

Special Coding Issues

Hypertension

Hypertensive diseases are organized under one block (I10-I1A). Pay attention to the note at the top of the category to use additional codes to identify exposure to environmental tobacco smoke, history of tobacco dependence, occupational exposure to environmental tobacco smoke, tobacco dependence and tobacco use.

The most challenging part of coding for hypertension is establishing its relationship with other conditions. **Remember**, 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. More specifically:

- **Hypertensive heart disease:** Hypertension with heart conditions classified to I50.-, Heart failure, I51.4, Myocarditis, unspecified, I51.89, Other ill-defined heart diseases, and I51.9, Heart disease, unspecified, is assigned to a code from category I11, Hypertensive heart disease. Use additional code(s) from category I50, Heart failure, or I51, Complications and ill-defined descriptions of heart disease, to identify the heart condition.

Hypertension with heart conditions classified to I51.5, Myocardial degeneration, or I51.7, Cardiomegaly, is assigned to a code from category I11, Hypertensive heart disease. No additional code is assigned to identify the specific heart condition.

The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has documented they are unrelated to the hypertension. The applicable hypertension code I10, Essential (primary) hypertension, or a code from category I15, Secondary hypertension, should be assigned. Sequence according to the circumstances of the admission/encounter.

- **Hypertensive chronic kidney disease:** Report the hypertensive chronic kidney disease (category I12) whether or not a causal relationship is stated in the documentation. Coding Guidelines instruct that you can assume that if both these conditions are present, they are related. You should also report an additional code from category N18 (chronic kidney disease). The classification assumes a relationship between HTN and any condition classifiable to N18 (CKD) and N26. The relationship may be assumed because of the pathology of hypertension, which impacts renal function, often resulting in CKD. However, CKD should not be coded as hypertensive if the physician has specifically documented a different cause. Do not confuse hypertensive chronic kidney disease with renovascular

hypertension, a condition in which the kidney dysfunction causes the hypertension. Renovascular hypertension is coded using I15.0.

- **Hypertensive heart and chronic kidney disease (CKD):** The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and chronic kidney disease. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not codes from I11 or I12.

For patients with both acute renal failure and chronic kidney disease, the acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter.

- **Hypertensive cerebrovascular disease:** An appropriate code from categories I60-I69 (cerebrovascular disease) is assigned first, followed by the appropriate hypertension code from I10-I1A.
- **Hypertensive retinopathy:** Subcategory H35.0 (Background retinopathy and retinal vascular changes) is coded first followed by a code from hypertension category I10 – I1A.
- **Hypertension, secondary:** Secondary hypertension is due to an underlying condition. Two codes are required to describe this condition. A code to identify the underlying etiology and a code from category I15, (Secondary hypertension). The actual sequence of the two codes is determined by the reason for admission/encounter.
- **Hypertension transient:** Code R03.0, Elevated blood pressure reading without a diagnosis, is coded unless a patient has an established diagnosis of hypertension.
- **Gestational (pregnancy-induced) hypertension** without significant proteinuria (O13.-), or preeclampsia (O14.-) is coded for transient hypertension associated with pregnancy.
- **Hypertension, controlled** as a diagnosis statement usually refers to an existing state of hypertension under control by therapy. Choose the appropriate code from categories I10-I1A (Hypertensive disease) to describe this situation.
- **Hypertension, uncontrolled** may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, the appropriate code from categories I10-I1A (Hypertensive disease) is

SP I49.49 Other premature depolarization

Ectopic beats
Extrasystoles
Extrasystolic arrhythmias
Premature contractions

SP SH SL I49.5 Sick sinus syndrome

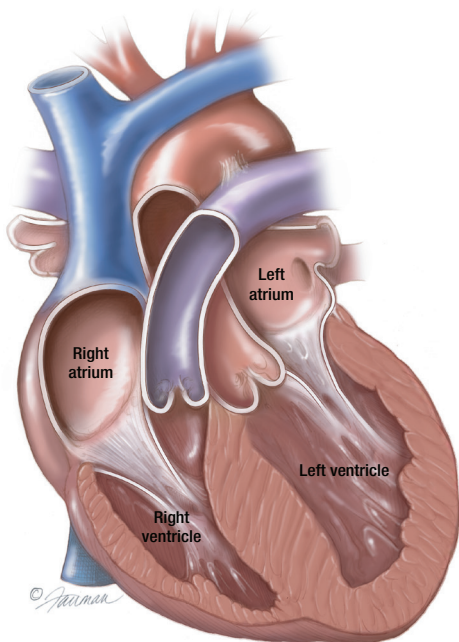
Tachycardia-bradycardia syndrome

SP SH SL I49.8 Other specified cardiac arrhythmias

Brugada syndrome
Coronary sinus rhythm disorder
Ectopic rhythm disorder
Nodal rhythm disorder

SP SH SL I49.9 Cardiac arrhythmia, unspecified

Arrhythmia (cardiac) NOS

**4 I50 Heart failure****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 cardiac arrest (I46.-)
neonatal cardiac failure (P29.0)

GUIDELINES Section I.C.9.a.1)

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CODING TIPS ✓ History of heart failure should be coded as chronic heart failure.

CODING TIPS ✓ Heart failure includes shortness of breath, pulmonary congestion, and peripheral edema. Pleural effusion may be coded separately with J91.8 if the pleural effusion requires separate treatment.

CODING TIPS ✓ When both heart failure and a code from category I11.- will be assigned, the heart failure (I50.-) code should immediately follow the code from category I11.-. When both heart failure and a code from category I13.- will be assigned, the heart failure code (I50.-) and the CKD code (N18.-) should immediately follow the code from I13.- (sequence I50 and N18 depending on which one has the greatest impact on the home health plan of care).

CODING TIPS ✓ Query the physician or NPP on the type of heart failure (systolic, diastolic, combined systolic and diastolic HF, end stage, right, or CHF) to aid in choosing a more specific 4th character in this category. If the patient has documented CHF and another type of heart failure (systolic, diastolic, end stage or combined) then code just the specific type. If an acute exacerbation of a chronic failure occurs, use 5th character 3 for acute on chronic. An acute heart failure of one type and chronic of another type should be coded separately. Do not code the combined type for these instances.

CODING TIPS ✓ Decompensated indicates there has been a flare-up or exacerbation of a chronic condition.

SP SH SL I50.1 Left ventricular failure, unspecified

Cardiac asthma
Edema of lung with heart disease NOS
Edema of lung with heart failure
Left heart failure
Pulmonary edema with heart disease NOS
Pulmonary edema with heart failure

EXCLUDES 1 edema of lung without heart disease or heart failure (J81.-)
pulmonary edema without heart disease or failure (J81.-)

CODING TIPS ✓ Code I50.1, left-sided heart failure, includes acute pulmonary edema; no additional code needs to be assigned. Never use I50.1 and I50.9 on the same claim.

5 I50.2 Systolic (congestive) heart failure

Heart failure with reduced ejection fraction [HFrEF]
Systolic left ventricular heart failure

Code also:

end stage heart failure, if applicable (I50.84)

EXCLUDES 1 combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)

CODING TIPS ✓ Documentation describing heart failure with ejection fraction as mid-range or mildly reduced (HFmrEF) is coded as systolic heart failure. Systolic dysfunction and heart failure must be linked by the provider before assigning a code for systolic failure. If not linked, assign I51.89 and I50.9.