CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 851

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 10, 2006

Change Request 4218

SUBJECT: Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institutions (RNHCI) Specialty Contractor Regarding Claims for Beneficiaries with RNCHI Elections

I. SUMMARY OF CHANGES: This transmittal manualizes instructions from Program Memorandum AB-03-145 and also creates new sections on the billing process for Religious Nonmedical Health Care Institution (RNHCI) claims. It removes a manual section on Canadian or Mexican Religious Nonmedical Health Care facility claims and revises a section referring to such claims. It also moves information regarding RNHCI from chapter 2 to chapter 3.

NEW/REVISED MATERIAL

EFFECTIVE DATE: May 11, 2006

IMPLEMENTATION DATE: May 11, 2006

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	2/120/Religious Nonmedical Health Care Institution (RNHCI) Admission
D	2/120.1/Election Requirements
D	2/120.2/Revocation of Election
D	2/120.3/Completion of the Uniform (Institutional Provider) Bill (Form CMS 1450) Notice of Election for RNHCI
D	2/120.4/Common Working File (CWF)
R	3/Table of Contents
D	3/110.10/Canadian or Mexican Religious Nonmedical Health Care Facility Claims
R	3/120.2/Designated FIs and Carriers

R	3/170/Billing and Processing Instructions for Religious Nonmedical Health Care Institution (RNHCI)Claims
N	3/170.1/RNHCI Election Process
N	3/170.1.1/Requirement for RNHCI Election
N	3/170.1.2/Revocation of RNHCI Election
N	3/170.1.3/Completion of the Uniform (Institutional Provider) Bill (Form CMS 1450) Notice of Election for RNHCI
N	3/170.1.4/Common Working File (CWF) Processing of Elections, Revocations and Cancelled Elections
N	3/170.2/Billing Process for RNHCI Services
N	3/170.2.1/When to Bill for RNHCI Services
N	3/170.2.2/Required Data Elements on Claims for RNHCI Services
N	3/170.3/RNHCI Claims Processing by RNHCI Specialty Contractor
N	3/170.4/Informing Beneficiaries of the Results of RNHCI Claims Processing
N	3/170.5/Billing and Payment of RNHCI Items and Services Furnished in the Home
N	3/180/Processing Claims For Beneficiaries With RNHCI Elections by Contractors Other Than the RNHCI Specialty Intermediary
N	3/180.1/Recording Determinations of Excepted/Nonexcepted Care on Claim Records
N	3/180.2/Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 851	Date: February 10, 2006	Change Request 4218

SUBJECT: Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institutions (RNHCI) Specialty Contractor Regarding Claims for Beneficiaries With RNHCI Elections

I. GENERAL INFORMATION

A. Background: In large part, this transmittal publishes enhancements to Medicare manuals to more clearly explain the RNHCI benefit. The majority of these manual changes do not create any new business requirements for Medicare contractors. However, this transmittal manualizes instructions from Program Memorandum (PM) AB-03-145. That PM changed the development process for claims for beneficiaries with RNHCI elections from a review of medical records to a telephone contact process. The CMS had determined that medical record review was an unnecessarily resource intensive process and was a use of medical review resources outside of its usual scope (program integrity). The intent of PM AB-03-145 was to simplify the development process.

Since the issuance of PM AB-03-145 a number of contractor sites other than the RNHCI specialty contractor (non-specialty contractors) have expressed sufficient concerns about the telephone contact process to cause CMS to revise it. Non-specialty contractors with high volumes of RNHCI related claims rejects reported difficulty contacting providers and reported beneficiaries were not willing or able to supply the necessary information to enable the contractor to make a determination of whether the care was excepted or nonexcepted care under RNHCI benefit policies. These contractors also expressed concerns about the lack of written documentation from the provider in the telephone-based process.

To address these concerns without reverting to a review of medical records, CMS has developed the requirements below. Telephone contacts will be replaced with the issuance of a simple development letter asking the questions key to a determination of excepted vs. nonexcepted care. The CMS does not mandate which staff within each non-specialty contractor site must process the providers' responses to these letters. However, typical responses will not require clinical background to process and can be performed outside of medical review departments (see requirements 4218.2 – 4218.3). Only in the case of non-response to the letter will a review of the claim coding by a clinically trained employee be required (see requirement 4218.4).

