



August 19, 2015

Mr. Sean Cavanaugh  
Deputy Administrator  
Director of Center for Medicare at the Centers for Medicare and Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244

Dear Mr. Cavanaugh:

The Association of Home Care Coding & Compliance (AHCC) and its credentialing body the Board of Medical Specialty Coding & Compliance (BMSC) write in support of the request from the National Association of Home & Hospice Care (NAHC) that CMS extend to home health and hospice providers the same consideration being afforded physicians as they transition to the ICD-10 code system.

Physicians now have a full year's "forgiveness" for ICD-10 code errors as long as the physician uses a code from the right family. On the other hand, from day one home health and hospice agencies are required to select and sequence ICD-10 codes to the highest level of specificity. We are simply seeking to be treated equally in this transition.

Equal treatment of the homecare industry is especially important because home health agencies rely on documentation from referring physicians to support the codes selected and sequenced that, in part, determine episode payments. But, as it stands physicians have no incentive to make any effort to provide the necessary information because they have twelve more months to get into compliance without penalty. This will cause an unequal and detrimental impact on home health and hospice providers.

AHCC and BMSC respectfully suggest that agencies should not be penalized for lack of specificity. Additional documentation requests and audits resulting from such code errors should be suspended for the same 12-month period extended to physicians.

There is another equally if not more compelling reason why CMS must consider a period of forgiveness for home health agencies: there is a serious conflict between guidance released by the AHA Coding Clinic and the Grouper Logic used to calculate home health episode payments.

The Coding Clinic has determined that it is sometimes appropriate for home health agencies to use the 7<sup>th</sup> character A (initial encounter) when submitting a claim. They have given one specific example of the appropriate use of A, and intend to be more expansive in the interpretation of "initial encounter" as it pertains to home health services.

The problem: The home health Grouper Logic was developed as a subsequent-care model and does not award case-mix or non-routine supply (NRS) points to any code with a seventh character of A, indicating an initial episode. Case-mix points are a critical factor in the complex formula that is applied to determine episode payment. Fewer case-mix points results in lower payments for episodes with acutely ill patients who require increased utilization. Surely, CMS did not intend to withhold from agencies accurate and full payment for medically necessary services, or to undertake such a serious regulatory change without appropriate due process. However, the impact of the Coding Clinic's guidance being contrary to the Grouper Logic and CMS' position on this over the previous months will result in an effective reduction to the episodic payment in tens of thousands of episodes.

This is a massive and sweeping change with a significant negative impact. Such a change should not be announced in an answer issued by the Coding Clinic, which is not available to providers unless they subscribe to the Coding Clinic's service. It should be done through notice and comment rule making so that the scope of the change can be evaluated before a change is implemented.

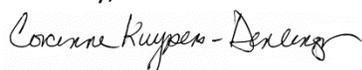
For example, the issue has been dismissed by CMS as having minimal impact on providers. That determination was made after 3M completed a code search at the request of CMS that showed fewer than 1,400 episodes would be affected by the 7<sup>th</sup> character issue. Unfortunately, the wrong codes were searched. We asked a benchmarking vendor that serves the home health industry to search the affected codes and uncovered 60,000 episodes in that same time period that once ICD-10 is implemented would have received lower payment. And that was just on a few codes; there are others. Following the appropriate regulatory process will prevent this issue from unfairly penalizing providers.

I and members of the AHCC and BMSC Boards have spent weeks in back and forth email exchanges with various CMS officials in a so far fruitless effort to impress upon them the urgency of this matter. I can forward those emails to you. I've asked for a conference call. No response. We are more than willing to meet face-to-face with those responsible for setting payment policy to explain just how serious the matter. And, I'm sure a representative from NAHC also would be eager to participate.

October 1, 2015 is 45 days away. Agencies already are dual coding, as every sixty-day episode since August 3 spans the October 1 implementation date. Please let me know how you and others at CMS intend to remedy this situation.

Thanks for your time and consideration.

Sincerely,



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