Coding Spotlight: Hypertension
A providers’ guide for coding

ICD-10-CM coding for hypertension

ICD-10-CM hypertension coding highlights:
- Hypertensive crisis can involve hypertensive urgency or emergency.
- Hypertension can occur with heart disease, chronic kidney disease (CKD) or both.
- ICD-10-CM classifies hypertension by type as essential or primary (categories I10-I13) and secondary (category I15).¹
- Categories I10-I13 classify primary hypertension according to a hierarchy of the disease from its vascular origin (I10) to the involvement of the heart (I11), CKD (I12), or heart and CKD combined (I13).¹

Hypertension categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>I10</td>
<td>Essential (primary) hypertension</td>
</tr>
<tr>
<td>I11.0</td>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>I11.9</td>
<td>Hypertensive heart disease without heart failure</td>
</tr>
<tr>
<td>I12.0</td>
<td>Hypertensive CKD with stage 5 CKD or end-stage renal disease (ERSD)</td>
</tr>
<tr>
<td>I12.9</td>
<td>Hypertensive CKD with stage 1 through stage 4 CKD or unspecified CKD</td>
</tr>
<tr>
<td>I13.0</td>
<td>Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD or unspecified CKD</td>
</tr>
<tr>
<td>I13.10</td>
<td>Hypertensive heart and CKD without heart failure with stage 1 through stage 4 CKD or unspecified CKD</td>
</tr>
<tr>
<td>I13.11</td>
<td>Hypertensive heart and CKD without heart failure with stage 5 CKD or ERSD</td>
</tr>
<tr>
<td>I13.2</td>
<td>Hypertensive heart and CKD with heart failure and with stage 5 CKD or ERSD</td>
</tr>
<tr>
<td>I15.-</td>
<td>Secondary hypertension</td>
</tr>
<tr>
<td>I16.-</td>
<td>Hypertensive crisis</td>
</tr>
</tbody>
</table>

Hypertensive heart disease
ICD-10-CM presumes a causal relationship between hypertension and heart involvement and classifies hypertension and heart conditions to category I11 (hypertensive heart disease) because the two conditions are linked by the term “with” in the Alphabetic Index of ICD-10-CM. These conditions should be coded as related even in the absence of provider documentation linking them. Code first I11.0 (hypertensive heart disease with heart failure) as instructed by the note at category I50 (heart failure). If the provider specifically documents different causes for the

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS 2019 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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hypertension and the heart condition, the heart condition (I50.-, I151.4 to I151.x9) and hypertension are coded separately.¹

Category I11 is subdivided to indicate whether heart failure is present. However, an additional code from category I50 is required to specify the type of heart failure, if known.

Documentation may vary, but coding instructions remain the same. For example:
- Congestive heart failure due to hypertension: I11.0 + I50.9
- Hypertensive heart disease with congestive heart failure: I11.0 + I50.9
- Congestive heart failure with hypertension: I11.0 + I50.9

Other heart conditions that have an assumed causal connection to hypertensive heart disease:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>I151.4</td>
<td>Myocarditis, unspecified</td>
</tr>
<tr>
<td>I151.5</td>
<td>Myocardial degeneration</td>
</tr>
<tr>
<td>I151.7</td>
<td>Cardiomegaly</td>
</tr>
<tr>
<td>I151.81</td>
<td>Takotsubo syndrome</td>
</tr>
<tr>
<td>I151.89</td>
<td>Other ill-defined heart diseases</td>
</tr>
<tr>
<td>I151.9</td>
<td>Heart disease, unspecified</td>
</tr>
</tbody>
</table>

**Hypertension and CKD**
When the diagnostic statement includes both hypertension and CKD, ICD-10-CM assumes there is a cause-and-effect relationship. A code from category I12 (hypertensive CKD) is assigned because the two conditions are linked by the term “with” in the *Alphabetic Index of ICD-10-CM*. These conditions should be coded as related even in the absence of provider documentation linking them, unless the documentation clearly states the conditions are unrelated.¹

A fourth character is used with category I12 to indicate the stage of the CKD. The appropriate code from category N18 should be used as a secondary code to identify the stage of CKD.

**Hypertensive heart and CKD**
Combination category I13 codes are assigned for hypertensive heart and CKD when there is hypertension with both heart and kidney involvement. If heart failure is present, an additional code from category I50 is assigned to identify the type of heart failure.¹

The appropriate code from category N18 (CKD) should be used as secondary code with a code from category I13 to identify the stage of CKD.

**Hypertensive cerebrovascular disease**
For hypertensive cerebrovascular disease, first the appropriate code from categories I60 to I69 is assigned followed by the hypertension code.

