



September 14, 2015

Sent via E-mail

Dr. William Rogers
ICD-10 Ombudsman
Centers for Medicare and Medicaid Services

Ms. Diane Kovach
Director, Provider Billing Group
Center for Medicare
Centers for Medicare and Medicaid Services

RE: ICD-10 Transition Flexibility for Home Health Agencies

Dear Dr. Rogers and Ms. Kovach:

I am writing on behalf of the Alliance for Home Health Quality and Innovation regarding concerns about the transition to using ICD-10 diagnosis codes, particularly focusing on two issues described below.

The home health community has been preparing diligently for the transition to ICD-10, however the complexity of the ICD-10 code set has a steep learning curve. We were pleased to hear that “transition flexibility” would offer physicians an opportunity to continue to learn how to use ICD-10 codes accurately during the first year of the transition without the added concern that claims will be denied based on ICD-10 coding, as long as the diagnosis is coded to the correct “family of codes.” We were disappointed, however, to hear the clarification from Dr. Cohen on the August 27, 2015 National Provider Call that this flexibility would not be extended to health care providers other than physicians.

This is a significant issue for home health agencies because many home health referrals come directly from physician practices. Home health agencies work closely with physician practices because of the requirements of the Medicare home health benefit. To qualify for the home health benefit, a physician must establish the plan of care and there is a face-to-face encounter requirement (between the physician and the patient). Home health agencies often rely on information from physicians in order to code accurately.

The limited application of “transition flexibility” will result in home health agencies being required to code to the highest level of specificity, while the referring physician is not. If there is no incentive for the physician to provide to the home health agency the level of detail needed to code accurately at the highest level of specificity, home health agencies will be unable to meet the higher standard of specificity for ICD-10 coding on home health claims. We ask that the transition flexibility granted to the physician community by CMS be extended to home health agencies so that both communities will be on a level playing field as we make the transition to ICD-10.

In addition, even among the most reputable experts in coding, there has been conflicting technical information and guidance offered to agencies regarding ICD-10. Specifically, the use of the 7th character “A” for initial encounter, and “D” for subsequent encounter has recently been addressed by the AHA Coding Clinic. The guidance states that “A” in the 7th character should be used for any encounter where the patient is still receiving active treatment for the clinical condition, including home health. Home health coding experts have previously advised that an “A” would never be an appropriate 7th character for a home health claim, and CMS’s own grouper logic is designed such that case-mix and non-routine supply (NRS) points are not provided for any code with a 7th character of “A.” As a result, the case-mix payment will not be adequate to provide a level of care that matches the patient’s needs. We ask that this disconnect between the Coding Clinic’s guidance and the grouper logic be resolved fully, with clear communication to the home health community well in advance of the October 1st implementation date.

Thank you so much for your consideration of these matters. We would be happy to discuss these issues with you and can be reached at tlee@ahhqj.org or 202-239-3671.

Sincerely,

A handwritten signature in black ink, appearing to read "T.L. Lee".

Teresa L. Lee, JD, MPH
Executive Director