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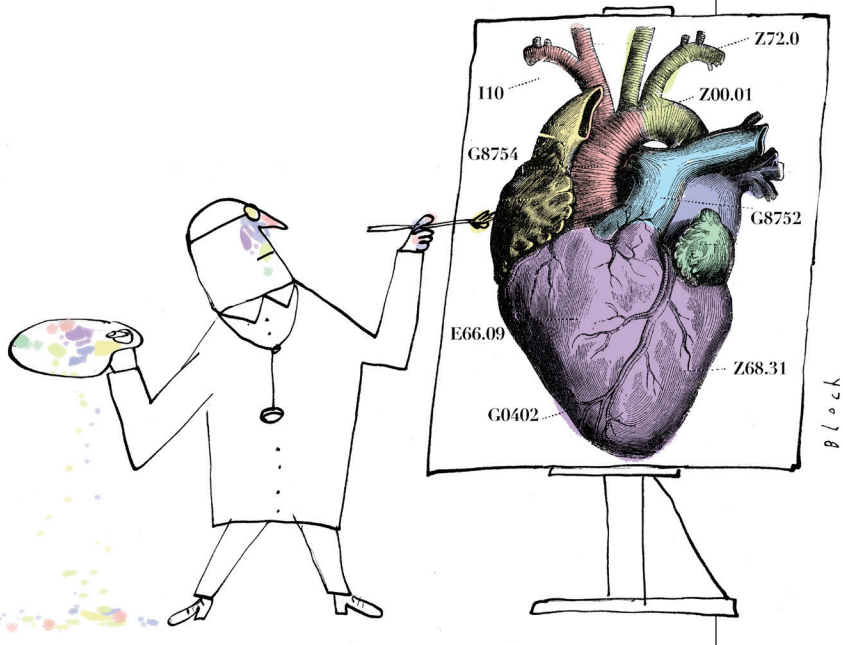
CME

Coding for Hypertension: Painting a Picture of the Severity of Illness

As risk-adjustment scoring increases, the pressure is on to code hypertension correctly. Here's an overview using common patient scenarios.



When a patient presents with elevated blood pressure, your documentation and coding should paint a picture of the severity of the patient presentation. Is the patient generally healthy but presenting with a single episode of elevated blood pressure, is the patient chronically ill with hypertension that has affected other organ systems, or is the patient's condition somewhere in between? With today's focus on population health management and documentation to support correct assignment of hierarchical condition categories (HCCs) for risk-adjustment scoring, it is more important than ever that family physicians understand current codes and guidelines. (See "Hypertension in risk adjustment," page 25.) ➤

ABOUT THE AUTHOR

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The patient scenarios presented in this article are intended to illustrate correct coding for elevated blood pressure and hypertensive conditions commonly seen in primary care. They are not intended to reflect advice on the practice of medicine or to indicate that coding would be the same for all patients with similar presentations. Code selection should be based on documentation specific to each unique patient presentation, including clinical findings and documented medical decision-making (e.g., management options affected by comorbidity).

Although documentation and coding for hypertension can be confusing, it essentially comes down to four questions:

1. Is hypertension the diagnosis, or is elevated blood pressure the appropriate diagnosis?
2. If hypertension is the diagnosis, is it primary or secondary?
3. Is there hypertensive urgency or emergency?
4. Does the patient also have heart or kidney disease?

With that framework in mind, let's take a look at some common scenarios.

ELEVATED BLOOD PRESSURE WITHOUT DIAGNOSIS OF HYPERTENSION

To record an episode of elevated blood pressure in a patient who has no formal diagnosis of hypertension or an isolated incidental finding, you should report ICD-10 code R03.0, "Elevated blood-pressure reading, without diagnosis of hypertension." This code applies to borderline, transient, or white-coat hypertension.

