OASIS Alert

Prospective Payment System: Hypertension Codes No Longer Predict Costs, CMS Says

Use of 401.9 more than doubled in last five years.

The **Centers for Medicare & Medicaid Services** threatened to strip two hypertension codes frequently listed in M1020/M1022 from the home health prospective payment system case mix model in 2011 and now these codes are back on the chopping block again for 2012. Get ready for a change in how you're reimbursed for your patients with hypertension if this change moves forward.

From 2005 to 2009, use of 401.9 (Essential hypertension, unspecified) increased from 27 percent of episodes to 56 percent, CMS notes in the 2012 PPS proposed rule published in the July 12 Federal Register. In the same time period, the other code proposed for reduction, 401.1 (Benign essential hypertension), increased only from 2.89 to 2.95 percent of episodes.

Probably due to the widespread use of these codes, "current data indicates that these diagnoses are not predictors of higher home health patient resource costs," CMS says in the rule. "Rather, current data indicates a lower cost associated with home health patients when these codes are reported."

Other hypertension codes saw big jumps as well. For example, use of the code for hypertensive renal disease (403.x) went from 0.31 percent of episodes in 2005 to 3.66 percent of episodes in 2009, the rule says. But perhaps that code still predicted resource use, observers speculate.

Removing the two codes, which CMS also proposed last year, will be budget neutral overall, CMS says. "The revisions of the case-mix weights would redistribute HH PPS payments among the case-mix groups such that removal of these hypertension codes would not result in lower aggregate payments."

But depending on how you code your patients, it could affect your reimbursement rate disproportionately, experts point out.

CMS withdrew its 2011 proposal to make this hypertension change after it was criticized by industry experts who held that this change could only be budgetneutral if CMS recalibrated all of the case mix weights, the **National Association for Home Care and Hospice** (NAHC) pointed out in its Aug. 8 NAHC Report. And "federal law prohibited changes in case mix systems that were not budget neutral."

Bottom line: If you want to determine the impact of all the proposed rate changes on your agency, NAHC recommends that you also "evaluate the impact of the proposed change in case mix weights, particularly the elimination of ICD-9 diagnosis codes 401.1 and 401.9 from the scoring in the clinical domain."

Try this: Select a time period of episodes and rerun the rate calculation using the new proposed model with its elimination of the 401.1and 401.9 scoring, NAHC suggests.