**Hypertensive retinopathy**
Subcategory H35.0 (background retinopathy and retinal vascular changes) should be used with a code from category I10 to I15 (hypertensive disease to include the systemic hypertension).²
**Hypertension, secondary**
Two codes are required — one to identify the underlying etiology and one from category I15 to identify the hypertension. For example:

- Hypertension due to systemic lupus erythematosus: M32.10 + I15.8
- Acromegaly with secondary hypertension seen for hypertension management: I15.2 + E22.0

**Hypertension, transient**
Code R03.0 (elevated blood pressure reading without diagnosis of hypertension) is assigned unless the patient has an established diagnosis of hypertension. For transient hypertension of pregnancy, code O13.- (gestational [pregnancy-induced] hypertension without significant proteinuria) or O14.- (pre-eclampsia).

**Hypertensive crisis**
A code from category I16 (hypertensive crisis) is assigned for any documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Report two codes, at a minimum, for hypertensive crisis. The crisis code is reported in addition to the underlying hypertension code (I10 to I15).

- Hypertensive urgency: I16.0
- Hypertensive emergency: I16.1
- Hypertensive crisis, unspecified: I16.9

**Pulmonary hypertension**
Pulmonary hypertension is classified to category I27 (other pulmonary heart diseases). For secondary pulmonary hypertension (I27.1, I27.2-), any associated conditions or adverse effect of drugs or toxins should be coded.

**More coding tips**
Blood pressure and medication management should be assessed at every encounter involving a hypertensive patient. Clarity is important in documenting hypertension. Ensure that the diagnosis is captured by noting it in the medical record documentation:

- Specify a pregnant patient with hypertension as having a pre-existing, gestational, pre-eclampsic or eclampsic hypertension.
- Document and code the smoking status of a patient with hypertension:
  - Current smoker: F17.
  - Personal history of tobacco dependence: Z87.891
  - Tobacco use: Z72.0
  - Exposure to environmental tobacco smoke: Z57.31
- Document any causal relationship between hypertension and background retinopathy or other condition in which the hypertension caused vascular changes and organ damage.

**HEDIS® Quality Measures for hypertension**
The Controlling High Blood Pressure (CBP) measure looks at a sample of members ages 18 to 85 years of age who have a diagnosis of hypertension and whose blood pressure (BP) is regularly monitored and controlled.

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Record your efforts
Document blood pressure and diagnosis of hypertension. Patients whose BP is adequately controlled include patients ages 18 to 59 with less than 140/90 mm Hg.

Both systolic and diastolic values must be below the stated value. The most recent BP measurement during the year counts toward compliance.

What does not count?
- A BP measurement taken on the same day or one day before the test or procedure (fasting blood tests not included).
- Patient reported BP measurements.
- A BP measurement taken on the same day as a diagnostic test or procedure that requires a change in diet or medication regimen. For example:
  - Procedures that require a change in diet or medication regimen: colonoscopy, dialysis, infusions, chemotherapy, nebulizer treatment with albuterol and injection of lidocaine prior to mole removal
  - Procedures (low-intensity or preventive) that would not disqualify the BP reading: vaccinations, injections, TB test, intrauterine device insertion and eye exam with dilating agents

Codes to identify hypertension

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>CPT Category II codes⁴</th>
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<tbody>
<tr>
<td>110</td>
<td>3074F: systolic BP &lt;130</td>
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<tr>
<td></td>
<td>3075F: systolic BP 130 to 139</td>
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<tr>
<td></td>
<td>3077F: systolic BP ≥140</td>
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Strategies for success
- Improve the accuracy of BP measurements performed by your clinical staff by:
  - Providing training materials from the American Heart Association.
  - Conducting BP competency tests to validate the education of each clinical staff member.
  - Making a variety of cuff sizes available.
- Instruct your office staff to recheck BPs for all patients with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits; have your staff record the recheck in the patient’s medical records.
- Educate your patients (and their spouses, caregivers or guardians) about the elements of a healthy lifestyle, such as:
  - Heart-healthy eating and low-salt diet.
  - Smoking cessation and avoiding secondhand smoke.
  - Adding regular exercise to daily activities.
  - Home BP monitoring.
  - Ideal body mass index.
  - The importance of taking all prescribed medications as directed.
- Remember to include the applicable Category II reporting codes on the claim form to help reduce the burden of HEDIS medical record review.
Resources
3 “HEDIS Measures and Technical Resources,” NCQA, accessed April 15, 2019, 
   https://www.ncqa.org/hedis/measures.