B. Policy: The statutory basis for the RNHCI benefit is contained in §1821 of the Social Security Act. Medicare regulations pertaining to RNHCI are found in 42 CFR 403 Subpart G.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4218.1	Upon receipt of a claim rejected by CWF due to an RNHCI election, contractors shall suspend the claim for development to determine whether care was excepted or nonexcepted.	X	X	X	X					
4218.2	Upon receipt of a claim rejected by CWF due to an RNHCI election, contractors shall issue a development letter designed to determine whether care was excepted or nonexcepted.	X	X	X	X					
4218.2.1	Contractors shall issue RNHCI development letters that ask questions about the following: • Whether the beneficiary paid for the services out of pocket in lieu of requesting payment from Medicare. • Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed. • Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.	X	X	X	X					
4218.2.2	Contractors shall phrase questions in RNHCI development letters to be answered with a Yes or No response.	X	X	X	X					
4218.2.3	Contractors should develop the wording and format of this letter based on their experience effectively communicating with their community of providers.	X	X	X	X					
4218.3	Contractors shall make determinations of excepted or nonexcepted care based on provider responses to development letters.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4218.3.1	Contractors shall make determinations of excepted care when a provider responds 'Yes' to any of the questions in the letter.	X	X	X	X					
4218.3.2	Contractors shall make determinations of nonexcepted care when a provider responds 'No' to all of the questions in the letter.	X	X	X	X					
4218.3.3	Contractors shall make determinations of excepted or nonexcepted care within 30 days of receipt of the provider's response.	X	X	X	X					
4218.4	Contractors shall make an excepted/nonexcepted determination based on the evidence presented by the claim itself if the provider does not reply timely to the development letter.	X	X	X	X					
4218.4.1	For claims for which no timely response was received, contractors shall make a determination of nonexcepted care if the claim contains durable medical equipment or prosthetic/orthotic devices.	X	X	X	X					
4218.4.2	For claims for which no timely response was received, contractor staff with a clinical background shall use the diagnoses and procedures reported on the claim to make their best determination whether the services were excepted or nonexcepted care.	X	X	X	X					
4218.4.3	Contractors shall apply the same timeliness standard to responses to RNHCI development letters as to all other documentation requests.	X	X	X	X					
4218.4.4	For claims for which no timely response was received, contractors shall make determinations of excepted or nonexcepted care within 30 days of the end of the timely response period.	X	X	X	X					
4218.5	Contractors shall deny the claim for excepted services if the response to the RNHCI development letter indicates the beneficiary paid for the services out of pocket.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4218.5.1	Contractors shall deny the claim for excepted services when the beneficiary paid out of pocket using reason code 125 and remark code MA47.	X	X	X	X					
4218.5.2	Contractors shall use Medicare Summary Notice (MSN) message 16.41 when they deny the claim for excepted services when the beneficiary paid out of pocket.	X	X	X	X					
4218.6	The RNHCI specialty contractor shall update their revenue code file to conform with the allowable revenue codes specified in Pub. 100-04, Chapter 3, Section 170.2.2.									RNHCI Specialty Contractor

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4218.7	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4218.1	The CWF reject code in this situation is 5189.
4218.3 and 4218.4	Determinations of excepted or nonexcepted care are recorded on claims as described in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 180.1.
4218.5.1	The definition of reason code 125 is "Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate." The definition of remark code MA47 is "Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment."
4218.5.2	The definition of MSN message 16.41 is "Payment is being denied because you refused to request reimbursement under your Medicare benefits."

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: The changes in this transmittal should reduce contractor workloads associated with telephone contacts of providers and beneficiaries**.**

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: May 11, 2006 **Implementation Date:** May 11, 2006 **Pre-Implementation Contact(s):** Jean-Marie Moore (RNHCI policy) at 410-786-3508 or Wil Gehne (claims processing) at 410-786-6148 **Post-Implementation Contact(s):** Jean-Marie Moore (RNHCI policy) at 410-786-3508 or Wil Gehne (claims processing) at 410-786-6148	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

120 - Religious Nonmedical Health Care Institution (RNHCI) Admission

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Upon admission to a religious nonmedical health care institution (RNHCI) and prior to the RNHCI billing for services, a beneficiary must make a written election to receive benefits under §1821 of the Act and to receive payment under the Medicare program. For policies and requirements concerning the election, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130. For instructions regarding submission of notice of election to Medicare, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 170.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

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(Rev. 851, 02-10-06)

120.2 - Designated FIs and Carriers

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

The appropriate FI processes claims for services provided. The hospital forwards these claims and any subsequent appeals directly to the appropriate FI. The State in which a beneficiary lives will determine which FI to send a shipboard or foreign claim. If a beneficiary lives in one state but receives emergency services from a VA or DOD provider in another state, the claims should be processed in the state where the emergency services were rendered.

