplemental oxygen or positioning. • **Fatigue:** A hallmark of heart failure and can significantly affect daily functioning. Palliative care can provide energy conservation techniques and help in planning daily activities, balancing rest and activity. Medications like antidepressants may also be considered if fatigue is related to depression. • **Pain/Discomfort:** Some patients with advanced disease may experience discomfort, either from the heart failure itself or comorbid conditions and can be managed with analgesics, including opioids in appropriate doses. • **Edema:** Medications, such as diuretics, can help reduce fluid buildup. Palliative care providers can also assist with physical therapies and techniques to relieve swelling and reduce discomfort. • **Depression and Anxiety:** It is common for heart failure patients to experience mental health struggles. Counseling, cognitive behavioral therapy, and antidepressant or anti-anxiety medications can be helpful.
Psychosocial Support & Family Support	• **Emotional Support:** Addresses the psychological impact of advanced heart failure, including grief, fear, and loss of independence. • **Caregiver Support:** The physical and emotional toll on caregivers can be significant. Offering support, counseling, respite care, and educational resources can help families navigate the challenges of a serious illness.
Advance Care Planning	• **Goals of Care:** Palliative care teams help facilitate conversations with patients and families about the prognosis and disease progression. This process allows patients to express their wishes regarding treatment goals, advance directives, code status and end of life care.
Transition to Hospice Care	• **End of Life Care:** For patients with end-stage heart failure, where prognosis is limited, palliative care can help transition to hospice services. This provides a focus on comfort care during the final stages of life, aiming for dignity, pain control, and support for both the patient and family.

Palliative Care Providers List

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Heart Failure Coding and Clinical Documentation

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Clinical Documentation: Heart Failure and Pre-Heart Failure

THE DIAGNOSIS	Heart Failure and Pre-Heart Failure
COMMON CONDITIONS INCLUDED IN HCC GROUP 226 **RAF Score = 0.360**	Heart failure, unspecified (Pre-HF) – I50.9 Left ventricular failure – I50.1 Chronic systolic (congestive) heart failure (HFrEF) – I50.22 Chronic diastolic (congestive) heart failure (HFpEF) – I50.32 Chronic right heart failure – I50.812
KEY CODING or DOCUMENTATION TIPS	There is a causal relationship between heart failure and hypertension. If your patient has heart failure and it is NOT linked to a declining cardiovascular status due to hypertension, then your note needs to explain that the two are not linked. Essential or benign hypertension (I10) is NOT the most appropriate diagnosis for a patient with heart failure, and the coder should update the diagnosis or query the provider.
MEAT the DOCUMENTATION **M = Monitor** **E = Evaluate** **A = Assess/Address** **T = Treat**	Assessment and Plan example: **Heart failure, unspecified (I50.9)** **Hypertensive heart disease with heart failure (I11.0)** Mr. X presents today for his wellness exam. He reports that he saw Dr. Cardio regarding his heart failure last month and no new medications were added. His blood pressure today was 142/84 and he denies any SOB or chest pain. He has 2+ pitting edema in bilat legs. Heart sounds normal, no gallop or murmur. Reviewed lab results taken last month after his cardiology appointment with him and answered all questions regarding his heart failure. M – Signs and symptoms, such as chest pain, SOB, edema. E – Test results or vital signs, such as BNP or renal panels. A – Order tests or patient discussion, such as echocardiogram. T – Medications, therapy, or other modalities, Entresto or cardiac rehab.
IMPACT on QUALITY – HEDIS MEASURE	Heart failure diagnoses (I50.x) are considered advanced illness diagnoses. When added to a claim twice in the current or prior year meets the advanced illness criteria. Frailty or advanced illness, ESRD, and/or palliative care diagnosis codes may provide a denominator exclusion. CMS quality metrics regarding heart failure: • CMS 135 – HF: ACE or ARB or ARNI Therapy for LV systolic dysfunction • CMS 144 – HF: Beta-blocker therapy for LV systolic dysfunction

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Clinical Documentation: ESHF/Heart Assistive Devices

THE DIAGNOSIS	End Stage Heart Failure and Heart Assistive Devices
COMMON CONDITIONS INCLUDED IN HCC GROUP 222/223 **RAF Score = 2.505**	HCC 222: • End stage heart failure (ESHF) – I50.84 HCC 223: • Presence of heart assist device – Z95.811 • Presence of fully implantable artificial heart – Z95.812
KEY CODING or DOCUMENTATION TIPS	Consider ESHF as the patient's diagnosis if the patient has evidence of Stage D, Class III/IV heart failure. ESHF disrupts the patient's ADLs and severe symptoms persist despite being on the optimal medical therapy. Expect the patient to have the following findings: (1) EF ≤ 25%, (2) Significant (echo) structural findings that indicate worsening heart function, (3) Frequent hospitalizations for HF issues, (4) Two signs and symptoms "at rest" – SOB, chest pain, dyspnea, persistent cough, inability to lie flat, etc., (5) two or more heart failure medications to support heart function and symptoms of HF. <u>Provider documentation of the clinical evaluation and judgement is the gold standard of this diagnosis.</u> You may see this condition suspected based on a prospective review of the patient's chart. The concurrent coder may query a provider if there are any questions regarding this diagnosis.
MEAT the DOCUMENTATION **M = Monitor** **E = Evaluate** **A = Assess/Address** **T = Treat**	Assessment and Plan example: **End-stage heart failure (I50.84)** **Hypertensive heart disease with heart failure (I11.0)** Mr. P presents today for his AWV. The patient reports that he has no energy and can't sleep in his bed anymore. He sleeps in his recliner. He can't put his socks on anymore, and he gets SOB walking to the bathroom with is walker. He saw Dr. Cardio regarding his heart failure last month and they reviewed his recent Echo. His EF is 22%. He is on metoprolol and lisinopril. His blood pressure today was 112/65. He has 3+ pitting edema in bilat legs. Heart sounds muffled and S4 gallop noted. Rales bilaterally. **M** – Signs and symptoms, such as chest pain, SOB, edema, at rest. **E** – Test results or vital signs, such as EF and BNP **A** – Order tests or patient discussion, such as echocardiogram. **T** – Medications, therapy, or other modalities, Entresto or cardiac rehab.

