

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



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MLN Matters® Number: MM8950 **Revised**

Related Change Request (CR) #: CR 8950

Related CR Release Date: December 17, 2014

Effective Date: April 1, 2015 (Effective for claims received on or after April 1, 2015)

Related CR Transmittal #: R3151CP

Implementation Date: April 6, 2015

### **Correction to Remittance Information When Health Insurance Prospective Payment System (HIPPS) Codes are Re-Coded by Medicare Systems**

**Note: This article was revised on December 19, 2014, to reflect the revised CR8950 issued on December 17. In the article, all references to CARC 169 have been replaced with CARC 186. In addition, the CR release date, transmittal number, and the Web address for accessing CR8950 are revised. All other information remains the same.**

### **Provider Types Affected**

This MLN Matters® Article is intended for Inpatient Rehabilitation Facilities (IRFs), Home Health Agencies (HHAs), and Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for services provided to Medicare beneficiaries.

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## Provider Action Needed

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Change Request (CR) 8950 contains no new payment policy. CR 8950 improves the implementation of existing policies.

CR 8950:

1. Provides approved remittance advice code pairs to apply to claims in which only a Remittance Advice Remark Code (RARC) is currently used. This correction is required for compliance with operating rules of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE).
2. Reflects changes to the Home Health (HH) Pricer logic that were implemented as part of the 2015 Home Health Prospective Payment System (HH PPS) payment update.

Make sure that your billing personnel are aware of these changes.

## Background

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The Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set was implemented by January 1, 2014, as the Affordable Care Act required. In order to be compliant with these Operating Rules, the processing of Original Medicare claims must use remittance advice code combinations that are included in this list that CAQH CORE developed.

Recently, MACs informed the Centers for Medicare & Medicaid Services (CMS) of two situations in which past instructions specified only a single code for a payment adjustment, rather than a compliant pair.

1. Since 2000, Medicare systems have re-coded the Health Insurance Prospective Payment System (HIPPS) code submitted on home HH PPS claims in various circumstances. Under prior instructions, Medicare systems applied only RARC N69 (PPS code changed by claims processing system) without a corresponding claim adjustment reason code (CARC).
2. In 2012, Change Request (CR) 7760 began the implementation of a process to validate HIPPS codes against the assessment records submitted to the Quality Improvement Evaluation System (QIES). This process currently applies to inpatient rehabilitation facility claims and will be expanded to HH and skilled nursing facility claims in the future. CR7760 only required Medicare systems to apply RARC N69 to claims recoded based on QIES data, also without a corresponding Claim Adjustment Reason Code (CARC). You can find the associated MLN Matters® Article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7760.pdf> on the CMS website.

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CR8950 seeks to correct these oversights. However, CAQH CORE has not yet assigned approved code pairs for RARC N69. Medicare will request the approval of RARC N69 to be paired with CARC 186, Medicare systems will apply CARC 186 with RARC N69 in both situations described above.

Your MAC will:

1. Apply the following remittance advice codes on claims with Type of Bill (TOB) 032x (Home Health Services under a Plan of Treatment) when the output HIPPS code returned by the HH Pricer is different from the input HIPPS code:
  - Group code: CO
  - CARC: 186
  - RARC: N69
2. Apply the following remittance advice codes on claims with TOBs 011x (Hospital Inpatient (Part A)) with CMS Certification Numbers (CCNs) XX3025 - XX3099, XXTXXX, or XXRXXX, or TOBs 018x (Hospital Swing Bed), 021x (SNF Inpatient) or 032x (Home Health) when a HIPPS code is changed due to response file information received from QIES:
  - Group code: CO
  - CARC: 186
  - RARC: N69

HIPPS codes changed on the basis of validation with QIES data are not currently displayed to providers on Direct Data Entry (DDE) screens and are not being sent to the remittance advice.

CR8950 also reflects changes to the HH Pricer logic that were implemented as part of the 2015 HHPPS payment update. You can find these changes in the updated “Medicare Claims Processing Manual,” Chapter 10 (Home Health Agency Billing), Section 70.4 (Decision Logic Used by the Pricer on Claims), which is attached to CR8950.

## Additional Information

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The official instruction, CR8950 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3151CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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