Hypertension Coding Guide

High Blood Pressure vs. Hypertension

According to the American Heart Association, high blood pressure occurs when the force of the blood pumping through the heart is too high, causing that force to push against the walls of the blood vessels. A patient can have one reading of high blood pressure due to stress, anxiety, physical exertion, and many other factors, and not be diagnosed with hypertension. However, when this pressure is too high for a long period, it can damage the walls of the blood vessels and cause structural harm. A patient is diagnosed with hypertension when the readings are consistently high (chronic) and do not come down after rest.

Blood Pressure Levels

Blood Pressure Category	Systolic Reading (upper numeric value)	And/or	Diastolic Reading (lower numeric value)
Normal	Less than 120	And	Less than 80
Elevated	120-129	And	Less than 80
High Blood Pressure (Hypertension stage 1)	130-139	Or*	80-89
High Blood Pressure (Hypertension stage 2)	140 or higher	Or*	90 or higher
Hypertensive Crisis	Higher than 180	And/or*	Higher than 120

*If either systolic or diastolic has a high reading, the patient qualifies as having high blood pressure.

Documentation Requirements

To appropriately select a hypertension code, the following documentation requirements are needed:

- **Type:** There are many different types and causes of hypertension. For example, essential hypertension is entirely different from renovascular hypertension. Establishing the type is essential to code selection.
- **Underlying causes:** For secondary hypertension, it is also important to document the disease or condition that is causing the hypertension, as this affects code selection.
- **Comorbidities:** Hypertension can be complex and can come with comorbidities that make the treatment of the elevated blood pressure more difficult. For example, hypertension with heart disease is far more complicated than essential hypertension and is coded differently to account for the difference in severity. This is the same for hypertension with chronic kidney disease and hypertension with heart failure. To document comorbidities, associate using linking terms like “with”, “and”, “due to”, “associated with”, “complicated by”, etc.

Coding Guidelines

Hypertension requires a provider's diagnosis to be billed on a claim. A coder cannot interpret a blood pressure reading and assume that the patient has hypertension without a formal diagnosis. If a patient has an elevated blood pressure reading without the formal hypertension diagnosis, code for the sign/symptom **R03.0 Elevated blood-pressure reading, without diagnosis of hypertension**.

Chapter 9: Diseases of the Circulatory System (I00-I99)

a. Hypertension

The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term "with" in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For hypertension and conditions not specifically linked by relational terms such as "with," "associated with" or "due to" in the classification, provider documentation must link the conditions in order to code them as related.

When hypertension is documented, it is appropriate to code I10 essential hypertension, unless a comorbidity is present. Per chapter nine of the ICD-10-CM coding guidelines, there is an assumed causal correlation between hypertension and its comorbidities. Comorbidities that are linked to hypertension in the ICD-10-CM using the term "with". Comorbidities found under the "with" below the code title should be interpreted to mean "associated with" or "due to." This classification presumes a causal relationship between the two conditions even in the absence of provider documentation explicitly linking them. This means coders can code to higher specificity even when not directly correlated in providers' documentation when a comorbidity is present. However, if the documentation clearly states that the two conditions are not related, then the combination code should not be selected.

ICD 10 Code	Code Description	Code Also
I10	Essential Hypertension	
Hypertension with Comorbidities		
I11.0	Hypertensive heart disease with heart failure	Use additional code to identify type of heart failure from code range **I50.--.**
I11.9	Hypertensive heart disease without heart failure	any condition in I51.4-I51.7, I51.89, I51.9 due to hypertension
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6).
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	Use additional code to identify the stage of chronic kidney disease (N18.1-N18.4, N18.9).
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	Use additional code to identify type of heart failure (I50.-) and stage of chronic kidney disease (N18.1-N18.4, N18.9).
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6).
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6).
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	Use additional code to identify type of heart failure (I50.-) and he stage of chronic kidney disease (N18.5, N18.6)

ICD 10 Code	Code Description	Code Also
Secondary Hypertension		
I15.0	Renovascular hypertension	Code also underlying condition causing the hypertension.
I15.1	Hypertension secondary to other renal disorders	Code also underlying condition causing the hypertension.
I15.2	Hypertension secondary to endocrine disorders	Code also underlying condition causing the hypertension.
I15.8	Other secondary hypertension	Code also underlying condition causing the hypertension.
I15.9	Secondary hypertension, unspecified	Code also underlying condition causing the hypertension.

