Hypertension - Improvement in Blood Pressure
Transcript from Live Session

Wednesday, March 27, 2019

Laurie Fink: Hello everyone and welcome to today's webinar, Hypertension Improvement in Blood Pressure. My name is Laurie Fink and I'm a communications specialist for Quality Insight. We're so glad you're able to take time out of your day today to join us for this live event. For those of you who are joining us through the recorded webinar, welcome. Before we get started with the program, I'd like to go over a few housekeeping items.

Laurie Fink: First, all participants under today's webinar are in listen-only mode. Should you have a question during the presentation, we ask that you please type it into either the chat or the Q&A box to the right of your screen. While we will not be doing a formal Q&A at the end of the session, we will be sure to provide you with answers to your questions via email following the webinar.

Laurie Fink: Today's webinar is being recorded. The recording will be posted on the Quality Insights website as well as the QPP Support Center website later this week, and that can be found on our Archived Events pages. You should have received a copy of the slide deck for today's webinar early this morning via email. But if for some reason you did not, I will send all of you a link to where these resources are posted online as soon as they are available. Joining us today are two guest speakers, Dr. Jimmie Drummond from HCD International and Denise Walsh from Medical Revenue Cycle Specialists.

Laurie Fink: I just want to do a quick check to see if Dr. Drummond was able to join us yet. I know he was having some connection issues. Is he with us yet?

Vicky Mitchell: Not yet. So we can go ahead and proceed with Mrs. Walsh'S presentation and he'll join us shortly thereafter.

Laurie Fink: Okay, Wonderful. Sounds good. So, kicking things off for us today will be Denise Walsh. She's a certified professional coder with Medical Revenue Cycle Specialists. So Denise, it's all yours.

Denise Walsh: Thank you. I appreciate this. Yeah, I think we should advance to our learning objectives, which is slide 11.

Vicky Mitchell: Okay. Yeah.

Denise Walsh: For today's presentation, we're going to discuss documentation and coding as it relates to hypertension, discuss best practices for documentations, coding best practices, looking at unspecified versus specified codes, and if we have time, we're going to go over some examples of de-identified hypertension progress notes. Advance the slide please.

Vicky Mitchell: Sure.

Denise Walsh: This next slide, I know there's a lot of information here in this slide, but what this is the CMS 2019 guidance for hypertension quality measure for MIPS. This is basically, I wanted to put this slide to give you a reference for MIPS measures. As you can see, I know it's small, but as you can see as part of the measures, there are requirements for age limitations. The MIPS measure refers to patients 18 to 85. It also states that patients must be diagnosed with hypertension starting this measure and that during the measure period, the patient must improve with their hypertension.

Denise Walsh: So again, this is just a reference for you for those who are participating with MIPS. This is their quality measure. Next slide please.

Vicky Mitchell: Okay.

Denise Walsh: So hypertension is a major risk factor for myocardial infarction, vascular disease, chronic kidney disease and stroke. Cardiovascular diseases, including hypertension, are on the HCC list and are chronic and they demand treatment. So blood pressure and the medications should be documented for a patient and assessed at every patient encounter. The key to documentation is the specificity in regards to the type, the stage, and acuity of hypertension. All of these should be documented in the patient encounter. Next slide.

Denise Walsh: We have some recommendations and tips for documenting hypertension. High blood pressure can be incidental and can be relative to a specific occurrence. But hypertension is chronic. You want to make sure that your documentation indicates the difference and you should not be vague or ambiguous in the documentation. If it is a specific incidence of high blood pressure, then it should be documented as such. If it's an isolated incident of elevated blood pressure, then you should make sure that you are documenting just that, that it is just an elevated blood pressure. And that your documentation reflects that in the coding. And you should use the ICD-10 code, R03.0, elevated blood pressure reading without a diagnosis of hypertension.

Denise Walsh: If a patient is on medication for hypertension and they have a normal blood pressure reading, they are still hypertensive and they should be diagnosed as such. They are not just a patient with a history of hypertension. They have hypertension. So you want to make sure that is documented in the notes,

because a coder cannot abstract the diagnosis from the patient's medical history. It has to be documented in the current encounter. ICD-10 guidelines state that a causal relationship can be assumed for hypertension with chronic diseases such as diabetes, heart failure and chronic kidney diseases.

Denise Walsh: But it should also be documented if these conditions, if they co-exist and if they are not relevant to the hypertension. So in both cases, that documentation needs to be there. Next slide please. Again, as I stated previously, coders cannot abstract information. It must be documented. So even if a patient has a high blood pressure reading for an encounter, such as 180 over 110, the coder cannot document this as hypertension, or the coder cannot code it as hypertension unless it is documented as such and documented in the provider's assessment. So you want to make sure that just because it is there in the vitals and documented the high blood pressure, that it's also documented in the note.