A - FIs

Canada

New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	Associated Hospital Services 2 Gannett Drive Portland, ME 04106-6911
Ontario	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804
Alberta Manitoba Saskatchewan	Blue Cross & Blue Shield of Montana, Inc. 3360 10th Avenue, South Post Office Box 5004 Great Falls, Montana 59403
British Columbia Northwest Territories Vancouver Yukon Territories	Premera Blue Cross 7001 - 220th S.W. Mountlake Terrace, Washington 98043

Mexico

Western Mexico (Sonora and the Bajas	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trailblazer Health Enterprises, LLC 8330 LBJ Freeway Executive Center 3 Dallas, Texas 75243 P.O. Box 660156 Dallas, Texas 75266-0156

See the Intermediary Carrier Directory at: http://www.cms.hhs.gov/apps/contacts/incardir.asp

Domestic Emergency Claims and Veterans Administration/Department of Defense Claims, Foreign (other than Canada and Mexico) and Shipboard Claims

Region I
Associated Hospital Services,
2 Gannett Drive, South
Portland, ME 04106-6911

Region III
Veritus Medicare Services
120 Fifth Avenue, Suite P5101
Pittsburgh, PA 15222

Region IV
Blue Cross and Blue Shield of Florida
532 Riverside Ave.
17th & 18th Floors
Jacksonville, FL 32202

Region VI
Trailblazer Health Enterprises, LLC
8330 LBJ Freeway
Executive Center 3
Dallas, Texas 75243
P.O. Box 660156
Dallas, Texas 75266-0156

Region VII
Blue Cross and Blue Shield of Nebraska
7261 Mercy Rd.
Omaha, NB 68124
P.O. Box 3248 Main Post Office Station
Omaha, NB 68180

Region IX
United Government Services
401 West Michigan Street
Milwaukee, Wisconsin 53202-2804

Because there is no designated FI for Regions II, V, VIII, and X, the affected institutions must submit the claims to the servicing FI in their State. See http://www.cms.hhs.gov/apps/contacts/incardir.asp for a list of FIs.

B - Designated Carriers

The following carriers are designated to process claims for physicians' and ambulance services furnished in connection with a covered hospital stay in Canada and Mexico.

Canada

New Brunswick
Newfoundland
Nova Scotia
Quebec
Prince Edward Island

National Heritage Insurance Company
402 Otterson Drive
Chico, CA 95928

National Heritage Insurance Company
75 Sgt. William Terry Drive
Hingham, MA 02044

Ontario	Wisconsin Physicians Service Insurance Corporation P.O. Box 8190 Madison, Wisconsin 53708 1601 Engel Street Madison, Wisconsin 53713
Alberta Manitoba Saskatchewan	Blue Cross & Blue Shield of Montana, Inc. 3360 10th Avenue, South Post Office Box 5017 Great Falls, Montana 59403
British Columbia Northwest Territories Vancouver Yukon Territories	Noridian Mutual Insurance Company 4305 13th Avenue, S.W. Fargo, North Dakota 58103
Mexico	
Western Mexico (Sonora and the Bajas)	National Heritage Insurance Company 402 Otterson Drive Chico, CA 95928
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trailblazer Health Enterprises, LLC 8330 LBJ Freeway Executive Center 3 Dallas, Texas 75243 P.O. Box 660156 Dallas, Texas 75266-0156

170 - *Billing and Processing Instructions for Religious Nonmedical Health Care Institution (RNHCI) Claims*

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

170.1 - RNHCI Election Process

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

See Chapter 5, Section 40 of Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual for a definition of RNHCI providers. See Chapter 1, Section 130 of Pub. 100-02, Medicare Benefit Policy Manual for more information about the RNHCI benefit and coverage.

170.1.1 - Requirement for RNHCI Election

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

The RNHCI benefit provides only for Part A inpatient services. For an RNHCI to receive payment under the Medicare program, the beneficiary must make a written election to

receive benefits under §1821 of the Act. To elect religious nonmedical health care services, the beneficiary or the beneficiary's legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment, and the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs.

All submissions regarding RNHCI services are processed by a specialty Medicare contractor. Currently the Riverbend GBA fiscal intermediary is the specialty contractor. The completed election form must be filed with the specialty contractor and a copy retained by the RNHCI provider. See section 170.1.3 below for instructions on the submission of the election to the specialty contractor.

The RNHCI provider should question each beneficiary prior to executing the election statement to determine if the beneficiary has Medicare Part B coverage in effect via a health plan or has recently received care (services or items, including physician-ordered durable medical equipment) for which Medicare payment was sought. An affirmative answer will alert the RNHCI provider that subsequent claims under the election may be denied.

170.1.2 - Revocation of RNHCI Election

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Under §1821(b)(3), a beneficiary may revoke an election in writing or by receiving nonexcepted medical care. Once an election has been revoked, Medicare payment cannot be made to an RNHCI unless a new valid election is filed. The RNHCI revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of his/her Medicare coverage. Multiple revocations may affect the beneficiary's ability to access the RNHCI benefit in the future (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130.2.2).

Written revocations received from a beneficiary must be filed by the RHNCI with the specialty contractor and a copy retained by the RNHCI provider. Revocations may be filed using the same format as elections, indicating a revocation in the type of bill code. See section 170.1.3 below for details.