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IMPACT on QUALITY – HEDIS MEASURE	ESHF and Heart Assistive Devices diagnoses are considered advanced illness. When added to a claim twice in the current or prior year meets the advanced illness criteria and will remove a patient from the denominator for many quality metrics. Frailty or advanced illness, ESHF, ESRD, and/or palliative care diagnosis codes may provide a denominator exclusion. CMS quality metrics regarding heart failure: • CMS 135 – HF: ACE or ARB or ARNI Therapy for LV systolic dysfunction • CMS 144 – HF: Beta-blocker therapy for LV systolic dysfunction Remember that I10 – essential or benign hypertension is NOT an appropriate diagnosis for someone with advanced heart disease. Make sure to use I11.0, I13.0, or I13.2 for your patient with ESHF and/or an assistive heart device. This will be the most appropriate code for the patient, and it removes them from the high blood pressure quality metric. • CMS 165 – Controlling High Blood Pressure

Heart Failure (HF) Coding and Clinical Documentation

Providers should document the etiology, type, and acuity of heart failure (HF) whenever possible:

Type of Heart Failure

- Systolic, Diastolic or Combination Systolic and Diastolic
- Reduced or preserved ejection fraction (HFrEF. HFimpEF, or HFpEF)
- Congestive
- Left or right side
- Pre-heart failure
- End-stage

Acuity/Status of the Condition

- Acute (decompensated)
- Chronic (compensated)
- Acute on chronic
- Historical condition only

It is good practice to include the status of the ejection fraction (EF). For example, a patient with HF and an EF ≤40 is considered to have heart failure with reduced ejection fraction or HFrEF (I50.22). Also include any causative factors, such as alcohol, diabetes, hypertension, ischemia, kidney disease, rheumatic, and so on. Remember, heart failure is not always "congestive," and selecting a diagnosis to the highest level of specificity (such as left, right, HFrEF, HFpEF, PreHF, etc.) is highly recommended.

Terms such as *diastolic dysfunction* or *restrictive ventricular disease* are not synonymous with heart failure and requires provider linkage to heart failure to select the appropriate code. The Coder should query for the provider for the specific condition(s).

Coding Guidelines – Heart Failure (HF) – I50.XX

Remember to first code the following diagnoses, if applicable:

Code First

- heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
- heart failure due to hypertension (I11.0)
- heart failure due to hypertension with chronic kidney disease (I13.-)
- heart failure following surgery (I97.13-)
- obstetric surgery and procedures (O75.4)
- rheumatic heart failure (I09.81)

Excludes 2 Note: The following codes are allowed to be coded with the HF codes, if applicable and documented by the clinician:

- cardiac arrest (I46.-)
- neonatal cardiac failure (P29.0)

Important to remember

When seeing your patient for a post hospitalization follow-up for heart failure, add the appropriate diagnosis code and documentation for the patient's health status at the time of the visit. Do not utilize the inpatient admit and discharge diagnoses.

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Hierarchical Condition Categories for Heart Failure

When the V28 CMS HCC risk adjustment model was introduced, it was noted that the heart failure and heart disease diagnoses that were once lumped into HCC 85 (V24 model) are now broken out into five distinct groups. Two additional groups were added for diagnoses that were part of HCC 186 and are part of the heart hierarchy, which focus on heart transplants and heart assistive devices. Breaking these diagnoses out into separate groups allows for more precise and accurate risk adjustment factor (RAF) values to be assigned to these distinctly different diagnostic groups, which vary significantly by complexity. This further allows for more appropriate allocation of funds for the proper care of patients who fall into these groups that require increased frequency of visits and/or tests and monitoring. The HCC groups, description and RAF values are listed below.

V28 HCC Group	Description	V28 RAF
HCC221	Heart Transplant Status/Complications	1.053
HCC222	End-Stage Heart Failure	2.505
HCC223	Heart Failure with Heart Assist Device/Artificial Heart	2.505
HCC224	Acute on Chronic Heart Failure	0.360
HCC225	Acute Heart Failure (Excludes Acute on Chronic)	0.360
HCC226	Heart Failure, Except End-Stage and Acute	0.360
HCC227	Cardiomyopathy/Myocarditis	0.189

Other Specialized Heart Failure Diagnoses

- **Pre-Heart Failure (PreHF) – I50.9**
  - Stage B heart failure per the American College of Cardiology and the American Heart Association.
  - Persons without current or previous symptoms of heart failure AND either structural heart disease, abnormal cardiac function (such as filling pressures), or other risk factors (such as abnormal BPN when no signs of CKD or myocarditis).
    - Examples of structural heart disease
      - Left ventricular hypertrophy (LVH)
      - Valvular heart disease
      - Chamber dilation (atrial and ventricular)
      - Cardiomyopathy

Note: heart failure stages A, B, C, and D are based on the American College of Cardiology and American Heart Association stages for heart failure, which complement, and should not be confused with, the New York Heart Association Classification of Heart Failure, into Class I, Class II, Class III, and Class IV

stage A Z91.89
stage B (*see also* Failure, heart, by type as diastolic of systolic) I50.9
stage C (*see also* Failure, heart, by type as diastolic of systolic) I50.9
stage D (*see also* Failure, heart, by type as diastolic of systolic, chronic) I50.84

Page 259 of the AAPC 2024 ICD-10-CM Expert coding book.

- **End Stage Heart Failure (ESHF) – I50.84**
  - Stage D heart failure.
  - Advance stage of heart failure, in which the heart has become too weak to effectively pump blood throughout the body.

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- **End Stage Heart Failure (ESHF) – I50.84 (continued)**
  - The patient begins to have more signs and symptoms of HF at rest.
  - BPN recommended clinical signs for classifying ESHF:
    - Echo ≤ 25% **AND**
    - Structural findings on echo (Ex. - LVH, LAD, DD, etc.) **AND**
    - Two HF medications **AND**
    - Signs and Symptoms – usually more than one that significantly interfere with performing one's ADLs.
      - SOB at rest
      - Dyspnea at rest
      - Persistent cough
      - CP at rest
      - Pitting edema – grade 3 or 4
      - Extreme fatigue/weakness
      - Inability to lie flat (when sleeping)
      - Cardiac assist devices
      - Frequent hospitalization for HF

- **Hypertensive Heart Disease**

  Essential hypertension is the most common ICD-10 diagnosis used across the country. It is also known that hypertension, especially uncontrolled hypertension, is a precursor for many other health conditions, such as heart failure (HF) and chronic kidney disease (CKD). Providers may not be aware that the AMA assumes a causal relationship between hypertension and the previously mentioned diseases. So much so, that for CKD *not to "be linked"* to hypertension, the provider is required to document that the patient's declining kidney health is due to another reason, like polycystic kidney disease.

  CMS 165, the Controlling High Blood Pressure (C-HBP) quality metric, looks for two things when determining who falls into the denominator for the C-HBP quality measure:

  - A diagnosis of essential hypertension (I10) during the previous year or first 6 months of the current measurement year.
  - A qualifying adult outpatient encounter.

  If your patient has hypertension, heart failure, and/or CKD, you will want to select the diagnosis code most appropriate for them.

  There are two key elements that *must be included* when using the hypertensive heart and/or chronic kidney disease diagnoses:

  - You must include the corresponding HF, CKD, or HF & CKD diagnoses in the same visit encounter:
    - Unspecified systolic (congestive) heart failure – I50.20
    - CKD Stage 3a – N18.31
    - Chronic systolic (congestive) heart failure (HFrEF) – I50.22
    - CKD Stage 3b – N18.32
    - Chronic diastolic (congestive) heart failure (HFpEF)– I50.32
    - CKD Stage 4 – N18.4
    - Heart failure, unspecified – I50.9
    - CKD Stage 5 – N18.5

- You must include the appropriate documentation to support your medical decision making for this diagnosis. Remember the MEAT mnemonic may help!