Denise Walsh: If a patient has secondary hypertension, it is essential to document the source of that hypertension and link that to the specific underlying condition. When a pregnant patient is documented with hypertension, it is also essential to document whether the hypertension is pre-existing, whether it was gestational hypertension, pre-eclampsic or eclampsic hypertension. Also when you're documenting hypertension, it is important to document whether the patient is a smoker, or what is the status for that patient. So are they a current smoker, do they have a history of tobacco dependence? Are they exposed to tobacco smoke in their environment?

Denise Walsh: When a patient is hypotensive, it is important to document the etiology when possible. It may not be possible, but when it is, it is important to document that. It is very relevant. Next slide. With ICD-10, the concept of benign or malignant hypertension no longer exists. ICD-10 now defines hypertension as essential or primary. So again, when we are documenting hypertension, we need to make sure that we include the type, again whether it's essential or secondary, and any casual relationships as with chronic conditions, whether it be pulmonary, renal. This is necessary to obtain the greatest specificity for diagnosing. Next slide.

Denise Walsh: There are a few hypertension ICD-10 updates for 2019. The first update is for hypertension with heart disease. Hypertension with heart conditions that are classified to the I50 category will be assigned to the diagnosis category I-11. Those are hypertensive heart diseases. When we are diagnosing hypertensive heart diseases, it is necessary to use an additional code. Those additional codes would come from the I-50 category and they would identify the type of heart failure. If the hypertension and the heart condition are unrelated, then we need to make sure that the document states such. And these two conditions would be coded separately. They would also be sequenced in order of relevance for that encounter, for that specific encounter. Next slide.

Denise Walsh: Another 2019 update for ICD-10 is pulmonary hypertension. Pulmonary hypertension should be classified in category I-27, other pulmonary heart disease. For secondary pulmonary hypertension, we much also code any

associated conditions. This includes adverse effects of drugs or toxins as well. Again, the sequencing of this is very important. It should be sequenced in the order of relevance and reasoning for each specific encounter. Next slide. As always, we are looking for the most specific codes to describe a patient's condition. And with ICD-10, it gives us the opportunity to be as specific as possible. Specific codes reflect the most appropriate level of certainty for that patient's condition.

Denise Walsh: Unspecified codes are codes that do not fully define the patient's condition or the parameters of the patient's condition. Each of them have a place. And each, whether it be a specified or unspecified code, are used to code hypertension and other chronic diseases. Next slide. There is a place for unspecified codes and whether we like them or not, they are necessary in coding chronic conditions. Actually in coding all conditions. But specifically chronic conditions. We can use unspecified codes when the patient may be early in the course of their evaluation and we may not have all the information necessary to get to the level of specificity for that chronic condition. We can use an unspecified code when the claim may be coming from a provider who is not directly diagnosing the patient's condition. They just might be a primary care provider or internist who is not the specialist treating that patient.

Denise Walsh: The clinician seeing the patient, as I said, may be more of a generalist and may not be able to define the condition at the level that is expected by the specialist. And there may also be insufficient information to accurately diagnose or define the condition to a certain level of specificity. So all of these are reasons why unspecified codes are necessary and why unspecified codes can and still are used. But it is always important to know that if the documentation is there, we should document to the highest level of specificity that we have. Next slide please. So I'm going to go over a few scenarios. These are the identified actual provider notes that relate to hypertension. The first scenario is for a patient who is here for a blood pressure check. The HPI states that the patient is here for a follow-up for hypertension.

Denise Walsh: The patient denies chest pain, shortness of breath, headaches or dizziness, states that she has a lump in her upper abdomen for five years that may be enlarged, that she has a hernia in her naval that has been hurting for one week. She also states that she is drinking at least seven glasses of wine a day. As I said, these are actual notes. As you can see in the documentation, the review of systems is documented, documenting the constitution of her general cardiovascular, respiratory and GI. Next slide please. We move on to the exam where you can see again, constitutional is documented. Next, lungs, heart, abdomen and psyche. So for this encounter, the assessment documents hypertension and it's defined as essential hypertension using the I-10 diagnosis.