KEY POINTS

- Proper ICD-10 coding of hypertension will help demonstrate the severity of the patient's illness, which can affect payment under value-based payment models.
- The first distinction you must make is whether the appropriate diagnosis is hypertension or simply elevated blood pressure.
- The patient scenarios in this article demonstrate proper diagnosis and procedure coding for suspected hypertension, primary or secondary hypertension, hypertensive crisis, and hypertension present with heart or kidney disease.

Scenario: Elevated blood pressure. An established patient with no history of hypertension or other chronic illness presents for a preventive evaluation and management (E/M) service. His blood pressure is elevated on the first reading and drops on reevaluation after he sits quietly for five minutes, but is still slightly above normal limits. The patient has no previous elevated reading. You instruct the patient to restrict sodium and monitor blood pressure periodically. Diagnoses for the visit include elevated blood pressure in addition to a routine health examination with abnormal findings.

Diagnosis	Routine health examination Elevated blood pressure
ICD-10	Z00.01 Encounter for general adult medical examination with abnormal findings R03.0 Elevated blood-pressure reading, without diagnosis of hypertension
CPT	99396 Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient

If you do suspect hypertension you should document it, but do not report a code for *suspected* hypertension in the outpatient setting, according to ICD-10. Only report codes for what is known at the end of the encounter. For example, if you ruled out suspected hypertension, you could use ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out." Note, however, that when this is the primary diagnosis, some insurers will not cover it, and the patient may have to pay out of pocket.

Scenario: Suspected hypertension. A patient without a diagnosis of hypertension has presented on two prior occasions with elevated blood pressure. At the current encounter for an unrelated problem, knee pain, her blood pressure is again elevated after being measured twice, but she states that it is not elevated when she measures it elsewhere. You recommend that the patient self-measure and record blood pressure with two readings one-minute apart taken twice daily, morning and evening, for a 30-day period so that you can

determine average systolic and diastolic pressures and assess whether blood pressure management is required. The patient is scheduled to bring in her blood pressure meter for calibration and training by clinical staff. You also treat her knee pain. You document that you spent 15 minutes of the 25-minute visit face-to-face with the patient counseling or coordinating care. Diagnoses for this visit include knee pain and elevated blood pressure/suspected hypertension.

Diagnosis	Elevated blood pressure/ suspected hypertension Knee pain
ICD-10	R03.0 Elevated blood-pressure reading, without diagnosis of hypertension M25.561 Pain in right knee
CPT	99214 Established patient E/M office visit (typical time of 25 minutes)

Scenario: Blood pressure meter calibration and training. A patient with suspected hypertension who has been instructed to begin self monitoring returns with her blood pressure monitoring device. A medical assistant who has been trained to calibrate the device against readings obtained with the practice's blood pressure meter determines the patient's device has acceptable accuracy. The patient is trained on use of the blood pressure cuff and demonstrates accurate use.

Diagnosis	Elevated blood pressure
ICD-10	R03.0 Elevated blood-pressure reading, without diagnosis of hypertension
CPT	99473 Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration

Scenario: Self monitoring leading to diagnosis. A patient emails a log of results from home readings to your medical assistant at the end of the 30-day period. The medical assistant calculates the average of the diastolic and systolic readings the patient obtained twice daily on 18 days within the 30-day monitoring period, and she documents all of the readings and the average in the patient record. You diagnose hypertension, order medications, and spend 10 minutes on the phone communicating with the patient about the diagnosis and plan of care. ➤

HYPERTENSION IN RISK ADJUSTMENT

A diagnosis of hypertension (I10) does not affect a patient's risk-adjustment score. However, hypertension with heart or kidney disease does affect a patient's risk-adjustment score if the proper hierarchical condition category (HCC) codes are assigned. This can potentially increase payment as well, due to health plan incentives for accurate documentation and coding of risk-adjusted conditions or value-based payment agreements that contrast the cost of care with the expected cost of care based on risk adjustment.