Clinical Documentation Examples:

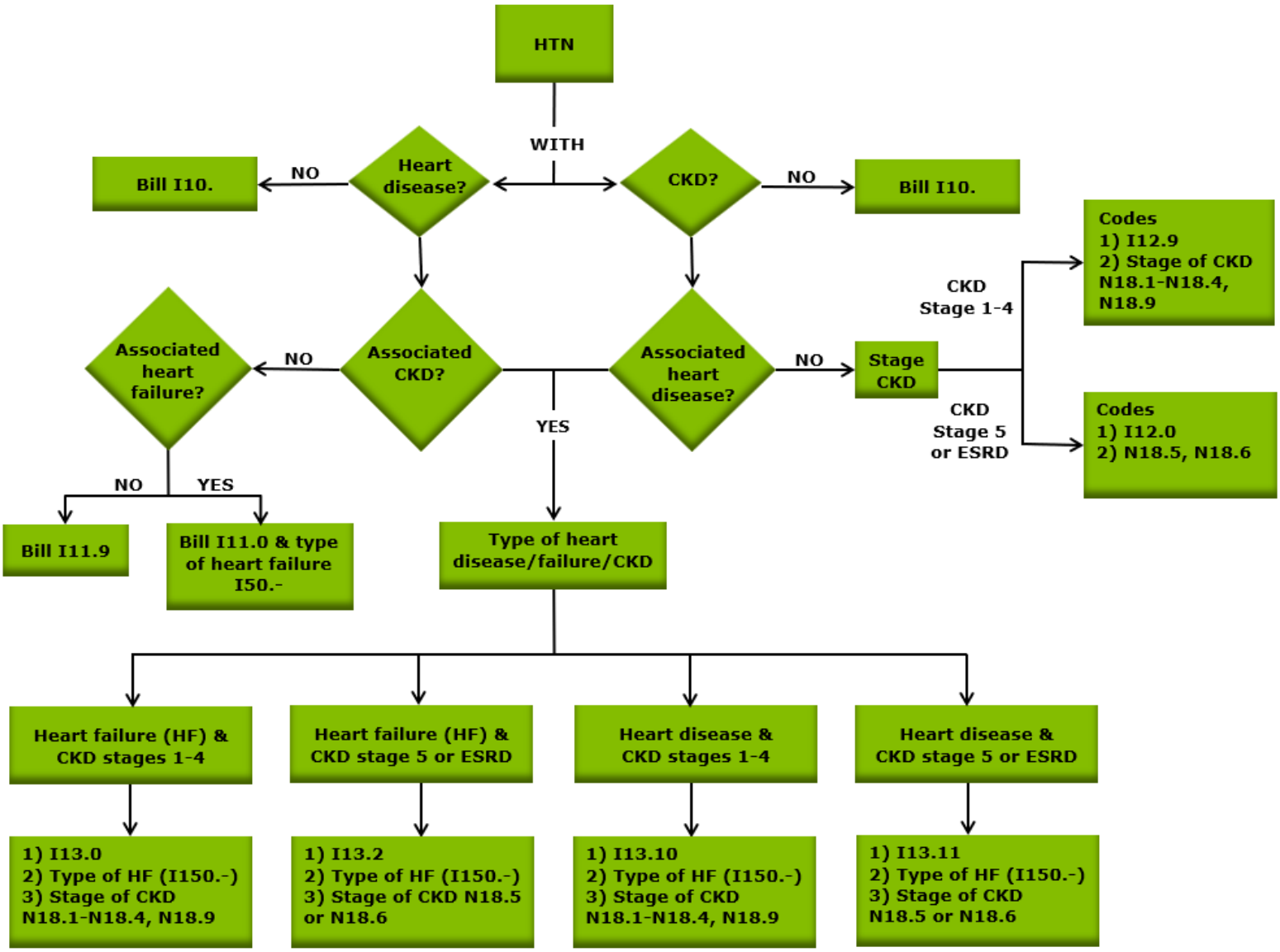
Below are two examples of appropriate documentation for two different patients who have heart failure.

- **A/P**:
  - Mr. X is a 68-year-old male patient seeing his PCP for his annual physical.
    - Hypertensive heart disease with systolic heart failure (I11.0, I50.20)
      - BP 152/88 today. On valsartan with moderate control. Review of labs show potassium 3.8. +1 pitting edema in bilateral ankles/feet. Has scheduled follow-up with cardiologist next week. No changes to meds.
- **Putting it all together**:
  - 65-year-old male with a hx of MI 5 years ago, smoking x 30 years and quitting 5 years ago is here for worsening LE edema (painful) and 7 lb. weight gain. He does have a hx of well controlled diabetes and "mild kidney disease". He is taking medication for his blood pressure. At his last office visit he was ordered an Echocardiogram with his results ready for review.
    - Ht: 5'8", Weight: 260 lbs, T: 98.6, RR: 16, HR: 94, BP 146/92, BMI 39.5
    - PMHX: HTN, Obesity, Diabetes, Hx MI
    - SocHX: 30 ppy hx – quit 5 years ago, School teacher.
    - Meds: Lisinopril 20 mg, Metformin 1000mg bid
    - Labs: GFR: 27 (last week) and 29 (3 mon ago) HGBA1C 7.3
    - Echo: EF 35%, Left atrial enlargement
    - GEN: Well-appearing, obese
    - CV: RRR, S1, S2
    - PULM: Decreased breath sounds
    - EXT: +2 pitting edema bilaterally to shins. Varicose veins bilaterally

    A/P:
    1. HFrEF – I50.22 (0.360) – Start sacubitril/valsartan 49/51 bid and metoprolol 25mg ER once daily. Discussed pressure socks/stockings. May consider spironolactone at next visit.
    2. Hypertensive heart and kidney disease – I13.0 (No RAF) – Start sacubitril/valsartan 49/51. Start metoprolol 25 mg ER once daily, stop lisinopril.
    3. CKD Stage 4 – N18.4 (0.514) – Avoid NSAIDs, encourage weight loss. Keep bp controlled. Monitor q 3 months.
    4. Diabetes with CKD –E11.22 (0.166)– Start Dapagalifozin 5 mg once daily. Stop Metformin (low GFR)
    5. Obesity, class 3– E66.813 (0.186) – Obesity complicated by diabetes and heart failure. *Referral* to dietitian. BMI 39.5 with comorbid condition of CHF

Remember to always tell the best patient story when selecting the most appropriate diagnosis and completing your documentation!