Denise Walsh: Again, there secondary and tertiary diagnoses: umbilical hernia, abdominal mass and alcohol abuse. Next slide please. The next encounter, the next note, excuse me, a 47 year old male is here for a hospital follow-up. The patient was admitted on 10/14/17 at the hospital for acute stroke. CT brain shows focal

hypo density in the right basal ganglia extended to the semi-oval subacute infarction. It also shows hypo density in the left peri-ventricular white matter in basal ganglia. He initially has slurred speech and by the time he got the ER, his symptoms had been recovered. BP in the ER was 161 over 117. Documentation shows results of the MRI, the echocardiogram, the carotid ultrasound and lab. Again, in this assessment, the hypertension is stated as essential, or primary, with the secondary hyperlipidemia, cerebral infarction and dizziness and [inaudible 00:18:22].

Denise Walsh: Next slide. In conclusion, we want to state that it's very important. Effective documentation and coding for hypertension is all about the details. The documentation tells the relevant story of the patient. So the more detailed a provider is in documenting on the initial visit, or the initial encounter, makes the subsequent encounters easier. Documentation is easier and it is easier to code. The key to accurate coding and billing is all in the documentation and documentation is all about detail. Next slide. Here's some reference materials that relate to our presentation as well as Dr. Drummond's. Is Dr Drummond available? Is he logged in?

Laurie Fink: I believe so, Denise. It looks like he is listed under our panelist list. Dr. Drummond, can you hear us?

Vicky Mitchell: Dr. Drummond?

Jimmie Drummond: Yes, I can hear you. Can you hear me?

Laurie Fink: We sure can. Welcome.

Jimmie Drummond: Yes. I am here. Thank you. How is the reception?

Laurie Fink: It sounds great.

Jimmie Drummond: It sounds great. Okay. All right. Are we going to ... I guess we can go back to the beginning, and I can just go through the key aspects of hypertension management if you can take us back to the beginning? I appreciate everyone's time here. We want to take a look at them here on slide two. Take a look here at 2017 ACCAJ guidelines overview. A little bit about the pressure monitoring, which is essential. In the new guidelines in terms of patient participation, take a look here also at the QPP hypertension measure. And a bit about special populations. I think that's the section most of whatever there is remaining. You have already gone through. So let's proceed on to slide one. The next slide please.

Jimmie Drummond: Okay. I want to just do a bit of review here with reference to the new aspects of the 2017 American College of Cardiology and American Heart Association guidelines for hypertension care. This is by no means all of them, but if you look at some of the key recommendations, there under the classification of blood

pressure, of course elevated blood pressure as you can see highlighted there, is essentially as you can see, the 120-129 systolic range and then less than 80. Again, new for 2017 so that there's normal blood pressure less than 120 over 80. Again, elevated in stages as you can see there.

Jimmie Drummond: In terms of some of the pharmacological recommendations, of course there's more aggressive attention to blood pressure in that normal range, especially when there's existing co-morbidity in special populations. We'll talk about, there are some new ones there. Again, a big emphasis on cardiovascular disease, both primary and secondary prevention and the role that blood pressure plays in that. One of the key focuses is actually on measurement and it involves a lot of patient participation.

Jimmie Drummond: We'll take a look at a little bit of that there. Coming on down to treatment recommendations. Of course, the dietary recommendations with the DASH diet. You can see it there. Ideal weight and whatnot. Those are all key and then in terms of anti-hypertensive treatment, and we'll talk a little bit more about that. Next slide. Okay. So in terms of non-pharmacological interventions, of course relating to the patient side of the equation, you can see here with regard to the new guidelines leaning very heavily on the dietary aspect. Weight loss, sodium intake; actually the 1.5 grams per day is considered optimal. As a practicing physician for more than 25 years, those recommendations have steadily decreased and again key there, you can see the potassium recommendations.

Jimmie Drummond: And then, getting into aspects of physical activity as well as alcohol consumption. Again, just recapsulating some of the newer recommendations that have come out as of 2017. Yes, next slide. Okay. With regard to blood pressure monitoring, when I review these guidelines, this aspect comes front and center. If you take a look there at the ambulatory blood pressure monitoring, that is considered the best predictor. So for example, patient is in the office, they may have one of the two hypertension that you see the least that, mask high blood pressure or why it's called hypertension.

Jimmie Drummond: What the guidelines really focus is on the ambulatory monitoring and those readings at various times of the day. Using that really as a best predictor of both the risk of hypertension and also management of hypertension. So again, that out-of-office blood pressure monitoring is used to help both confirm and adjust medications, and I think much more emphasis is being put on that in the new guidelines. So as you're seeing patients and what not, just really focus on technique, how that ambulatory blood pressure monitoring are done and ensure those readings are retrieved and brought in so that it can be co-management with those ambulatory blood pressure readings key to diagnosis and treatment. Next slide.

