DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9826 | **Related Change Request (CR) #: CR 9826**

Related CR Release Date: October 27, 2016 | **Effective Date: Claims received on or after April 1, 2017**

Related CR Transmittal #: R3630CP | **Implementation Date: April 3, 2017**

Correcting Editing for Condition Code 54 and Updating Remittance Advice Messages on Home Health Claims

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9826 informs MACs about corrections to Medicare systems to require condition code 54 on Home Health (HH) appropriately. The system edit that enforces proper reporting of condition code 54 should only set when no skilled visits are reported by the provider. Currently, the edit is also setting when skilled service lines are denied during review. CR9826 also updates remittance advice coding combinations to ensure compliance with industry standards. CR9826 contains no new policy.

Background

CR9474 updated Original Medicare systems to accept and process condition code 54 in cases when a HH claim contained no skilled visits in a billing period and a policy exception is documented at the Home Health Agency (HHA). A system edit requires condition code 54 to be present when a claim for an episode of continuing care is submitted for payment with no skilled visits. This edit is functioning properly with regard to visits submitted as non-covered by the HHA. Shortly after CR9474 was implemented, MACs reported that the edit is also setting on claims that were submitted with covered skilled visits but those visits were non-covered during medical review. CR9826 corrects this problem.

As a result of CR9826, Medicare will return claims to the HHA when the type of bill is 0327 or 0329 and the From Date is not equal to the Admission Date, and no revenue code 042x, 043x, 044x or 055x line with covered charges is present **upon receipt of the claim**, and condition code 20, 21 or 54 is not present and the claim receipt date is on or after July 1, 2016. This revises the criteria for CR9474 in order to exclude lines for which charges are moved from covered to non-covered during adjudication.

Medicare has determined the remittance advice code pair used when the HH outlier limit is applied is not compliant with industry standards. The Remittance Advice Remark Code (RARC) that was created for this policy, N523, is no longer part of any compliant code pair and will no longer be used. When an outlier amount is withheld due to the HH outlier limitation policy, MACs will use Group Code CO and Claim Adjustment Reason Code (CARC) 119.

Additional Information

The official instruction, CR9826, issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3630CP.pdf**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.