Coding Decision Tree



These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Heart Failure Coding

Heart Failure Diagnosis	ICD-10-CM Diagnosis Code	HEDIS Exclusion	Frailty Diagnosis	Which Quality Metric	Coding Guidelines and Documentation Best Practice
Rheumatic heart failure	I09.81	**	Yes		There is no causal relationship to hypertension with this diagnosis.
Left ventricular failure, unspecified	I50.1	**	Yes		If a more specific diagnosis is known, do not use this code.
Unspecified systolic (congestive) heart failure	I50.20	**	Yes		If the diagnosis used includes preserved ejection fraction, you will need to document the most recent HFpEF in your note.
Acute systolic (congestive) heart failure	I50.21	**	Yes		Acute conditions are expected to resolve and should not be added month after month.
Chronic systolic (congestive) heart failure	I50.22	**	Yes		
Acute on chronic systolic (congestive) heart failure	I50.23	**	Yes		Acute conditions are expected to resolve and should not be recaptured annually.
Unspecified diastolic (congestive) heart failure	I50.30	**	Yes		
Acute diastolic (congestive) heart failure	I50.31	**	Yes		Acute conditions are expected to resolve and should not be recaptured annually.
Chronic diastolic (congestive) heart failure	I50.32	**	Yes		
Acute on chronic diastolic (congestive) heart failure	I50.33	**	Yes		Acute conditions are expected to resolve and should not be recaptured annually.
Unspecified combined systolic (congestive) and diastolic (congestive) heart failure	I50.40	**	Yes		
Acute combined systolic (congestive) and diastolic (congestive) heart failure	I50.41	**	Yes		Acute conditions are expected to resolve and should not be recaptured annually.
Chronic combined systolic (congestive) and diastolic (congestive) heart failure	I50.42	**	Yes		
Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	I50.43	**	Yes		Acute conditions are expected to resolve and should not be recaptured annually.
Right heart failure, unspecified	I50.810	**	Yes		If a more specific diagnosis is known, do not use this code.

** = The diagnosis is considered a frailty and/or advanced illness diagnosis and may aid in a quality metric exclusion.

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Heart Failure Diagnosis	ICD-10-CM Diagnosis Code	HEDIS Exclusion		Which Quality Metric	Coding Guidelines and Documentation Best Practice
Acute right heart failure	I50.811	**	Yes		Acute conditions are expected to resolve and should not be recaptured annually.
Chronic right heart failure	I50.812	**	Yes		
Acute on chronic right heart failure	I50.813	**	Yes		Acute conditions are expected to resolve and should not be recaptured annually.
Right heart failure due to left heart failure	I50.814	**	Yes		
Biventricular heart failure	I50.82	**	Yes		
High output heart failure	I50.83	**	Yes		
End stage heart failure	I50.84	**	Yes		
Other heart failure	I50.89	**	Yes		If this diagnosis is selected, the "other" type of heart failure must be noted in the documentation.
Heart failure, unspecified	I50.9	**	Yes		If a more specific diagnosis is known, do not use this code.
Pediatric Heart Failure	**ICD-10-CM Diagnosis Code**	**HEDIS Exclusion?**	**Frailty Diagnosis?**	**Which Quality Metric**	**Coding Guidelines and Documentation Best Practice**
Neonatal cardiac failure	P29.0	No	NA	NA	New diagnosis to risk adjustment model in 2024.
Hypertensive Heart Disease	**ICD-10-CM Diagnosis Code**	**HEDIS Exclusion?**	**Frailty Diagnosis?**	**Which Quality Metric**	**Coding Guidelines and Documentation Best Practice**
Hypertensive heart disease with heart failure	I11.0	Yes	Yes	CBP	There is an assumed causal relationship between hypertension and heart failure. Therefore, if the patient's HF is not due to hypertension, you will need to add the cause of the heart failure to your documentation.

** = The diagnosis is considered a frailty and/or advanced illness diagnosis and may aid in a quality metric exclusion.

Key	
Controlling High Blood Pressure	CBP
Kidney Health Evaluation for Patients with Diabetes	KED

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Hypertensive Heart Disease	ICD-10-CM Diagnosis Code	HEDIS Exclusion?	Frailty Diagnosis?	Which Quality Metric	Coding Guidelines and Documentation Best Practice
*Hypertensive heart disease without heart failure**	I11.9	Yes	No	CBP	There is an assumed causal relationship between hypertension and heart failure. Therefore, if the patient's HF is not due to hypertension, you will need to add the cause of the heart failure to your documentation.
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I13.0	Yes	Yes	CBP	There is an assumed causal relationship between hypertension and heart failure. Therefore, if the patient's HF is not due to hypertension, you will need to add the cause of the heart failure to your documentation.
*Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease**	I13.10	Yes	No	CBP	There is an assumed causal relationship between hypertension and heart failure. Therefore, if the patient's HF is not due to hypertension, you will need to add the cause of the heart failure to your documentation.
Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	I13.11	Yes	Yes	CBP, KED	There is an assumed causal relationship between hypertension and heart failure. Therefore, if the patient's HF is not due to hypertension, you will need to add the cause of the heart failure to your documentation.
Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	I13.2	Yes	Yes	CBP, KED	There is an assumed causal relationship between hypertension and heart failure. Therefore, if the patient's HF is not due to hypertension, you will need to add the cause of the heart failure to your documentation.

**Note: No HF HCC or RAF, but important to meet CBP quality measure.*

Key	
Controlling High Blood Pressure	CBP
Kidney Health Evaluation for Patients with Diabetes	KED

Palliative Care – ICD-10-CM: Z51.5

Quality Metric Exclusions:

- Palliative Care, Pregnancy, Death during the measurement year, ESRD, Dialysis
- Kidney transplant, Nephrectomy, Age 66 - 0 w/ dx of frailty AND advanced illness, or age ≥ 81 two indications of frailty during two different encounters

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Direct Test Ordering

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Direct Test Ordering

Direct Test Ordering (No Consult Required)						
	BMG	**BUMG**	**Cardiac Solutions**	**CVAM**	**Phoenix Heart**	**Tri-City**
TIN	900730397	901116753	860633950	860711625	860770482	860516994
ECHO	YES	BUMG Patients Only	YES			
Exercise Stress Test	YES	BUMG Patients	YES			
Nuclear Stress Test	**Cardio Consult Required**	BUMG Patients Only	**Cardio Consult Required**			
Peripheral Ultrasound	Varies: Contact Amber Scott 602.747.1088	BUMG Patients Only	YES			
Direct Test Notes	Indicate **TEST Only**, with diagnosing & testing codes	N/A	**TEST Only Form**: Please specify tests needed and applicable diagnosis		Indicate **TEST Only**, with diagnosing & testing codes	**TEST Only Form:** Please specify tests needed and applicable diagnosis
Link to Referral Form	N/A	N/A	Cardiac Solutions Referral Form	CVAM Referral Form	N/A	Tri-City Cardiology Referral Form
Additional Referral Details						
Consult Note Return Timeline	A letter will be mailed to the external PCP to the address on the referral. This may be faxed (e-fax) if there is a fax number included		24 hours		48-72 hours	24 hours
Backline Numbers	**Triage:** 480.733.7305 **Urgent:** 602.747.1088 (Amber Scott, Sr. Mgr.) **Referrals:** Chandler: 480.733.7306 Baywood: 480.896.3372	**Member Experience Call Center:** 602.521.3090	**Priority Referring Physician Direct Line:** 623.977.3594 (new & existing patients)	**Main Line:** 408.641.5400 **PCP to Cardiologist:** 602.620.7761 **CHF Line:** 480.654.7112	Dr. Patel: 602.418.6408 Dr. Sellberg: 602.430.9266 Dr. Gomes: 602.684.1110 Dr. O Khan: 602.684.1125 Dr. Parasher: 602.421.3838 Dr. Dizon: 602.469.7330 Dr. Doss: 480.227.8383 Dr. Kaplan: 602.228.0600	**Priority Referring Physician Direct Line:** 480.993.1089
Procedures at Banner Facilities	Yes		Yes & Partnered with Banner Atlas		Yes: Banner Thunderbird Surgery Centers: Atlas Scottsdale	Yes: All East Valley Banner Hospitals
Additional Notes	Send all records with referrals & ECG tracing visual documentation	Send medical records, including testing with referral	Abnormal EKG = cardiologist needs the record, please send with referral	Same Day NP & Follow-Up Visits. Notes send automatically via EMR within 24-72 hours	N/A	Same/Next day appointments for new & established patients

Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. Please contact the specific health plan for authorization requirements and coverage details.

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CARDIAC SOLUTIONS

PHONE: 623.876.8816 | FAX: 623.933.6739
SCHEDULING@CARDIACSOLUTIONS.NET
DIRECT MESSAGE: CARDIACSOLUTIONS@157.DIRECT.EZ.ACCESS.COM

PLEASE FAX THE COMPLETED REQUEST FORM TO OUR OFFICE AND WE WILL CONTACT YOUR PATIENT TO SCHEDULE AN APPOINTMENT. FOR URGENT REQUESTS CALL OUR OFFICE.

PATIENT INFORMATION

NAME: _____
PHONE: _____
D.O.B : _____

INSURANCE: _____
REFERRING PROVIDER: _____

PLEASE INDICATE APPROPRIATE DIAGNOSIS FOR EACH

Cardiac Consultation

☐ New Patient Consult
DIAGNOSIS: _____

☐ EP Consult
DIAGNOSIS: _____

Vascular Consultation

☐ New Patient Consult
DIAGNOSIS: _____

ULTRASOUND TESTING ONLY

☐ Echocardiogram
DIAGNOSIS: _____

☐ Pulmonary Function Test (PFT)
DIAGNOSIS: _____

☐ Carotid Doppler
DIAGNOSIS: _____

☐ Arterial Doppler
DIAGNOSIS: _____
☐ Bilateral ☐ Left ☐ Right

☐ Abdominal Aorta (must fast 4 hours prior)
DIAGNOSIS: _____

☐ Ankle Brachial Index (ABI)
DIAGNOSIS: _____

☐ Venous Doppler
DIAGNOSIS: _____
☐ Bilateral ☐ Left ☐ Right

NUCLEAR TESTING ONLY

☐ Nuclear Stress Test
DIAGNOSIS: _____

☐ Chemical Stress Test
DIAGNOSIS: _____

☐ Regular Treadmill Stress Test
DIAGNOSIS: _____

PATIENT WEIGHT: _____ (required for scheduling)

PLAZA MEDICAL CENTER
13460 N. 94TH DR J-1
PEORIA, AZ 85381

DEL WEBB MEDICAL
14420 W. MEEKER BLVD A-305
SUN CITY WEST, AZ 85375

TALAVI CORPRORATE CENTER
5651 W TALAVI BLVD #160
GLENDALE, AZ 85306

WEST 101 GATEWAY
9520 W PALM LANE #150
PHOENIX, AZ 85037

WWW.CARDIACSOLUTIONS.NET | PHONE: 623.876.8816 | FAX: 623.933.6739

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New Consult & Testing Order Form

F (480)396-1571
E np@cvam.com

☐ **STAT** within 24 hours ☐ Next Available

☐ 6309 E Baywood Ave, Ste 101, Mesa, AZ 85206 ☐ 3367 S Mercy Rd, Ste 201, Gilbert, AZ 85297
☐ 4838 E Baseline Rd, Ste 105, Mesa, AZ 85206 ☐ 37200 N Gantzel Rd, Ste 350, Queen Creek, AZ 85140

Patient Information

Name: _____ DOB MM/DD/YYYY: _____
Phone:_____ Authorization # (if required): _____
Diagnosis (Required):_____

Requested Physician

☐ Alphonse M. Ambrosia, DO ☐ Muhanad Al-Zubaidi, MD ☐ Faraj Kargoli, MD, MPH
☐ Ambrose F. Panico, DO ☐ Santosh Desai, DO ☐ Varun Tandon, MD
☐ Amy E. Daliman, DO ☐ Alan M. Grossman, MD ☐ No Preference
☐ David M. Bell, DO ☐ Andrew Williams, MD

Consultation

☐ New Patient Cardiovascular Consultation ☐ Structural Heart Consultation
☐ Pre-Operative Evaluation ☐ Electrophysiology Consultation
☐ Vascular Consultation

Testing ONLY

☐ Holter Monitor (93241)
☐ ABI with Segmentals (93923)
☐ Aortic Duplex (93978)
☐ Bubble Study (93306)
☐ Carotid Ultrasound (93880)
☐ Echocardiogram (93306)
☐ Lower Extremity Arterial Bilateral Ultrasound (93925)
☐ Renal Ultrasound (93975 or 93976)
☐ Upper Extremity Arterial Ultrasound (93930)
☐ Venus Reflux Study (93970)
☐ Wireless Telemetry (93228, 93229)
☐ Pharmacological (Lexiscan) Nuclear Stress Test (78452, A9502X2, J2785X4, & 93015)
☐ Exercise Stress Test (78452, A9502x2, & 93015)
☐ Cardiac PET Scan (78431, A9555 x2, 93015, J2785 x4)
☐ ABI with Exercise (93924)
☐ Dobutamine Stress Echocardiogram (93351, J1250)
☐ Exercise Treadmill Stress Test (93015)
☐ Stress Echocardiogram (93351)

Referring Provider Information

Physician/Provider:_____ Contact Person: _____
Phone:_____ Fax: _____ Physician Signature: _____

***PLEASE ATTACH THE FOLLOWING* (Incase authorization from insurance is needed)**

☐ Patient Demographics ☐ Copy of Insurance Card ☐ Blood Work & EKG ☐ Insurance Referral
☐ Progress Note ☐ Written Physician Order/Signed RX (if not sending this form)

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TRI-CITY CARDIOLOGY

NEW CONSULT AND TESTING ORDER FORM

PLEASE FAX ALL MEDICAL RECORDS, DEMOGRAPHICS & COPY OF INSURANCE CARDS TO (480) 461-4243.

PHYSICIANS AND OFFICE STAFF DIRECT LINE: (480) 993-1089

MULTIPLE CONVENIENT LOCATIONS IN MESA, GILBERT, CHANDLER, SAN TAN VALLEY, CASA GRANDE, AND SUN LAKES INCLUDING STATE-OF-THE-ART VEIN CENTER.

