Billing & Coding for Hypertension

When a patient presents for family planning services and has elevated blood pressure or hypertension, it is important for the clinician to document clinically relevant information and capture the correct codes for each unique patient visit.

Below are a few common scenarios with suggested codes for the related services, excluding common lab testing such as pregnancy testing and STD screening.

Scenario 1: Elevated Blood Pressure

An established 26-year-old female patient (she/her/hers) with no history of elevated blood pressure or hypertension presents for a routine gyn exam and birth control. Her blood pressure is elevated on the first reading, but on re-evaluation, after sitting quietly, it drops, but is still above normal limits. The clinician provides counseling, including restricting sodium and monitoring blood pressure periodically. Patient-centered counseling is provided on birth control options and the patient is prescribed Depot-medroxyprogesterone acetate (DMPA). She will return to the clinic for a blood pressure check and repeat DMPA in three months. In addition to coding and billing for the DMPA x 150 units IM administered, the injection, and pregnancy/other screening tests as appropriate, the clinician codes and bills for 'elevated blood pressure'.

Scenario 1	Related ICD-10 Codes	Visit CPT Code
• Routine GYN exam • Elevated blood pressure • DMPA	• Z01.411 Encounter for gynecological exam (general) (routine) with abnormal findings • R03.0 Elevated blood-pressure reading, without diagnosis of hypertension • Z30.013 Initial prescription of injectable contraceptive	• 99395 Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient, 18-39 years

Scenario 2: Elevated Blood Pressure with Suspected Hypertension

A 29-year-old patient (they/them) returns for a blood pressure follow-up visit after presenting on two prior occasions with elevated blood pressure. At the current encounter, their blood pressure is again elevated after being measured twice, but they state it is not elevated when they measure it elsewhere. The patient currently smokes about 10 cigarettes per day. The clinician recommends smoking cessation and self-measurement and documentation of their blood pressure for six months to assess whether lifestyle interventions have been successful or further assessment is needed. Patient-centered counseling is provided, and the patient is given a refill prescription for their combined oral contraceptive (COC). The clinician documents total time spent on the date of the encounter (35 minutes). The clinician also codes and bills for the COCs if dispensed during the visit and pregnancy/other screening tests as appropriate.

Scenario 2	Related ICD-10 Codes	Visit CPT Code
• OCP refill • Elevated blood pressure/suspected hypertension • F17.210	• Z30.41 Encounter for surveillance of oral contraceptive pills • R03.0 Elevated blood-pressure reading, without diagnosis of hypertension • Nicotine dependence, cigarettes, uncomplicated	• 99214 Established patient E/M office visit (30-39 minutes)

To record an episode of elevated blood pressure in a patient with no formal diagnosis of hypertension or an isolated incidental finding, report ICD-10 code ***R03.0, "Elevated blood-pressure reading, without diagnosis of hypertension."*** This code applies to borderline, transient, and white-coat hypertension. Do not code hypertension without a formal diagnosis.

Scenario 3: Blood Pressure Recheck

A patient returns for an ordered blood-pressure recheck by a registered nurse. If their blood pressure is normal, the RN may code a 99211 E&M code with a Z01.30 Encounter for examination of blood pressure without abnormal findings. Alternatively, if the patient's blood pressure is elevated, the RN may instead code for a Z01.31 Encounter for examination of blood pressure with abnormal findings. These codes are used if no other clinical services were provided on the same day by the clinician.

Scenario 3	Related ICD-10 Codes	Visit CPT Code
• Blood pressure recheck	• Z01.30 Encounter for examination of blood pressure without abnormal findings • Z01.31 … with abnormal findings	• 99211 (nurse only visit – no physician services provided)

Scenario 4: Hypertension

A 35-year-old established female patient (she/her/hers) presents for a routine gyn exam. The patient had been seen four weeks earlier for diagnosis and treatment of a yeast infection. On that visit her BP was 138/94. The BP measurement today is 135/89. The clinician diagnoses Stage 1 hypertension and refers her to a specialist for follow-up care.

Scenario 4	Related ICD-10 Codes	Visit CPT Code
• Routine GYN exam • Hypertension	• Z01.411 Encounter for gynecological exam (general) (routine) with abnormal findings • I10 Essential (primary) hypertension	• 99395 Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient, 18-39 years

Under ICD-10, there is only a single code for individuals who meet criteria for hypertension and do not have comorbid heart or kidney disease: ***I10, Essential (primary) hypertension***.

The concept of controlled and uncontrolled are no longer part of the coding choice, although good clinical documentation should include the status of the patient and the type of hypertension being treated.

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Common ICD-10 Diagnosis Codes to Support Elevated Blood Pressure and Hypertension in Family Planning Office Visit Settings:

R03.0	Elevated blood-pressure reading, without diagnosis of hypertension
Z01.30 Z01.31	Encounter for examination of blood pressure without abnormal findings Encounter for examination of blood pressure with abnormal findings
I10	Essential (primary) hypertension
I16.0 I16.1	Hypertensive urgency Hypertensive crisis
O10-O16	Edema, proteinuria, and hypertensive disorders in pregnancy, childbirth, and the puerperium
E66-	Overweight and obesity Add secondary code to identify body mass index (BMI) if known (Z68-)
Z71.3	Dietary counseling and surveillance
Z71.82	Exercise counseling
F17.2-	Nicotine dependence (see codes for further coding detail)
Z30.09	General family planning advice
Include other relevant ICD codes as indicated	

Common Procedure Codes to Capture the Evaluation and Management, Counseling and Instruction:

99202-99215	Office/outpatient Evaluation and Management including counseling and instruction (Select E&M code based on total clinician time or medical decision-making applying updated 2021 guidelines) **See codes below**	Add Modifier 95 (telemedicine) if the visit is performed via audio/visual platform
99384-99397	Periodic comprehensive preventive medicine reevaluation and management of an individual based on patient age and if new or established to the practice	
Other time-based codes:		
99401-99404	Preventive medicine counseling (based on time)	
99406-99407	Smoking cessation counseling	
99441-99443	Telephonic E&M services	
G2010	Virtual check-in	

Office/Outpatient Visit E&M Codes:

New Pt.	MDM	Time	Est Pt.	MDM	Time
99202	Straightforward	15 - 29 minutes	99212	Straightforward	10 -19 minutes
99203	Low	30 - 44 minutes	99213	Low	20 -29 minutes
99204	Moderate	45 - 59 minutes	99214	Moderate	30 -39 minutes
99205	High	60 - 74 minutes	99215	High	40 - 54 minutes