Jimmie Drummond: Okay. With respect to the quality measures, of course these outcome measures related to processes and patient experience, this one is a high priority measure. Again the hypertension measure looks at ages 18 to 85, so you've got the top end of the pediatric population clear on into the geriatric group. This measure

looking at blood pressure being out of control less than 140 over 90 milligrams of mercury. Again, reflecting on what the previous slide showed, this is not actually good blood pressure control. The goal would be, as we saw it earlier, less than 120 over 80 as normal blood pressure.

Jimmie Drummond: So even at this level, you've got people that are heading into that stage one blood pressure reading. Really this quality measure, I think as far as at the far end of the spectrum in terms of having the patient under control. But again, it is a priority measure and an intermediate outcome and you can see at the bottom the different specialties and groups that it relates to. Okay. Next slide please. So when we talk about special populations, and again here in the inner city where I am, in an urban area, special populations and co-morbidities are very common.

Jimmie Drummond: The recommendations have certain specific guidelines that relate to populations and as you can see here, the first one related to reduction of cardiovascular disease is Chlorthalidone. Also, and again, a lot of this is familiar information I'm sure to population here, those that are caring for primary care and specialty care with relates to hypertension. But you can see here, there are certain classes of medication. For example ARBs and ACE inhibitors being discontinued during pregnancy. You can see some of the calcium channel blockers here.

Jimmie Drummond: As you know, there are three classes of calcium channel blockers. Actually, some of them are more associated with edema and would be avoided in cases where there's heart failure with a reduced ejection fraction. But you can see here that this particular class, the dihydropyridines can cause edema. The other classes of CCBs here are associated with bradycardia and heart block wouldn't be advised in that population and that's related to for example the dihydropyridines or verapamil.

Jimmie Drummond: Abrupt cessation, as you can see here, should be avoided due to the reflexive aspects of that related to heart and pulse rate and other things. Again, loop diuretics for heart failure decrease glomerular filtration rate would be in order. Yes, next slide please. All right, moving on. In primary aldosteronism, you can see here are related to the resistant and resistant hypertension, the two agents there related to treatment, spironolactone and eplerenone. Going on down to, and there's alpha blockers being used. You can see here orthostatic hypertension and the benign prosthetic hyperplasia. Again, those agents would be good in that population. Moving on down to diabetes and hypertension, again, fairly common occurrence with co-morbidities. The first action is in the new guidelines, is that blood pressure should be treated aggressively any time when there's a BP over 130 over 80 milligrams of mercury.

Jimmie Drummond: You can see the first line agents there. If there is albuminuria or pronuria, the ACE inhibitors of ARBs may be useful in that. In African-American population, without heart failure or chronic kidney disease, again a thyazide diuretic or a calcium channel blocker might be the appropriate way to go there. Two or more meds are generally recommended in the African-American population as well may be the case in others, again, to achieve the target goal of less than 130 over

80 millimeters of mercury. Next slide please. All right. We're wrapping up here. In terms of improvement strategies around that hypertension measure, adherence to the 2017 ATCHA treatment guidelines is something that I think is key to emphasize. If you've reviewed that document, it's a very extensive document with very, very good patient flow charts and diagrams. Specifically, it's heavy on special populations. I think adherence is close to those treatment guidelines with really the emphasis on the ambulatory management and co-management with the patient using that ambulatory blood pressure.

Jimmie Drummond: It is really going to help add to the efficacy of getting those patients in the proper range. So familiarity and implementation of those guidelines I think would be key. Again, ensuring patient's accuracy of the home blood pressure monitoring, we kind of talked about that. The lifestyle aspect of dietary recommendations and exercise are key to maintaining that control. We talked about the ambulatory. Encourage family and patient engagement. Again, hypertension is a lifestyle. You're talking about diet. You're talking about exercise. Those are things that involve the family. So again, encouraging the family to be a part of this is a key part. Ensuring compliance with drug therapies, especially for special populations. And I think also to the extent that the pharmacists and other staff, not just the physician or other healthcare provider, be involved in the educational aspects, both around the education, around exercise recommendations and dietary recommendations is good to have that patient home focus with related to hypertension and I think it will actually add benefits in other areas as well.

Jimmie Drummond: Next slide please. Okay. We talked a little bit about the guidelines, blood pressure monitoring, that hypertension measure and improvement strategies. That concludes my presentation.

Laurie Fink: All right. Well thank you, Dr. Drummond, and also thanks to Denise Walsh from Medical Revenue Cycle Specialist for your tips on coding. We really appreciate all this great information. I wanted to just remind everybody that when you close out of today's session, you will be automatically directed to a very brief evaluation. We ask that you please just take a quick moment to complete it, as we greatly appreciate your feedback and all of your comments. So thanks again for joining us today. Hope you have a great rest of the day and this session is now concluded. Thank you.

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