Cardiology	Interventional Cardiology	Interventional Cardiology & Peripheral Vascular		Electrophysiology
____1st Available	____1st Available	____1st Available	____Duane Heinrichs, MD*	____1st Available
____Camille Phuc Le, MD	____Kelly Guld, MD	____Satya Atmakuri, MD*	____Jaskamal Kahlon, MD*	____Aron Kolli, MD
____Loan Nguyen, MD	____David Kassel, MD	____Joshua Berkowitz, MD*	____Praneet Sharma, MD*	____Kai Sung, MD
____Todd Perlstein, MD	____Craig Robison, MD	____Sreedivya Chava, MD*	____Ephraim Weiss, MD	____Benjamin Jenny, MD
____Thomas Ritchie, MD	____Sulay Patel, MD	____Joshua Cohen, MD*	____Pridhvi Yelamanchili, MD*	
____Arman Talle, MD	____Shashank Jain, MD	____Rizaldy Villegas, MD*	____Suntharo Ly, MD*	
____Roger Bies, MD	____Jacob Green, MD	____Sunny Jhamnani, MD*		

*Performs Venous Ablations

ORDERING PHYSICIAN:	
OFFICE PHONE #: ( ) -	**FAX #: ( ) -**
PATIENT FIRST NAME:	**PATIENT LAST NAME:**
SOCIAL SECURITY #: - -	**DATE OF BIRTH: - -**
PATIENT HOME PHONE #: ( ) -	**PATIENT CELL #: ( ) -**
CARDIOVASCULAR DX:	

Please choose the urgency of appointment:

____Next Available ____Within 2 weeks ____Within 1 week ____STAT

Insurance Plan: _____ ID Number: _____

Office Contact Person: _____ Direct Phone: _____

Do you require a follow up with appointment date and time?

(Please circle one)Yes, phone call / Yes, fax back / No contact needed

Is a referral required? ____ Yes (please fax with this form) ____No

Please choose from the following:

____Consultation - please circle (Cardiac / Vascular / Electrophysiology)
____Echocardiogram (M Mode 2D & Color flow)
____Carotid Duplex
____Abdominal Ultrasound
____Holter Monitor (24 hr only)
____30 Day Event Monitor
____Pacemaker/Defibrillator Check
ABI ____ Rest ____ Exercise ____
____Bilateral Venous Ultrasound (Vein Mapping)
____EKG Overread
____Other: _____

(Or) Choose Stress Treadmill Testing:

Weight limit for stress testing is 300 lbs.

(Patient Weight/Height required for all Treadmill Testing)

Weight:_____ Height:_____

____ Exercise Treadmill Test (ETT)
____ Stress Echocardiogram
____ Nuclear Stress Test/Myocardial Perfusion Imaging
____ Exercise (patient must be able to walk on a treadmill)
____ Pharmacologic
____ Lexiscan____ Low Level Exercise____No Exercise
____ Dobutamine
____ Cardiac PET Imaging

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Care Management and Support Resources

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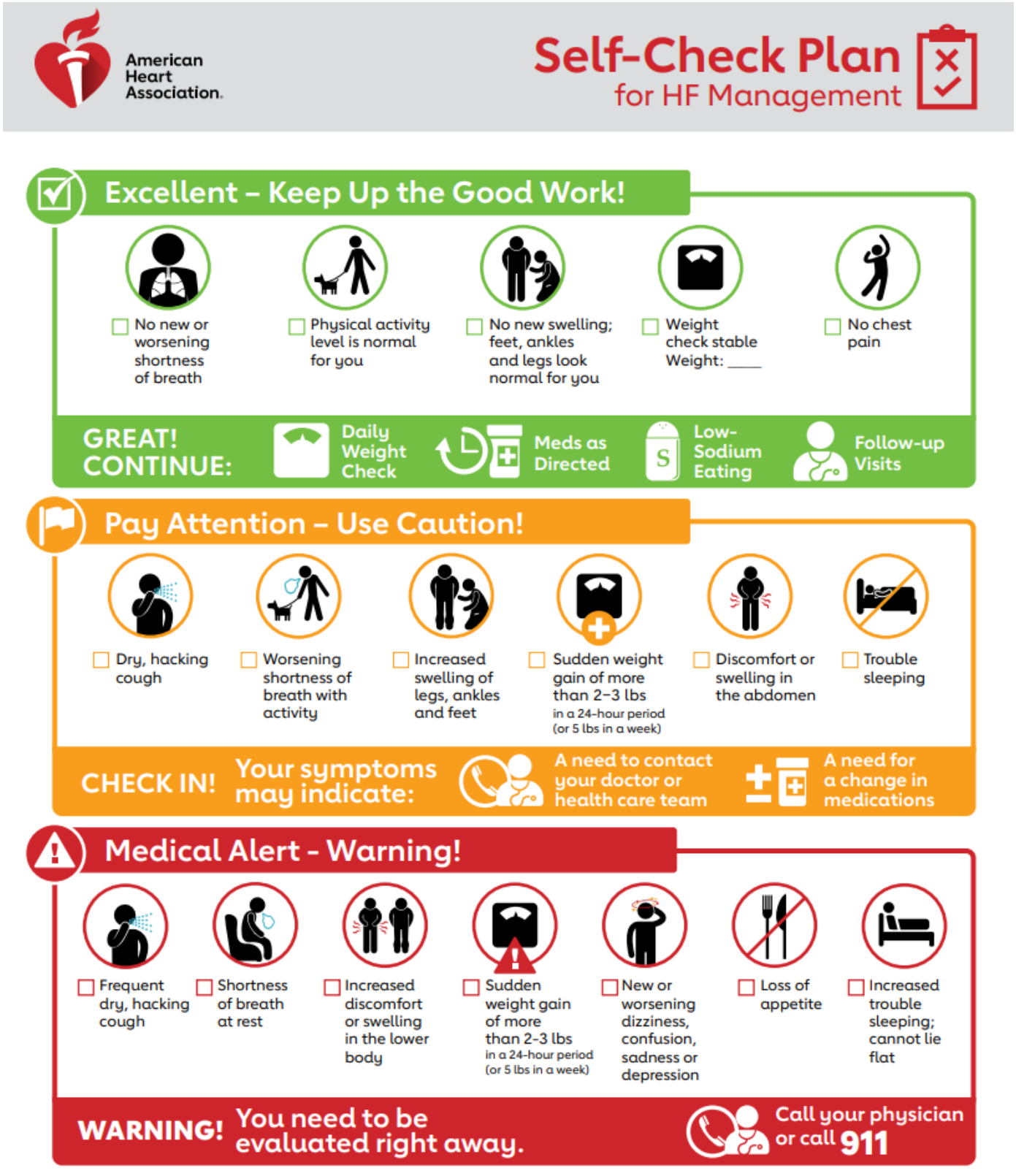
Patient Heart Failure (HF) Action Plan



heart.org/HF

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American Heart Association.