(For more information, see "HCC Coding, Risk Adjustment, and Physician Income: What You Need to Know," *FPM*, September/October 2016, https://www.aafp.org/fpm/2016/0900/p24.html.)

HCC codes	ICD-10 codes
HCC85 Congestive heart failure	I11.0 Hypertensive heart disease with heart failure
HCC136 Chronic kidney disease, stage 5	I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease
HCC85 and HCC139 Chronic kidney disease, stage 4	I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
HCC136	I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end-stage renal disease
HCC85 and HCC136	I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end-stage renal disease

Diagnosis	Primary hypertension
ICD-10	I10 Essential (primary) hypertension
CPT	99474 Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

For ambulatory blood-pressure monitoring for 24 hours or longer, you would use codes 93784, 93786, 93788, or 93790.

BLOOD PRESSURE CHECK BY CLINICAL STAFF

Code 99211 is appropriate for blood pressure checks performed by clinical staff on a date when no physician service takes place. The nonphysician service must be in compliance with incident-to policy, when applicable (i.e., it is a continuation of a physician's plan of care, provided by clinical staff of the physician practice, and in compliance with the in-office supervision requirement). Do not report 99211 when a patient requests a blood pressure check not included in the physician's plan of care if the payer follows Medicare's incident-to policy. Additionally, remember that diagnosis coding should be based only on the physician or other qualified health care professional's documentation. That means if elevated blood pressure is the documented reason for the check by clinical staff and the reading is abnormal, a code for hypertension cannot be assigned without appropriate documentation by a physician or other qualified health care professional.

A diagnosis of "high blood pressure" may not be clear. Is the intent to diagnose hypertension or elevated blood pressure without diagnosis of hypertension?

Scenario: Normal blood pressure check. A week after you have seen a patient who had a borderline high blood pressure reading, the patient returns to your office at your request for blood pressure measurement by your clinical staff (e.g., nurse or medical assistant). The patient's blood pressure is within normal limits, so you advise the patient to schedule the next annual wellness visit.

Diagnosis	Blood pressure check
ICD-10	Z01.30 Encounter for examination of blood pressure without abnormal findings
CPT	99211 Established patient E/M office visit *Incident-to policy applies*

If the blood pressure reading in the above scenario was abnormal and you saw the patient and diagnosed hypertension, you would report a code for the type of hypertension and an appropriate office visit code (99212-99215). If the blood pressure reading was abnormal but you did not diagnose hypertension, you would report ICD-10 code R03.0, "Elevated blood-pressure reading, without diagnosis of hypertension."

Scenario: Blood pressure check due to inadequate control of hypertension. A patient being treated for primary hypertension was not showing adequate control with current medication at her last visit. You added a second medication and advised the patient to return for evaluation of hypertension by clinical staff. A medical assistant measures the patient's blood pressure and documents the patient's denial of symptoms or complaints. After reviewing the medical assistant's documentation, you advise that the patient should continue current management and return in three months for follow-up.

Diagnosis	Hypertension
ICD-10	I10 Essential (primary) hypertension
CPT	99211 Established patient E/M office visit

DIAGNOSED HYPERTENSION

ICD-10 guidelines state the assignment of a diagnosis code is based on the physician's diagnostic statement that the condition exists, not based on clinical criteria used to establish the diagnosis. The physician's statement that the patient has a particular condition is sufficient. However, a diagnosis of "high blood pressure" may not be clear. Is the intent to diagnose hypertension or elevated blood pressure without diagnosis of hypertension? If you aren't specific, coders will need to verify the intended diagnosis before assigning the proper code.

If hypertension is the intended diagnosis, the most basic code is I10, "Essential (primary) hypertension." Use this code for malignant, resistant, and refractory hypertension as well, which are not indexed in ICD-10. Secondary hypertension is reported with codes in category I15 (e.g., I15.0, "Renovascular hypertension") along with a code for the underlying cause. For postprocedural hypertension, report I97.3. And for hypertensive crisis, report a code from category I16 as well as a code for the type of hypertension (e.g., primary or secondary), and make sure your documentation states crisis, emergency, or urgency. If hypertension is documented as accelerated or malignant, codes from I16 should not be assigned, per ICD-10 guidelines.

