

Coding and documentation: hypertension, hypertensive heart disease and hypertensive kidney disease

February is American Heart Month, and a great time to think about how accurate documentation of cardiovascular conditions helps overall risk adjustment capture! Accurate documentation and coding for hypertension and its related heart and kidney complications is essential for appropriate risk adjustment factor code assignment. While essential (primary) hypertension itself does *not* carry HCC risk-adjustment impact, when hypertension contributes to heart disease, heart failure and/or chronic kidney disease (CKD) – these conditions *do* carry HCC values. Regardless, all conditions must be documented and coded correctly.

Hypertension

Essential (primary) hypertension should be documented when present and managed.

Documentation expectations:

- Specify primary vs. secondary hypertension, if applicable.
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Hypertensive heart disease

When hypertension contributes to heart disease or heart failure, ICD-10 guidance indicates a causal relationship is presumed by default, unless the provider documents the conditions are unrelated.

Documentation expectations:

- State that the patient has hypertension with heart involvement.
- If heart failure is present, document the type and chronicity of the heart failure:
 - Type: Systolic, Diastolic, Combined, or other type as applicable
 - Chronicity: Acute, Chronic, Acute on Chronic

Hypertensive chronic kidney disease (CKD)

When both hypertension and CKD are present, ICD-10 guidelines direct coders to assume a causal relationship and assign a hypertensive chronic kidney disease diagnosis rather than separate codes, unless the record clearly indicates CKD is unrelated to hypertension.

Documentation expectations:

- Chronic kidney disease stage with clinical evidence such as GFR trends.
- A clear statement of CKD as coexisting with hypertension, if applicable.

Hypertensive heart and kidney disease combined

In patients with hypertension plus both heart and kidney involvement, official coding guidelines recommend the use of a single combination diagnosis that includes heart and kidney disease rather than separate codes; combined conditions are coded together by design.

Documentation expectations:

- Document hypertension with heart disease and CKD.
- Include specifics such as heart failure details and CKD stage.
- If acute renal failure is also present, document that and include it in coding when clinically relevant.

General documentation expectations

Across these conditions, key documentation practices improve coding accuracy and support risk adjustment assignment:

- Link conditions when appropriate
 - If your clinical assessment considers heart disease or CKD to be a consequence of hypertension, state that linkage in your note. ICD-10 instructs that when hypertension and these conditions coexist, they are assumed to be related unless documentation says otherwise.
- Document severity and specifics
 - Heart failure details (e.g., type, chronicity)
 - CKD stage
 - Any complicating factors (e.g., acute kidney injury, dialysis)

Accurate, detailed documentation allows for the correct diagnoses based on current coding guidelines ensuring risk-adjusted conditions are captured correctly and appropriately.