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Internal Medicine Coding Alert

Mythbusters: Document High Blood Pressure Diagnoses Definitively by Busting These Myths

Understand these three scenarios to master hypertension reporting.

Let's face it: hypertension coding isn't always straightforward. In some patients, the condition causes complications; in other patients, other conditions are the cause. It's no wonder, then, that high blood pressure diagnoses have created their own set of myths that need to be dispelled.

So, we asked our expert mythbusters to weigh in with some great tips to help clear up the most common misconceptions surrounding this complex condition.

Myth 1: High blood pressure means hypertension.

Scenario: For the third time in as many visits to your office, a patient records two blood pressure readings greater than 140/90 mm Hg - the classic definition of hypertension. But your provider notes that two separate blood pressure readings taken outside of the office are in the normal range, and there is no evidence of any end-organ damage.

In this scenario, the provider has documented a condition that has been labeled "white coat hypertension." It is so called because blood pressure readings are elevated during office visits, but they are not replicated outside of the clinical setting.

The fact that these readings are not consistent busts this myth. As **Marcella Bucknam, CPC, CCS-P, COC, CCS, CPC-P, CPC-I, CCC, COBGC**, manager of clinical compliance with PeaceHealth in Vancouver, Washington points out, "You can only code for hypertension when the physician specifically diagnoses it." So, according to Bucknam, "if the patient has his/her blood pressure taken under other reliable circumstances - for example, by a home health nurse - and actual hypertension is ruled out," you would code R03.0 (Elevated blood-pressure reading, without diagnosis of hypertension) rather than I10 (Essential (primary) hypertension) for this particular scenario.

Myth 2: Hypertension and heart disease go together, so it doesn't matter which one you report first.

Scenario: Your physician documents a diagnosis of left ventricular failure caused by hypertension.

In this scenario, as hypertension is the cause of the heart failure, you would report I11.0 (Hypertensive heart disease with heart failure). However, the note for I11.0 indicates you must report an additional code from the I50 series "to identify the type of heart failure," which, in this scenario, would be I50.1 (Left ventricular failure, unspecified). And all the I50 codes come with a code first note that states I50.1 must always be reported after I11.0, when appropriate.

Donelle Holle, RN, President of Peds Coding Inc., and a healthcare, coding, and reimbursement consultant in Fort Wayne, Indiana, offers the reminder that "code first notes indicate the primary reason for the diagnosis; they indicate the main cause for this other diagnosis." The code first note, then, busts the myth as, in Holle's words, "it says 'this disease or illness has caused this other disease or illness.'" So, you would report I11.0 before I50.1 if hypertension was the cause of the heartfailure.

Myth 3: Code for hypertension first when linked with kidney disease.

Scenario: Your internist examines a patient with hypertension and renal artery stenosis. You look to I12 (Hypertensive chronic kidney disease) codes, but you cannot find a precise code for the diagnosis in that set, because both codes in the set refer to the patient also having some stage of chronic kidney disease, which is not the case.

The diagnosis in this scenario could possibly create confusion for a coder, because the hypertension is not causing the kidney disease; rather, the situation is the opposite - the narrowing of the arteries that carry blood to the kidneys creates a rise in blood pressure. So, hypertension isn't the "essential" or "primary" condition in this case and should not be coded first.

In this scenario, the hypertension is secondary to the renal condition. The Excludes1 note under I12.- refers you to the I15 codes for hypertension due to kidney disease, so you would look to I15.- (Secondary hypertension) and particularly I15.0 (Renovascular hypertension) for the precise code for this diagnosis. A note under I15.- directs you to code also the underlying condition, which is I70.1 (Atherosclerosis of renal artery) in this scenario.

"There is an assumption in coding thatalmost all hypertension is renal in origin," Bucknam explains, "and Code I15 implies a situation where resolving the other condition would resolve the hypertension. You would not typically switch the order of these codes because the purpose of the renal code is to give more details about the type and degree of renal injury," Bucknam continues. "You should never see I15 and another hypertension code on the same claim."

Holle agrees, and advises coders "to be certain that they pick the correct hypertension code, and decipher if the hypertension is the cause of a secondary disease (like renal disease) or vice versa. That," she concludes, "is where a discussion will have to take place with the provider and coder."