Even when hypertension is not the focus of the current encounter, if it is relevant to the other conditions, list it in the diagnoses. Documentation of the impact of hypertension on management of other conditions (e.g., contraindications to certain medications) supports code assignment. Likewise, if other conditions, such as diabetes or morbid obesity, are assessed or managed at a visit, it is appropriate to report those codes in addition to the code for hypertension.

Scenario: Hypertension relevant to visit. A patient requests the Medicare initial preventive physical examination (IPPE). The patient was diagnosed with hypertension five years ago. A staff member measures and documents his blood pressure at 128/84 mm Hg. The patient complains of painful knees that prohibit exercise to lose weight. You recommend acetaminophen for the pain rather than ibuprofen, which the patient is currently using, due to ibuprofen's potential to elevate blood pressure. You verify the patient is taking antihypertensive medications as prescribed and does not yet need a refill. You also advise the patient to continue efforts to reduce calories and limit sodium, and you recommend activities that may help alleviate joint pain. Your diagnoses are routine health examination, bilateral knee pain, hypertension currently controlled with two medications, and obesity with body mass index (BMI) of 31. You order screening laboratory tests to assess blood sugar, cholesterol, etc. All required elements of the IPPE are provided and documented.

Diagnosis	IPPE (routine health examination) Bilateral knee pain Hypertension Obesity BMI 31
ICD-10	Z00.01 Encounter for general adult medical examination with abnormal findings M25.561 Pain in right knee M25.562 Pain in left knee I10 Essential (primary) hypertension E66.09 Other obesity due to excess calories Z68.31 Body mass index (BMI) 31.0-31.9, adult
CPT	G0402 IPPE Optional: G8752 Most recent systolic blood pressure < 140 mm Hg G8754 Most recent diastolic blood pressure < 90 mm Hg

In the above scenario, if evaluation of the patient's knee pain or status of hypertension resulted in a significant E/M service with separately identifiable documentation of history, examination, and medical decision making, you could report an E/M office visit code (99212-99215) in addition to G0402. The optional HCPCS codes shown are typically reported only if you are participating in a quality measurement initiative that requires code assignment. (See "Hypertension in quality measure reporting," page 28.)

Scenario: Malignant hypertension. A new, 48-year-old patient who is morbidly obese with a BMI of 42 presents to establish care for hypertension and Type 2 diabetes with retinopathy managed with oral medication. The patient has no complaints. The patient's blood pressure is 178/118 mm Hg dropping to 166/98 mm Hg after a period of rest. You note the A1C is 7. You spend 25 minutes of a 35-minute visit face-to-face with the patient discussing medication compliance, diet, and exercise recommendations. You add a second antihypertensive medication. You diagnose malignant hypertension in addition to diabetes type 2 with diabetic retinopathy and morbid obesity.

Diagnosis	Malignant hypertension Diabetes type 2 Morbid obesity
ICD-10	I10 Essential (primary) hypertension E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema Z79.84 Long term (current) use of oral hypoglycemic drugs E66.01 Morbid (severe) obesity due to excess calories Z68.41 Body mass index (BMI) 40.0-44.9, adult
CPT	99203 New patient E/M office visit (typical time of 30 minutes)

Scenario: Secondary hypertension. An established, 55-year-old female patient returns for test results following evaluation for atherosclerosis of the renal artery due to sudden onset of hypertension. Based on test results, you diagnose renovascular stenosis due to atherosclerosis of the renal artery.

