# Home Health ICD-9/ICD-10 Alert

## Coding News: Expect More Belt-Tightening with Hypertension Case Mix Changes

**Alert: The average payment reduction is $281 per episode.**

As a coder, you know that hypertension (HTN) can negatively impact your patients with' health. Now, the **Centers for Medicare & Medicaid Services**' proposal to remove HTN from case mix Table 2B (currently Table 4) may negatively impact your agency's bottom line.

**Reporting Jump Inspires CMS**

CMS announced its intention to remove two hypertension codes from the case mix diagnosis code list in the Medicare Home Health Prospective Payment System update for 2011. The two codes in question are 401.1 (Essential hypertension; benign) and 401.9 (Essential hypertension; unspecified).

Why? CMS points to a sudden increase in the reporting of unspecified hypertension and benign hypertension on 2008 home health claims. CMS traces this increased reporting back to changes in blood pressure classification established in 2003 by the National Heart, Lung and Blood Institute (NHLBI).

NHLBI established a "pre-hypertension" classification for people with a systolic blood pressure of 120-139 mm Hg or a diastolic blood pressure of 80-89 mm Hg for which no medical treatment was ordered.

This new classification may have led some coders to assume that 401.1 was the appropriate way to report a patient with prehypertension, CMS theorizes. Based on the revised guidelines, some patients deemed hypertensive may not need skilled services, CMS says in the proposed rule.

CMS also notes that there has been an "increase in reporting unspecified hypertension, along with evidence that home health patients with either unspecified or benign hypertension no longer require extra resources."

"CMS is not considering that coders have increased competence over the years," says **Lisa Selman-Holman, JD, BSN, RN, HCSD, COS-C,** consultant and principal of **Selman-Holman & Associates** and **CoDR -- Coding Done Right** in Denton, Texas. In the past, misunderstandings regarding the definition of "secondary diagnoses" led some coders to list just two diagnoses, for example, she says. When CMS changed the prospective payment system effective January 1, 2008, those who were resistant to coding comorbidities became aware that they were supposed to be including all diagnoses with impact on the Plan of Care. CMS's statement linking the increase in reporting unspecified hypertension to NHBLI classifications misses the mark, Selman- Holman says. "I've seen very few cases of a physician documenting hypertension within those guidelines. I attribute the increased reporting of unspecified hypertension to increased competency of coders," Selman-Holman says. Official coding guidelines indicate that unspecified hypertension codes should be used if the physician doesn't document benign or malignant hypertension and physicians rarely document that specifically, she says.

Bottom line: Including unspecified and benign hypertension in the HH PPS case mix model "reduces the model's accuracy", CMS concludes. "As such we do not believe that we should be including these diagnoses in our case-mix system." Analysis Shows Financial Impact Upon seeing the proposed HTN changes, the **National Association for Home Care & Hospice** (NAHC) heard from many home health agencies concerned about the payment impact. NAHC collaborated with **OCS HomeCare** to conduct an analysis of the effect these changes, NAHC reported in the Aug. 24 NAHC Report.

Looking at over one million home health PPS episodes that occurred during 2009, OCS found that 62 percent contained

the two HTN codes CMS plans to eliminate from the case mix list. In 46 percent of those episodes, the loss of HTN as a case mix code negatively affected the clinical score, with an average payment reduction of $281 per episode, NAHC said. "Spread across all 1.1 million episodes analyzed by OCS, the overall effect of this proposed action would be a negative 1.87 percent change in episodic payment," the NAHC Report explains.

Unfair: "Eliminating the two hypertension diagnosis codes from home health case-mix is not appropriate at this time. Doing so would constitute double dipping by CMS when carried out simultaneously with the case-mix creep adjustment, which includes creep due to the increase in hypertension coding," NAHC concluded. NAHC also pointed out that CMS "provided no real evidence" to back up its theory that home health coders were classifying pre-hypertensive patients as hypertensive.

**Check for Hypertension Documentation**

Reporting a hypertension diagnosis when the condition isn't addressed in the plan of care is a risky move, says **Sparkle Sparks, MPT, HCS-D, COS-C,** with Redmond, WA-based **OASIS Answers**. Sparks says she was not at all surprised to find that CMS jumped on the increased reporting of HTN. "If you put a diagnosis in the top six, you should be actively addressing it in your plan of care or it should be a condition that is so serious that it will impact the patient's rehabilitative prognosis or how care is provided," Sparks says.

**Document Thoroughly for Top Six**

When a diagnosis is serious enough that it will make it harder for a patient to attain his home health goals or will change the way you provide care, you must clearly document why you think the condition will have such an affect, Sparks says. This kind of documentation has been lacking -- and not just with hypertension, Sparks says. "Any conditions listed as secondary diagnoses in M1022 that are not included in the plan of care should be justified with an explanation regarding how that condition complicates the patient's rehab prognosis or the provision of care," she says.

Optimally these details would be explained in a summary that is part of the comprehensive assessment, Sparks says. If you're going to report diagnoses that are not receiving active treatment then spell it out for anyone looking at that chart.

Try this: "Clinicians are going to have to do a better job of actually 'free texting' what's wrong with their patients in a clinical narrative using vocabulary that demonstrates skilled care," Sparks says "The days of only depending on check marks in boxes are long gone. The ancient art of note writing needs to be a priority in documentation standards."