Heart Failure: Partnering in Your Treatment

Bring this sheet with you to your appointment and discuss the following with your doctor.

Understand Your HF

- How serious is my heart failure?
  Mild Moderate Severe
- In what ways does having heart failure increase my health risks?
- How likely is it that having HF will worsen the effects of other conditions I may have?
- Would any of the following lifestyle changes help me to better manage the progress of HF?
  Managing weight
  Quitting smoking
  Making other important changes?

Identify Your HF Needs

- Am I a candidate for HF cardiac rehab?
  Yes No
- Are there any additional tests we need to do to learn more about my heart function? If so, which ones?

Explore HF Treatment

- What are the most important things I can do to manage my HF?
- What should I expect in the coming weeks, months or years?

- Are there any activities that are off-limits for me at this time? (List specific concerns you may have, such as exercise, sex, housework.)
- What treatment options should I be thinking about for managing my HF?

What are my treatment goals at this time?

Symptoms of HF

- Should I be tracking and reporting my symptoms to you?
  Yes (instructions below) No
- What symptoms or problems would you want me to notify you about?

Questions About Medication

- Will I be taking a medication(s) for HF?
  Yes No
- What should the medication(s) do?
- What will happen if I don't take the prescribed medication(s)?

Learn to recognize and manage symptoms of HF.


Shortness of breath


Chronic coughing or wheezing


Build-up of fluid (edema)


Fatigue or feeling lightheaded


Nausea or lack of appetite


Confusion or impaired thinking


High heart rate

heart.org/HF

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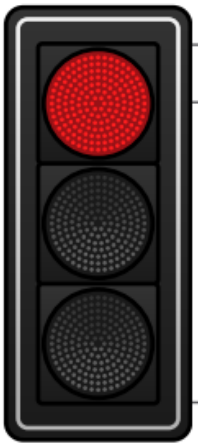
Banner Health

Heart Failure Action Plan

Green Light: Go	Action Plan
• **Breathing:** No shortness of breath or trouble breathing at rest or with minimal activity • **Weight:** No weight gain • **Swelling:** No swelling in your feet, ankles, or legs	• Plan time every day for walking or other activities, unless your health care provider has given you other instructions • Take all medications as directed • Continue to weigh yourself every day • Eat low-sodium diet • If you smoke or chew tobacco, you must quit

Yellow Light: Caution	Action Plan
• **Breathing:** Shortness of breath at rest, with minimal activity, or while lying flat, and having to sleep with multiple pillows or sitting upright • **Weight:** Weight gain of 2-3 pounds in one day, or 5 pounds within a week (whichever amount you were told to report) • **Swelling:** Any signs of swelling in feet, ankles, legs or abdomen • **Fatigue:** Constant feeling of tiredness • Decrease in how much you urinate	• Call your health care provider if you have any of these symptoms



Red Light: Emergency	Action Plan
• **Breathing:** Very short of breath, speaks in single words, struggling to breathe, sitting hunched forward • **Weight:** Weight gain of more than 5 pounds within a week • **Swelling:** Severe swelling in feet, ankles, legs or abdomen • **Pain:** New onset of chest pain • New onset of confusion	• Call **911** now • You need to see a health care provider immediately if you have any of these symptoms

Reference:

Banner Health Cardiology Clinical Consensus Group (2020)

This information is not intended as a substitute for professional medical care. Always follow your health care provider's instructions.

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Care Management Referral Form

Banner Plans & Networks

CARE MANAGEMENT REFERRAL FORM

Population Health Management: 602-747-7799

Completed Medical Forms can be sent to:
Fax: 480-655-2537 or Email: BHNPopHealthManagement@BannerHealth.com

Please send Maternal Health or Behavioral Health referrals to:
Behavioral: BUHPCareMgmtBHMailbox@bannerhealth.com Maternal Health: BUHPMaternalChildHealth@bannerhealth.com

Appropriate stabilization of EMERGENT medical or behavioral health concerns shall be initiated through proper emergency or crisis services channels, BEFORE submitting Care Management Referrals. Care Management will outreach to the member within 24 business hours.

Referral Date:_____

Member Information	Referral Information
Primary Health Plan: Please Select	Requested By:_____
Additional Insurances *(If Any)*: _____	Requester Name:_____
Name_____	Phone:_____
Address:_____	
ID #:_____ DOB: _____	Diagnosis:_____
Phone:_____ Language:_____	PCP:_____

Reason(s) for Care Management Request

MEDICAL

- ☐ General Medical Issues *(ex: Member needs help understanding their diseases, coordinating care with their doctors, etc.)*
- ☐ High or Inappropriate medical utilization *(ex: frequent ER visits, frequent PCP changes, medication management issues)*
- ☐ Post Discharge Assistance for continued care management support
- ☐ Medication Assistance *(ex: education, cost barriers, adherence, and polypharmacy)*
- ☐ Chronic condition / Newly diagnosed condition*(s) (specify below)*
- ☐ Non-adherence to PCP treatment plan, missed appointments and/or annual screening
- ☐ High Priority Transplant, HIV, Hemophilia member requesting assistance
- ☐ Interdepartmental Medical Management request for immediate assistance
- ☐ Maternal Child Health – Pregnant, Postpartum (up to 1 year after delivery), Pediatric *(under age 21)*, and CRS
- ☐ Dial Into Diabetes Program – Diabetic Care Management
- ☐ Home Safety Concerns
- ☐ Advance Directive / End of Life Planning
- ☐ Community Resources *(ex: financial needs, transportation, caregiver support, support groups)*
- ☐ ALTCS ONLY – Refer to assigned CM / RN
- ☐ Other *(specify below)*

BEHAVIORAL

- ☐ Routine BH referrals *(ex: member requests advocacy for Behavioral Health or indicates need for BH assistance in some way that is not urgent or related to inpatient and/or medication)*
- ☐ Member / Family member has questions about BH services, how to access covered services, complaints, etc.
- ☐ Suicidal / Homicidal caller. *(Please refer **AFTER** you follow SI/HI protocol)*
- ☐ Member requests referral for BH services *(ex: therapy, groups, etc.)*
- ☐ Mental Health needs *(ex: Dementia, Alzheimer's, depression, substance abuse)*
- ☐ Urgent need for psychotropic medication
- ☐ ALTCS ONLY – Refer to assigned CM/RN
- ☐ Other *(specify below)*

Details Relating to Reason for Referral and Additional Comments *(What happened? What do you want done?)*

Rev: 1/16/2024 (ECT)

