CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1956	**Date: April 28, 2010**
	Change Request 6897

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

I. SUMMARY OF CHANGES: This Change Request implements a new remittance advice remark code. This code will enable home health agencies to more easily identify on their remittance advice when a claim is subject to the HH PPS outlier limitation.

EFFECTIVE DATE: March 1, 2010
IMPLEMENTATION DATE: October 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.1.21/Adjustments of Episode Payment - Outlier Payments

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1956	Date: April 28, 2010	Change Request: 6897

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

Effective Date: March 1, 2010
Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: Effective January 1, 2010, for calendar year 2010, the outlier payments made to each HHA are subject to an annual limitation. Medicare systems ensure that outlier payments comprise no more than 10% of the HHA's total HH PPS payments for the year. When Medicare systems identify that a claim would be eligible for an outlier payment, but the HHA's outlier limitation is already met, the outlier payment is not made and claim adjustment reason code (CARC) 45 has been used to identify the reason.

The definition of CARC 45 is "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." While this code is applicable to the outlier limitation, it does not fully describe the payment situation to the HHA. To improve the clarity of the remittance advice coding in these cases, CMS requested a new remittance advice remark code (RARC) to use in cases when the outlier limitation is met. The new code 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.

This new RARC is effective March 1, 2010. Additionally, the committee that assigns new RARC codes has advised CMS that CARC B5 would be more appropriate for this situation. The definition of this CARC is:

B5 Coverage/program guidelines were not met or were exceeded.

CMS agrees that the combination of CARC B5 and RARC N523 describes the outlier limitation more accurately. This transmittal instructs Medicare contractors to use this code combination when Medicare's outlier limitation applies.

B. Policy: This transmittal contains no new policy. This transmittal creates coding to enable current policy to be more completely described on remittance advices.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6897.1	Medicare contractors shall use claim adjustment reason code B5, rather than code 45, on the remittance advice of institutional home health claims with dates of service on or					X	X				HH MAC (J14

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	after March 1, 2010, when an outlier amount is calculated but cannot be paid.										only)
6897.2	Medicare contractors shall use remittance advice remark code N523 in addition to claim adjustment reason code B5 on the remittance advice of institutional home health claims with dates of service on or after March 1, 2010, when an outlier amount is calculated but cannot be paid.					X	X				HH MAC (J14 only)
6897.3	Medicare contractors shall take no action to adjust institutional home health claims with dates of service on or after March 1, 2010, which were processed before October 4, 2010, for the purpose of changing the assigned remittance advice coding.					X					HH MAC (J14 only)

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6897.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					X					HH MAC (J14 only)

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148 or Yvonne Young, yvonne.young@cms.hhs.gov, 410-786-1886

Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.1.21 - Adjustments of Episode Payment - Outlier Payments

(Rev. 1956; Issued: 04-28-10; Effective Date: 03-01-10; Implementation Date: 10-04-10)

HH PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in 60-day periods, Medicare claims processing systems will provide extra or "outlier" payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

Outlier determinations will be made by comparing the **total of the products** of:

- The number of visits of each discipline on the claim **and** each wage-adjusted national standardized per visit rate for each discipline; with

- The **sum** of the episode payment **and** a wage-adjusted standard fixed loss threshold amount.

If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode.

Outlier payment amounts are wage index adjusted to reflect the CBSA in which the beneficiary was served. Outlier payments are to be made for specific episode claims. The outlier payment is a payment for an entire episode, and therefore carried only at the claim level in paid claim history; and not allocated to specific lines of the claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total payment for the episode claim on a remittance, but it will be identified separately on the claim in history using value code 17 with an associated dollar amount representing the outlier payment.

Outlier payments will also appear on the electronic remittance advice in a separate segment. The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HH PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

Effective January 1, 2010, for calendar year 2010, the outlier payments made to each HHA will be subject to an annual limitation. Medicare systems will ensure that outlier payments comprise no more than 10% of the HHA's total HH PPS payments for the year. Medicare systems will track both the total amount of HH PPS payments that each HHA has received and the total amount of outlier payments that each HHA has received. When each HH PPS claim is processed, Medicare systems will compare these two amounts and determine whether the 10% has currently been met.

If the limitation has not yet been met, any outlier amount will be paid normally. (Partial outlier payments will not be made. Only if the entire outlier payment on the claim does not result in the limitation being met, will outlier payments be made for a particular claim.) If the limitation has been met or would be exceeded by the outlier amount calculated for the current claim, other HH PPS amounts for the episode will be paid but any outlier amount will not be paid. When the calculated outlier amount is not paid, HHAs will be alerted to this by the presence of *the following codes on their remittance advice:*

Group code CO: "Contractual Obligation"

Claim adjustment reason code B5: "Coverage/program guidelines were not met or were exceeded."

Remittance advice remark code 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."

Since the payment of subsequent claims may change whether an HHA has exceeded the limitation over the course of the timely filing period, Medicare systems will conduct a quarterly reconciliation process. All claims where an outlier amount was calculated but not paid when the claim was initially processed will be reprocessed to determine whether the outlier has become payable. If the outlier can be paid, the claim will be adjusted to increase the payment by the outlier amount.

These adjustments will appear on the HHA's remittance advice with a type of bill code that indicates a contractor-initiated adjustment (type of bill 3XI) and the coding that typically identifies outlier payments. This quarterly reconciliation process occurs four times per year, in February, May, August and November.