



Via Electronic Submission

May 17, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: **Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD–10–CM and ICD–10–PCS Medical Data Code Sets [CMS–0040–P] [RIN 0938–AQ13]¹**

Dear Acting Administrator Tavenner:

The American Association for Homecare (AAHomecare) submits these comments in response to the Centers for Medicare and Medicaid Services' (CMS) request for comments on the above captioned proposed rule. The proposed rule would impose a one-year delay on the transition to ICD-10 CM codes under the HIPAA administrative simplification regulations. AAHomecare strongly supports the proposed delay and believes that the benefits of the delay far outweigh costs to durable medical equipment suppliers (providers) or the health care system as a whole.

AAHomecare represents providers and manufacturers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) used by patients in their homes. A majority of public and private sector health plans include a DMEPOS benefit, and AAHomecare members must use electronic data interchange (EDI) to submit claims for DMEPOS to the plans. Consequently our members must use HIPAA standard electronic transactions and code sets when they perform electronic billing. As we explain in more detail below, AAHomecare members are significantly impacted by the transition from ICD-9 to ICD-10 codes for reasons that are unique to claim submission and payment for DMEPOS and that support the proposed delay.

¹ 77 Fed. Reg. 22950 (April 17, 2012)

I. HEALTH PLAN PAYMENT FOR DMEPOS

By way of background, the majority of DMEPOS items are furnished to patients either as monthly equipment rentals or as recurring purchases for supplies. Patients who require DMEPOS typically have a chronic or progressive medical condition that requires them to use equipment and supplies, often for the remainder of their lives. This means that providers bill health plans monthly for the DMEPOS over the course of a several-month period, with each rental period or sale constituting a new date of service (DOS) on the claim even though the equipment was actually furnished on the initial DOS many months before. This payment methodology is common under private and public health plans and distinguishes the DMEPOS health benefit from other inpatient or outpatient health services where each DOS corresponds to a single care episode rather than to an ongoing service.

When a provider bills for DMEPOS there could be as many as 36 months – or more – between the DOS for the initial claim and the DOS for subsequent claims. During the rental period, moreover, there will not have been an intervening change in the medical condition precipitating a patient's need for DMEPOS. If new or updated diagnosis codes take effect between the DOS for the initial and subsequent claims, HIPAA requires providers to use the most specific current code as of the DOS of the claim. This is inherently problematic for providers who are billing for a DMEPOS item based on the diagnosis a physician furnished months before when he or she gave the order for equipment or supplies. Inasmuch as there is no "one-to-one" crosswalk between ICD-9 and ICD-10 codes, providers will be forced to update claims "manually" to reflect the current ICD-10 code for the DOS billed. Consequently, the transition to ICD-10 codes has the potential to create significant hurdles to timely DMEPOS electronic claim submission and payment.

Depending on how CMS approaches the transition, providers also face the prospect of having inadequate medical necessity documentation to support their claims. CMS must give providers explicit guidance on how to handle the inevitable mismatch between the ICD-9 code they obtained with the initial order and the more specific ICD-10 code that may be applicable to subsequent claims. In issuing this guidance, it is foremost that the Agency consider that, for rentals initiated before the effective date of the transition, providers will be submitting claims for the same item furnished to the same patient with the same medical condition that he or she had prior to the transition, notwithstanding the existence of a more specific current ICD-10 code to describe it.

II. DMEPOS PROVIDERS' OPERATIONS AND DIAGNOSIS CODES

As an example, consider a typical provider's workflow with respect to a claim for home oxygen. Oxygen and oxygen equipment are reimbursed as ongoing rentals by a majority of health plans. Typically, oxygen patients suffer from long-term, progressive lung disease such as chronic obstructive pulmonary disease (COPD) which results in chronic hypoxemia. This means that the typical patient on home oxygen has no reasonable expectation of improving such that he or she will no longer require home oxygen therapy.

In this case, the provider receives a verbal order for oxygen from the patient's physician. The provider has an intake process through which additional information is obtained from the

physician to confirm the patient's medical necessity for the oxygen. This information includes the patient's diagnosis. Subsequently, the provider confirms this information in writing with the physician. The provider maintains this information, along with other medical necessity documentation, in its files. Thus, if the provider furnished oxygen to a patient with a diagnosis of COPD on May 12, 2012, that same patient will likely continue to require oxygen for the same diagnosis more than two years later on November 12, 2014. However, in the interim between the initial DOS, May 12, 2012, and the November 12, 2014 DOS, the HIPAA standard medical code set transitioned from ICD-9 CM to ICD-10 CM (assuming CMS implements the delay).

Now the provider in the example is unable to submit a HIPAA compliant claim for the oxygen because HIPAA requires him to use the most specific current diagnosis code as of the DOS on the claim. In this scenario, the provider has been using 496, the ICD-9 code which corresponds with the diagnosis he was given by the patient's physician in May 2012. In this case, the provider should be allowed to crosswalk the ICD-9 code to ICD-10 J44.9, COPD not specified, without having to contact the physician for a new diagnosis code.

