Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which creates a 3% add-on to payments made for home health services to patients in rural areas. The add-on applies to episodes ending on or after April 1, 2010, through December 31, 2016. Similar to temporary rural add-on provisions in the past, claims that report a rural state code (code beginning with 999) as the Core Based Statistical Area (CBSA) code for the beneficiary's residence will receive the additional 3% payment. The CBSA code is reported associated with value code 61 on home health claims. The Centers for Medicare & Medicaid Services is working to expeditiously implement the home health rural add-on provision, Section 3131(c), of the PPACA. Be on the alert for more information about this provision and its impact on past and future claims.

MLN Matters® Number: MM6897 Revised
Related Change Request (CR) #: 6897
Related CR Release Date: April 28, 2010
Effective Date: March 1, 2010
Related CR Transmittal #: R1956CP
Implementation Date: October 4, 2010

Remittance Advice Coding to Identify Claims Subject to the Limitation on Home Health Prospective Payment System (HH PPS) Outlier Payments

Note: This article was updated on November 30, 2012, to reflect current Web addresses. This article was previously revised on May 17, 2011 to add a reference to MLN Matters® article MM7395 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7395.pdf) for an explanation of the calculation errors that have affected Home Health PPS outlier payments, and how Medicare will adjust any claim paid for dates of service since January 1, 2010. All other information is the same.

Provider Types Affected

This article is for Home Health Agencies (HHA) who submit claims to their Regional Home Health Intermediary (RHHI) or to the Home Health Medicare Administrative Contractor (HH MAC -- National Heritage Insurance Corporation (J 14 only)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6897, from which this article is taken, instructs Medicare RHHIs and the J14 HH MAC to use the combination of a new Remittance Advice Remark Code

(RARC) and a changed Claim Adjustment Reason Code (CARC) for institutional home health agency (HHA) claims that are subject to the Home Health Prospective Payment System (HH PPS) outlier limitation (effective on claims with dates of service on or after March 1, 2010).

The new RARC is N523 (*The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.*); and the newly associated CARC is B5 (*Coverage/program guidelines were not met or were exceeded.*).

Note: CR 6897 contains no new policy, but only creates coding to enable current policy to be more completely described.

Background

Effective January 1, 2010, the calendar year 2010 outlier payments made to each HHA are subject to an annual limitation of no more than 10% of the HHA's total HH PPS payments for the year.

Until now, CARC 45 (*charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement*) has been used to alert you when an outlier payment for a claim, that was otherwise eligible for an outlier payment, was not made because your outlier limitation had already been reached. However, while the Centers for Medicare & Medicaid Services (CMS) determined that CARC 45 is generally applicable to the outlier limitation, it does not fully describe the payment situation to you; and therefore, to improve the clarity of the remittance advice coding in these cases, and to facilitate your more easily identifying when a claim is subject to the HH PPS outlier limitation, CMS requested a new remittance advice remark code (RARC) to use in cases when the outlier limitation is met.

This new RARC is N523. CR 6897, from which this article is taken, instructs your RHHI to use RARC N523 for outlier payments; in conjunction with CARC B5, which CMS feels is more appropriate than CARC 45, when an outlier amount is calculated but cannot be paid.

Therefore, effective for claims with dates of service on or after March 1, 2010, when the calculated outlier amount is not paid due to the limitation, you will be alerted to this by the presence of the following codes on your remittance advice:

- Group code CO: "Contractual Obligation;"
- Claim adjustment reason code B5; and
- RARC N523.

Additional Information

Note that Medicare will take no action on claims processed prior to October 4, 2010, for the purpose of changing the assigned remittance advice coding.

You can find the official instruction, CR 6897, issued to your RHHI or HH MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1956CP.pdf on the CMS website.

You will find the updated *Medicare Claims Processing Manual,* Chapter 10 (Home Health Agency Billing) Section 10.1.21 (Adjustments of Episode Payment - Outlier Payments) as an attachment to that CR.

If you have any questions, please contact your RHHI or HH MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.