Plan of Care

Coding Specifications

Codes required to document patient has Hypertension and a visit occurred:

An ICD-9-CM diagnosis code for Hypertension and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Hypertension ICD-9-CM diagnosis codes

- 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93

AND

CPT codes

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality codes for this measure:

G-code and CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code or combination of codes.)

- *G8677:* Most recent systolic blood pressure < 130 mmHg
- *G8678:* Most recent systolic blood pressure 130 to 139 mmHg
- *G8675:* Most recent systolic blood pressure ≥ 140 mmHg
- *G8679:* Most recent diastolic blood pressure < 80 mmHg
- *G8680:* Most recent diastolic blood pressure 80–89 mmHg
- *G8676* Most recent diastolic blood pressure ≥ 90 mmHg
- *CPT II 4050F:* Hypertension plan of care documented as appropriate
- *CPT II 4050F–8P:* Hypertension plan of care not documented, reason not otherwise specified