While the above example is straightforward, the transition to ICD-10 for other diagnoses is more involved. For example, a patient with a fracture of the tibia and fibula, ICD-9 823, may be renting a wheelchair on August 1, 2014. On November 1, 2014, the patient continues to need the wheelchair for the same medical diagnosis, but the ICD-9 code the provider reported on the claim October 1, 2014, is no longer valid. Now the provider is faced with choosing from among nine ICD-10 codes that potentially apply to the patient's diagnosis because there is a higher degree of specificity under these codes.² Finally, the diagnosis information in the provider's medical necessity documentation does not match the ICD-10 codes on his claims because the ICD-9 codes in his records are no longer valid for the patient's diagnosis.

Again, the provider in this example should not be required to contact the physician for a new code. The provider should be permitted to crosswalk the ICD-9 code to the "not otherwise specified" ICD-10 code to submit the claim if he/she has no information to suggest that a more specific ICD-10 code would be appropriate.

III. AAHOMECARE RECOMMENDATIONS

AAHomecare raised this issue in 2003 when CMS implemented the administrative simplification regulations. Back then, CMS recognized the operational burdens that a transition to more specific diagnosis codes would entail for DMEPOS providers. In order to address these concerns, CMS delayed the transition and clarified providers' obligations in transitioning to more specific codes. CMS allowed providers to use diagnosis information in their records to migrate to a more specific

² S82Fracture of lower leg, including ankle; S82.0Fracture of patella; S82.1Fracture of upper end of tibia; S82.2Fracture of shaft of tibia; S82.3Fracture of lower end of tibia; S82.4Fracture of shaft of fibula; S82.5Fracture of medial malleolus; S82.6Fracture of lateral malleolus; S82.9 Unspecified fracture of lower leg; available at: <http://www.icd10data.com/ICD10CM/Codes/S00-T88/S80-S89/S82>; See <http://www.icd10data.com/ICD10CM/Codes/S00-T88/S80-S89/S82>; last accessed on May 16, 2012.

ICD-9 code if the information in the provider's files supported using the more specific code. If the information available in the provider's records did not support a more specific code, providers could submit a claim using an "unspecified" ICD-9 code for that particular diagnosis. Likewise, providers could use the information available in their records to support the medical necessity of a claim in an audit. The fact that the physician did not report a more specific ICD-10 code would not be the basis for a lack of medical necessity claim denial.

Importantly, CMS did not require providers to contact the physician for a more specific diagnosis code or to obtain a new order or certificate of medical necessity (CMN). CMS understood that the patient's underlying medical necessity for the DMEPOS item did not change by virtue of a change in an administrative requirement. In other words, CMS' response to providers' concerns in 2003 acknowledged that, for equipment furnished before the transition to more specific codes, providers would still be submitting claims for the same item furnished to the same patient with the same medical condition that he or she had before the transition, notwithstanding the existence of a more specific diagnosis code to describe it.

AAHomecare recommends that CMS take a similar approach to addressing the concerns we raised above. First, adopt a one-year delay of the transition to the ICD-10 CM code set. However, because implementing a delay is necessary, but not sufficient, CMS must also provide specific guidance on how DMEPOS providers should approach claim submission and medical necessity documentation in the transition to ICD-10 codes. AAHomecare strongly recommends that CMS continue its current policy of allowing providers to use information in their records to migrate to a more specific ICD-10 code if the information would support using that code. We also urge CMS to refrain from requiring providers to contact physicians to obtain a new order or other medical necessity documentation such as a CMN given that a change in the diagnosis code that describes a medical condition typically would not change the underlying condition.

CMS also must not deactivate ICD-9 codes so that providers can appeal or resubmit claims for DMEPOS with DOS prior to the transition to ICD-10.

IV. CONCLUSION

As we stated above, AAHomecare strongly supports CMS' proposal for a one-year delay in the implementation of the ICD-10 CM codes. AAHomecare recommends that CMS use the delay to address and clarify claim submission and medical necessity documentation for DMEPOS claims during the transition. We urge CMS to continue its current policy of allowing providers to migrate to a more specific code based on the diagnosis information in their records if the information supports using the more specific code.

Finally, providers should not be required to contact the physician to obtain a more specific current code or to obtain a new physician order or other medical necessity documentation such as a CMN. Requiring providers to contact physicians for this information is unnecessary and will only increase the operational burdens resulting from the transition.

Marilyn Tavenner

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Thank you for the opportunity to submit these comments. Please feel free to contact me at (703) 535-1894 if we can answer any questions or be of further assistance.

Sincerely,

A handwritten signature in black ink, appearing to read "Walter J. Gorski". The signature is fluid and cursive, with the first name "Walter" being the most prominent.

Walter J Gorski,

Vice President of Government Relations