OASIS Alert

Medical Review: Bolster Documentation to Keep Long-Stay HTN Claims Secure

Do you know which OASIS data items can help you prevent HTN denials?

If you're listing an unspecified hypertension diagnosis in M1020a for a patient in her third or later episode, you'd better make sure your documentation is superlative or you'll risk your Medicare payment.

HHH Medicare Administrative Contractor **CGS** has been conducting a widespread edit of claims with hypertension as the primary diagnosis and length of stay greater than two episodes, the MAC notes on its website. In the last quarter, CGS denied a whopping 97 percent of the claims reviewed under this edit. That's up from an 88 percent denial rate a year ago, the MAC points out.

This has been an ongoing problem for home health agencies, experts say. "I am not in the least surprised at the denial rate for the hypertension recertifications," says clinical consultant **Pam Warmack** with **Clinic Connections** in Ruston, La.

The problem: The top denial reason under the edit "is related to documentation of medical necessity of the skilled services, primarily for skilled nurse visits for observation and assessment," CGS explains on its website. "For a skilled service of observation and assessment to be covered by Medicare, there must be clear documentation of the patient's condition that warrants this service."

To show medical necessity for O&A, agencies typically need "documentation of changes in diagnosis, exacerbations, medication or treatment changes that continue to put the beneficiary at risk for further plan of care changes," CGS says. "Nursing may continue observation and assessment when there have been continued changes and risks for further need to change the plan of care."

Important: Look to this statement from the Medicare Benefit Policy Manual to help understand O&A coverage, CGS suggests: O&A "of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized."

The patient's condition isn't the only factor, however. Treatment changes also must be present to justify the skilled service need. CGS points to this section of the Manual: "Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition which itself does not require skilled services and there is no attempt to change the treatment to resolve them."

Some HHAs seem to have difficulty grasping Medicare coverage criteria. "The primary intent of the Medicare home health care program is to cover short-term exacerbations of illness in a patient's home," explains consultant **Lynda Laff** with **Laff Associates** in Hilton Head Island, S.C. Therefore, Medicare won't cover endless O&A, especially of a stable patient.

Check OASIS Physician Notification Parameters

The OASIS can only tell you what the patient's status is at the time of assessment -- it doesn't provide support for medical necessity for ongoing care, Laff says. But it does provide a checkpoint that you can use to track whether your HTN patients are being properly monitored. Item M2250a -- Patient-specific parameters for notifying physician of

changes in vital signs or other clinical findings could help your agency better track patients with a principal diagnosis of hypertension to make certain you are providing appropriate interventions.

Using M2250a, if your agency documents receiving physician-approved vital signs on the plan of care, you would be able to determine what is considered aberrant for that particular patient. Then you would be able to audit the notes to determine whether the orders are being followed, Laff says.

"One thing I often find is that patients will have a primary diagnosis of HTN but as an agency, [clinicians] will select 'No' or 'N/A' for M2250a. Not having patient-specific vital sign parameters really defeats any argument for support of HTN 'monitoring,'" Laff says.

"The question becomes, what blood pressure exactly are you 'monitoring' and how are you 'monitoring' the patient's blood pressure?" Laff says. "If you do not have an agreed-upon parameter to determine when you should notify the physician of aberrant readings, you are not adequately or appropriately monitoring or managing the patient's care based upon a primary diagnosis of HTN."

Keep an Eye on SOC and M1020

To track patients with a long length of stay and a principal diagnosis of 401.9 (Essential hypertension, unspecified), you can turn to M0030 -- Start of care date and M1020a -- Primary diagnosis. Using these two items you can single out HTN patients who have been recertified multiple times.

Caution: Make sure you're not using HTN as a "fall back" diagnosis to support ongoing care for a patient who perhaps has had a HTN issue at some point but is currently stable, Laff cautions. Trying to "find" a reasonable diagnosis to keep a patient on service for PT/INR monitoring isn't wise, she says.

You can also track long-term HTN patients by looking at OASIS outcomes data to see if a patient has been hospitalized or had emergent care related to HTN during the current episode, whether there were any medication changes relevant to HTN, and whether the vital sign trend (not one or two aberrant blood pressure readings) identified that the patient's blood pressure was out of control, Laff says. These occurrences can help support the need for ongoing care.

"To use HTN as a primary diagnosis, it must be the focus of care and there must be substantial evidence of aberration, order changes and signs and symptoms of HTN," Laff says. Don't try to argue that the patient's blood pressure "might" spike, she cautions. "If it hasn't changed substantially enough for the physician to increase or change a medication dose in five to seven weeks -- the patient should be discharged."

Bottom line: "Ongoing monitoring is nice and may be appropriate but it is not a Medicare-billable service unless there is substantial medical necessity," Laff says.

Note: See CGS's article at www.cgsmedicare.com/hhh/pubs/mb_hhh/2012/03_2012/index.html#006.

Note: For more tips on running a successful home care agency, see Eli's Home Care Week. Information on subscribing is online at www.elihealthcare.com or by phone at 1-800-874-9180.