Diagnosis	Renovascular stenosis due to atherosclerosis of the renal artery
ICD-10	I15.0 Renovascular hypertension 170.1 Atherosclerosis of renal artery
CPT	99212-99215 Established patient E/M office visit

Scenario: Hypertensive emergency. You see an ill-appearing, established male patient. His blood pressure is 260/170 mm Hg. A daughter is present and states the patient seems very confused today, and it appears the patient has not taken medications for at least four days. The patient states he has a pounding headache and feels nauseous. After examination, you diagnose hypertensive emergency and send the patient to the emergency department of the nearest facility by ambulance. Additional diagnoses include change in mental status and unintentional underdosing of antihypertensive medications.

HYPERTENSION IN QUALITY MEASURE REPORTING

Controlling high blood pressure is a high-priority measure in the Medicare Merit-Based Incentive Payment System (MIPS). Family physicians in small practices (no more than 15 eligible clinicians/NPIs) can report this measure on claims using the following HCPCS codes.

Eligible patients	Services provided	HCPCS codes
Patients with a diagnosis of hypertension (I10) Exceptions: • Patients receiving hospice care during the measurement period, • Patients with documentation of end-stage renal disease, dialysis, or renal transplant before or during the measurement period, • Patients who are 65 years and older with institutional special needs plans (SNPs) or who reside in long-term care facilities at any time in the measurement period.	E/M office visit (99201-99215) Home visit (99341-99350) Initial preventive physical exam (G0402) Medicare annual wellness visit (G0438-G0439)	Most recent systolic blood pressure: • G8752 < 140 mm Hg (performance met) • G8753 ≥ 140 mm Hg (performance not met) Most recent diastolic blood pressure: • G8754 < 90 mm Hg (performance met) • G8755 ≥ 90 mm Hg (performance not met) No documentation: • G8756 No documentation of blood pressure measurement, reason not given (performance not met)

Diagnosis	Hypertensive emergency Change in mental status Unintentional underdosing of antihypertensive medications
ICD-10	I16.1 Hypertensive emergency I10 Essential (primary) hypertension R41.82 Altered mental status, unspecified Code for underdosing of antihypertensive medication (e.g., T50.2X6A Underdosing of carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics) Z91.138 Patient's unintentional underdosing of medication regimen for other reason
CPT	99215 Established patient E/M office visit or 99291-99292 Critical care E/M service (if the visit meets the time and intensity of illness/intervention requirements)

HYPERTENSIVE HEART DISEASE

The ICD-10 guidelines state that a causal relationship between hypertension and heart disease is assumed, and the conditions should be coded as related (even in the absence of documentation explicitly linking them), unless the documentation clearly states the conditions are unrelated. To report hypertensive heart disease, use a code from category I11 (e.g., I11.0, "Hypertensive heart disease with heart failure") and report a code for the type of heart failure (e.g., I50.32, "Chronic diastolic heart failure"). Reporting the presence of these conditions is appropriate per ICD-10 guidelines: "Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management." Failure to document them may also affect the bottom line in value-based payment environments.

If the patient's heart disease and hypertension do not have a causal relationship and *if the provider has specifically documented a different cause*, the heart disease should be reported with a separate code from category I50.- or I51.4-I51.9. An Excludes1 note advises that codes I51.4-I51.9 should not be reported in conjunction with codes in the I11 category.

Scenario: Hypertension with heart failure. You see a patient for a Medicare subsequent annual wellness visit (AWV). You note the status of the patient's chronic diastolic congestive heart failure and hypertension and compliance with the current treatment plan. All elements of the AWV are provided and documented.

Diagnosis	Annual wellness visit Chronic diastolic heart failure Hypertension
ICD-10	Z00.00 Encounter for general adult medical examination without abnormal findings I11.0 Hypertensive heart disease with heart failure I50.32 Chronic diastolic (congestive) heart failure
CPT	G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit

Scenario: Hypertension without heart failure. You see an established patient who has hypertension and left ventricular hypertrophy (without diagnosed heart failure). The patient has no new complaints and current medications are maintained.