Note: This is not an extensive list of all hypertension codes, but rather a comprehensive list based on common codes used. For additional codes, please reference the ICD-10-CM.

Quality Performance and Exclusions

CPT II Coding for Quality

To be able to submit the CPT II codes of a patient's blood pressure reading for HEDIS measures, the encounter must list the hypertension diagnosis, the date the vitals were taken, and the blood pressure results. Compliant readings can come from outpatient visits, virtual or telephonic visits, remote monitoring events, and other non-acute or inpatient visits. To report a patient's blood pressure reading, you must code two separate CPT II codes- one for the systolic reading and one for the diastolic reading. If multiple readings are taken on the same day, report the lowest of both the systolic and diastolic readings taken:

Systolic		Diastolic	
3074F	Systolic reading less than 130mm Hg	**3078F**	Diastolic reading of less than 80 mm HG
3075F	Systolic reading between 130-139 mm HG	**3079F**	Diastolic reading between 80-89 mm HG
3077F	Systolic reading greater than or equal to 140 mm Hg	**3080F**	Diastolic reading greater than or equal to 90 mm Hg

What are Exclusions?

Quality measures utilize exclusions when an advanced illness impacts the quality of life for a patient to the point where preventative screenings and disease-specific monitoring become less important to maintaining daily function and quality of life for a patient's declining health status. These exclusions change the eligible population (denominator) for select measures.

How do Exclusions relate to Controlling Blood Pressure?

This measure can be positively affected, as coding to the highest level of specificity can directly aid your quality scores! By coding hypertension with complications, along with a frailty code (if applicable to the patient), you are effectively pulling the patient out of the measure and will not have your quality scores adversely impacted due to uncontrolled blood pressure results.

Below are examples of when a patient could be excluded from a measure:

Patients 66- 80 years old with advanced illness and frailty, or 81+ years with just frailty	Patients 66 years old and older with frailty and advanced Illness	Patients Receiving Palliative Care
• **Controlling High Blood Pressure (CBP)** • Kidney Health Evaluation for Patients with Diabetes (KED) • Persistence of Beta Blocker Treatment after Heart Attack (PBH) • Patients 67- 80 years old with advanced illness and frailty, or 81+ years with just frailty • Osteoporosis Management in Women (OMW)	• Breast Cancer Screening (BCS) • Colorectal Cancer Screening (COL) • Eye exam for Patients with Diabetes (EED) • Hemoglobin A1c Control for Patients with Diabetes (HBD) • Stating Therapy for Patients with Cardiovascular Disease (SPC) • Statin Therapy for Patients with Diabetes (SPD)	• Breast Cancer Screening (BCS) • **Controlling High Blood Pressure (CBP)** • Colorectal Cancer Screening (COL) • Eye exam for Patients with Diabetes (EED) • Hemoglobin A1c Control for Patients with Diabetes (HBD) • Kidney Health Evaluation for Patients with Diabetes (KED) • Osteoporosis Management in Women (OMW) • Statin Therapy for Patients with Cardiovascular Disease (SPC) • Statin Therapy for Patients with Diabetes (SPD)

When excluding a patient from one HEDIS quality measure using advanced illness and frailty exclusions, a patient will be excluded from all applicable quality measures in which they are in the denominator. It is important to look at how excluding one patient could affect all the denominators of the quality gaps.

How are Exclusions Identified?

Exclusions can only be identified and removed by insurance payers through claim submissions. Codes from the National Committee for Quality Assurance (NCQA) Advanced Illness Value Set and/or Frailty Value Sets for devices, diagnoses, encounters, and symptoms are used to identify patients who will be removed from a measure denominator.

To exclude a patient from a measure, you must bill an advanced illness coded twice in the calendar year, with a frailty code also coded and billed twice in the calendar year. These two codes must be captured on a claim at two separate outpatient visits, two observation or non-acute inpatient visits, one acute inpatient visit, or be given one dispensed dementia medication to qualify. Palliative care exclusions are based on any single claim with a palliative care code submitted during the current measurement year.