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Palliative Care Providers

Palliative Care										
Provider Name	**Webpage**	**Service Areas**	**Banner MA HMO**	**Banner MA DUAL**	**Aetna MA**	**BCBS MA**	**UHC MA**	**BUHP ACC**	**BUHP ALTCS**	**Banner Aetna**
Doctor Care 480-575-057 7010 E Acoma Dr, Ste 102 Scottsdale, AZ 85254	https://doctorcareaz.com/about.php	Phoenix Metro	X	X				X	X	
Casa de la Luz Palliative Care (formerly East Valley Palliative Care) 480-801-2416 2152 S Vineyard, Ste 118 Mesa, AZ 85210	www.lhcgroup.com	Phoenix Metro	X	X			X	X	X	
Casa De La Luz Palliative Care 520-544-9890 7740 N Oracle Rd Tucson, AZ 85704	www.lhcgroup.com	Tucson	X	X				X	X	
Sage Primary & Palliative Care 480-771-3400 3030 N Central Ave, Ste 1200 Phoenix, AZ 85012	www.sagefoc.com	Maricopa, Pinal & Pima	X	X				X	X	X
Southwestern Palliative Care 928-276-4477 1950 W 3rd St Yuma, AZ 85364	www.swpchospice.com	Yuma	X	X				X	X	X
Compassus - Phoenix 623-900-2645 5333 N 7th St, STE C-123 Phoenix, AZ 85014	Compassus | Home Health, Infusion, Hospice, & Palliative Care	Maricopa & Pinal	X	X			X	X	X	
Eternity Hospice & Palliative 602-374-68781 4122 W McDowell Rd, #204 Goodyear, AZ 85395	www.eternityhospicepalliativecare.com	Phoenix Metro	X	X				X	X	
Agave Hospice & Palliative Care 602-855-3500 3240 E. Union Hills Dr, Ste 145 Phoenix, AZ 85050	Agave – Hospice & Palliative Care (agavehealthcare.com)	Phoenix Metro	X	X			X	X	X	
Palliative Care Alliance 602-269-6011 426 N 44th St, Ste 450 Phoenix, AZ 85008	https://palliativeca.com/	Maricopa & Pinal							X	
Divine Hospice & Palliative Care 623-566-7995 18185 N 83rd Ave, Ste 203 Glendale, AZ 85308	https://www.divinehospiceaz.com/	Glendale		X				X	X	
Caring Hands Palliative & Hospice Care Inc 602-742-0370 1000 N 31st Ave, D119 Phoenix, AZ 85051	https://www.caringhandspalhs.com/	Phoenix Metro	X	X			X	X	X	
Bristol Palliative Care Services 520-300-9337 5210 E Williams Circle, Ste 530 Tucson, AZ 85711	https://bristolhospice.com/location/bristol-hospice-tucson/	Pima	X	X				X	X	

It has been the objective of Banner to identify local resources available for patients and their families. Any errors or omissions in the above list is unintentional. Furthermore, exclusion from this list does not imply lack of approval, nor does inclusion indicate coverage endorsement of any resource or its program.

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Home Care Providers

Home Providers										
Provider Information	**Webpage**	**Service Areas**	**Banner MA HMO**	**Banner MA DUAL**	**Aetna MA**	**BCBS MA**	**UHC MA**	**BUHP ACC**	**BUHP ALTCS**	**Banner Aetna**
Geriatric Solutions 602-954-0444 1510 E Flower St Phoenix, AZ 85014	www.geriatricsolutions.org	Maricopa County	X	X			X	X	X	
Your Health Connection 480-268-2670 1510 E Flower St Phoenix, AZ 85014	https://yhcaz.org/	Maricopa, Pinal & Pima	X	X			X	X	X	
My Doctor Now 480-677-4663 Multiple Locations	www.mydrnow.com	Phoenix Metro		X			X			
ASAP Health Solutions 602-996-5595 29455 N Cave Creek Rd #118 Cave Creek, AZ 85331	www.asaphealthsolutions.com	Phoenix Metro		X						
Southwest Geriatric 520-314-3412 6890 E Sunrise Dr Tucson, AZ 85750	www.swgeriatrics.com	Tucson	X	X				X	X	
Dispatch Health Urgent Care at Home 480-351-3918 Multiple locations	www.dispatchhealth.com	Phoenix Metro	X	X			X	X	X	

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Additional Resources

American Heart Association

https://www.heart.org/en/health-topics/heart-failure

https://www.heart.org/en/health-topics/heart-failure/heart-failure-tools-resources

Healthier Living with Heart Failure (Interactive workbook)

https://mydigitalpublication.com/publication/?i=753422

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Heart Failure (HF) Provider One Pager

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2. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. . Heidenreich, P, Bozkurt, B, Aguilar, D. et al. 17, s.l. : J Am Coll Cardiol, 2022, Vol. 79.
3. 2017 ACC expert consensus decision pathway for optimization of heart failure treatment: Answers to 10 pivotal issues about heart failure with reduced ejection fraction. Yancy CW, Januzzi JL, Allen LA, et al. 201, s.l. : JACC, 2018, Vol. 71.

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9. Ferreira JP, Mehta C, Sharma A, Nissen SE, Rossignol P, Zannad F. Alogliptin after acute coronary syndrome in patients with type 2 diabetes: a renal function stratified analysis of the EXAMINE trial. *BMC Med*. 2020;18(1):165. Published 2020 Jun 4. doi:10.1186/s12916-020-01616-8

Resources for Coding

- CMS 2024 ICD-10-CM Coding Manual
- Optum 2024 ICD-10-CM Expert for Physicians
- 3M Coding reference- Integrated Codebook
- Stage B heart failure: *https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure>*

Acronyms

ACEi:	Angiotensin converting enzyme inhibitor
ARB:	Angiotensin receptor blocker
ARNi:	Angiotensin receptor-neprilysin inhibitor
AWV:	Annual Wellness Visit
BHC:	Banner Home Care
BHN:	Banner Health Network
BID:	Twice a day
BP:	Blood pressure
BUN:	Blood urea nitrogen
CAD:	Coronary artery disease
CHF:	Congestive heart failure
CKD:	Chronic kidney disease
CR:	Controlled release
CRT:	Cardiac resynchronization therapy
DDP-4:	Dipeptidyl peptidase 4 inhibitor
ED:	Emergency Department
EF:	Ejection fraction
GDMT:	Guideline-directed medical therapy
GLP-1 RA:	Glucagon-like peptide 1 receptor agonists
HF:	Heart Failure
HFimpEF:	Heart failure with improved ejection fraction
HFmrEF:	Heart failure with midrange ejection fraction
HFpEF:	Heart failure with preserved ejection fraction
HFrEF:	Heart failure with reduced ejection fraction
HTN:	Hypertension
ICD:	Implantable cardioverter defibrillator
LVEF:	Left ventricular ejection fraction
mg/dL:	Milligrams per deciliter
MI:	Myocardial infarction
mmHg:	Millimeters of mercury
MRA:	Mineralocorticoid receptor antagonist
NSAIDs:	Non-steroidal anti-inflammatory drugs
NYHA:	New York Heart Association
PCP:	Primary Care Physician
PHS:	Population Health Services Organization
Qday:	Once a day
RD:	Registered Dietitian
RN:	Registered Nurse
SDOH:	Social Determinants of Health
SGLT-2i:	Sodium-glucose cotransporter-2 inhibitors
SUD:	Substance Use Disorder
SW:	Social Worker
TID:	Three times a day
XL:	Extended release

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