Diagnosis	Hypertension Left ventricular hypertrophy (without heart failure)
ICD-10	I11.9 Hypertensive heart disease without heart failure
CPT	99212-99215 Established patient E/M office visit

In the above scenario, you would report code I51.7 (Cardiomegaly) for ventricular hypertrophy in the absence of hypertension or if your documentation specifically stated the conditions were unrelated.

Scenario: Hypertension and heart condition with different cause. You see a patient for follow-up care who was recently hospitalized for cardiac symptoms now diagnosed as Takotsubo syndrome. The patient also has hypertension. ➤

Diagnosis	Takotsubo syndrome Hypertension
ICD-10	I51.81 Takotsubo syndrome I10 Essential (primary) hypertension
CPT	99212-99215 Established patient E/M office visit

HYPERTENSIVE KIDNEY DISEASE

When both hypertension and chronic kidney disease are diagnosed, a causal relationship is assumed (in the absence of documentation of a different cause) and a combination code for hypertensive chronic kidney disease is reported in lieu of I10, "Essential (primary) hypertension." A code for the stage of chronic kidney disease is also reported.

Scenario: Hypertension and chronic kidney disease. An established patient presents in the office for follow-up of hypertension and stage 2 chronic kidney disease.

Diagnosis	Hypertension Stage 2 chronic kidney disease
ICD-10	I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease N18.2 Chronic kidney disease, stage 2 (mild)
CPT	99212-99215 Established patient E/M office visit

When both diabetes and hypertension are diagnosed in conjunction with chronic kidney disease, assume both diabetes and hypertension contributed to the kidney disease and report combination codes describing each condition (E11.22, "Type 2 diabetes mellitus with diabetic chronic kidney disease," and I12.9, "Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease") with the applicable stage of chronic kidney disease (e.g., N18.2, "Chronic kidney disease, stage 2, mild").

HYPERTENSIVE HEART AND KIDNEY DISEASE

A single code, I13.0, is used to report a combination of hypertensive heart and chronic kidney disease. However, additional codes are necessary to describe the type of heart failure and the stage of chronic kidney disease.

Scenario: Hypertensive heart and kidney disease. An established patient presents in the office for follow-up of chronic systolic left heart failure, diabetes type 2, hypertension, and stage 3 chronic kidney disease.

Diagnosis	Chronic systolic left heart failure Diabetes type 2 Hypertension Stage 3 chronic kidney disease
ICD-10	I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease N18.2 Chronic kidney disease, stage 2 (mild) I50.22 Chronic systolic (congestive) heart failure
CPT	99212-99215 Established patient E/M office visit

BUT WAIT, THERE'S MORE

For the hypertension codes discussed in this article, ICD-10 instructs clinicians to report an additional code to identify tobacco use or exposure:

- Exposure to environmental tobacco smoke (Z77.22),
- History of nicotine dependence (Z87.891),
- Occupational exposure to environmental tobacco smoke (Z57.31),
- Nicotine dependence (F17.-),
- Tobacco use (Z72.0).

Additionally, there are other hypertensive conditions in ICD-10 that are beyond the scope of this article:

- Hypertension of the vessels of the eye (H35.0-) or brain (I60-I69),
- Hypertension in pregnancy, childbirth, or the puerperium (O10-O11 and O13-O16),
- Neonatal hypertension (P29.2).

Consult the ICD-10 book for an explanation of these and other codes.

For a quick reference to the most common diagnosis codes for hypertension, see the *FPM* tool "Coding Hypertensive Diseases Under ICD-10" (https://www.aafp.org/fpm/2014/0300/fpm20140300p5-rt1.pdf). FPM

Editor's note: See the related article, "Managing Hypertension Using Combination Therapy," in the March 15, 2020, issue of *American Family Physician*: https://www.aafp.org/afp/2020/0315/p341.html.

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