Advanced Illness Codes for Hypertension		
I11.0	ICD-10	Hypertensive heart disease with heart failure
I12.0	ICD-10	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease
I13.0	ICD-10	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.11	ICD-10	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end-stage renal disease
I13.2	ICD-10	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end-stage renal disease

Frailty Code Set

Code	Code Type	Code Description
L89.000 - L89.96	ICD-10	Pressure ulcers
M62.50	ICD-10	Muscle wasting and atrophy, not elsewhere classified, unspecified site
M62.81	ICD-10	Muscle weakness (generalized)
M62.84	ICD-10	Sarcopenia
R26.0	ICD-10	Ataxic Gate
R26.1	ICD-10	Paralytic Gait
R26.2	ICD-10	Difficulty in Walking, not elsewhere classified
R26.89	ICD-10	Other abnormalities of gait and mobility
R26.9	ICD-10	Unspecified abnormalities of gait and mobility
R41.81	ICD-10	Age-related Cognitive Decline
R53.1	ICD-10	Weakness
R53.81	ICD-10	Other malaise
R53.83	ICD-10	Other fatigue
R54	ICD-10	Age-related physical debility
R62.7	ICD-10	Adult failure to thrive
R63.4	ICD-10	Abnormal weight loss
R63.6	ICD-10	Underweight
R64	ICD-10	Cachexia
Falls		
W01.0-	ICD-10	Fall on same level from slipping, tripping and stumbling without subsequent striking against object
W01.10-	ICD-10	Fall on same level from slipping, tripping and stumbling with subsequent striking against unspecified object
W01.110-	ICD-10	Fall on same level from slipping, tripping and stumbling with subsequent striking against sharp glass
W01.111-	ICD-10	Fall on same level from slipping, tripping and stumbling with subsequent striking against power tool or machine
W01.118-	ICD-10	Fall on same level from slipping, tripping and stumbling with subsequent striking against other sharp object
W01.119-	ICD-10	Fall on same level from slipping, tripping and stumbling with subsequent striking against unspecified sharp object
W01.190-	ICD-10	Fall on same level from slipping, tripping and stumbling with subsequent striking against furniture
W01.198-	ICD-10	Fall on same level from slipping, tripping and stumbling with subsequent striking against other object
W06. -	ICD-10	Fall from bed
W07. -	ICD-10	Fall from chair
W08. -	ICD-10	Fall from other furniture
W10.0-	ICD-10	Fall (on)(from) escalator
W10.1-	ICD-10	Fall (on)(from) sidewalk curb
W10.2-	ICD-10	Fall (on)(from) incline
W10.8-	ICD-10	Fall (on)(from) other stairs and steps
W10.9-	ICD-10	Fall (on)(from) unspecified stairs and steps
W18.00-	ICD-10	Striking against unspecified object with subsequent fall
W18.02-	ICD-10	Striking against glass with subsequent fall
W18.09-	ICD-10	Striking against other object with subsequent fall
W18.11-	ICD-10	Fall from or off toilet without subsequent striking against object

Code	Code Type	Code Description
W18.12-	ICD-10	Fall from or off toilet with subsequent striking against object
W18.2-	ICD-10	Fall in (into) shower or empty bathtub
W18.30-	ICD-10	Fall on same level, unspecified
W18.31-	ICD-10	Fall on same level due to stepping on an object
W18.39-	ICD-10	Other fall on same level
W19. -	ICD-10	Unspecified fall
Y92.199	ICD-10	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	ICD-10	Problems related to living in residential institution
Z73.6	ICD-10	Limitation of activities due to disability
Z74.01	ICD-10	Bed confinement status
Z74.09	ICD-10	Other reduced mobility
Z74.1	ICD-10	Need for assistance with personal care
Z74.2	ICD-10	Need for assistance at home and no other household member able to render care
Z74.3	ICD-10	Need for continuous supervision
Z74.8	ICD-10	Other problems related to care provider dependency
Z74.9	ICD-10	Problem related to care provider dependency, unspecified
Z91.81	ICD-10	History of falling
Z99.11	ICD-10	Dependence on respirator [ventilator] status
Z99.3	ICD-10	Dependence on wheelchair
Z99.81	ICD-10	Dependence on supplemental oxygen
Z99.89	ICD-10	Dependence on other enabling machines and devices

Sources

1. What is High Blood Pressure? | American Heart Association
2. High blood pressure vs hypertension: what's the difference? | American Heart Association
3. FY2022 April 1 update ICD-10-CM Guidelines