170.1.3 - Completion of the Uniform (Institutional Provider) Bill (Form CMS-1450) Notice of Election for RNHCI

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

This form, also known as the UB-92, was developed to be suitable for submitting claims to most third party payers (both Government and private). Because it serves the needs of many payers, a particular payer may not need some data elements. Detailed information is given only for items required for the notice of election and related transactions. Items not listed need not be completed, although the RNHCI may complete them when billing multiple payers.

Elections, revocations and cancellations of elections may be submitted to the specialty contractor via the hard copy UB-92 format or via the contractor's Direct Data Entry (DDE) system. Election transactions are not covered transaction under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and therefore the HIPAA standard claim transaction is not required. Additionally, the HIPAA standard claim transaction (ANSI ASC

X12 837 Institutional claim format) does not support the data requirements of these transactions.

Such RNHCIs complete FLs 1, 4, 12, 13, 14, 15, 17, 51, 58, 60, and 85 of the hard copy UB-92 or the equivalent DDE fields as described below.

Form Locator (FL) 1 - Provider Name, Address, and Telephone Number

Required - The minimum entry is the RNHCI's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five- or 9-digit ZIP codes are acceptable. The RNHCI uses the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4 - Type of Bill

Required - The RNHCI enters the 3-digit numeric type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit (commonly referred to as a "frequency" code) indicates in this instance the nature of the election related transaction. The RNHCI enters type of bill 41A, 41B, or 41D as appropriate.

Valid codes for RNHCI elections:

1st Digit - Type of Facility

4- Religious Nonmedical Health Care Institution

2nd Digit - Classification (Special Facility)

1- Inpatient (Part A)

3rd Digit – Frequency

A - RNHCI election notice

B - RNHCI revocation notice

D – Cancellation

The RNHCI submits type of bill 41D to the specialty contractor as a cancellation of a previously submitted notice of election or notice of revocation, when it was submitted in error. In situations where the RNHCI is correcting a previously submitted date, they submit a new type of bill 41A to the specialty contractor for processing.

FL 12 - Patient's Name

Required - The RNHCI enters the patient's name with the surname first, first name, and middle initial, if any.

FL 13 - Patient's Address

Required - The RNHCI enters the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

FL 14 - Patient's Birth Date

Required - (If available.) The RNHCI enters the month, day, and year of birth numerically as MMDDCCYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

FL 15 - Patient's Sex

Required - The RNHCI enters an "M" for male or an "F" for female.

FL 17 - Admission Date

Required - The RNHCI enters the date of the election, revocation or cancellation. In no instance should the date be prior to July 1, 2000. Show the month, day, and year numerically as CCYYMMDD.

FLs 51 A, B, or C - Provider Number

Required - This is the 6-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50. RNHCI provider numbers are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

FLs 58A, B, or C - Insured's Name

Required - The RNHCI enters the beneficiary's name on line A if Medicare is the primary payer. The RNHCI enters the name as on the beneficiary's HI card. If Medicare is the secondary payer, the RNHCI enters the beneficiary's name on line B or C, as applicable, and enters the insured's name on line A.

FLs 60A, B, or C - Certificate/Social Security Number and Health Insurance Claim/Identification Number

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL 58, the RNHCI enters the patient's HICN. For example, if Medicare is the primary payer, it enters this information in FL 60A. The RNHCI enters the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, MSN, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 85-6 - Provider Representative Signature and Date

Required - An RNHCI representative makes sure an original, signed RNHCI election statement has been sent to the specialty contractor and the RNHCI has retained a copy in its records before signing Form CMS-1450. A stamped signature is acceptable on Form CMS-1450.

170.1.4 - Common Working File (CWF) Processing of Elections, Revocations and Cancelled Elections

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

The specialty contractor submits all RNHCI election, revocations and cancelled elections to CWF for approval. The CWF will transmit a disposition 01 to notify the specialty contractor that these transactions were received and accepted. The CWF uses these records to maintain a beneficiary file of all RNHCI beneficiary elections and revocations. This file is used in processing claims for RNHCI services (see section 170.3 below) and for other Medicare services (see section 180).

CWF rejects any notices of revocations or cancellations when:

- *CWF history shows no RNHCI elections are on file;*
- *The submitted dates do not match the elections on file;*
- *The revocation date is prior to the date of the election;*
- *The election in question has already been revoked or cancelled; or*
- *CWF history indicates an RNHCI claim has been processed during the election period to which the revocation or cancellation applies. If these claims were submitted in error, the RNHCI must cancel the claims prior to resubmitting the revocation or cancellation.*

170.2 - Billing Process for RNHCI Services

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

170.2.1 - When to Bill for RNHCI Services

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

RNHCIs submit claims to the specialty contractor in the following situations:

- *At the time of beneficiary's discharge, or death.*
- *At the time the beneficiary's benefits are exhausted.*
- *On an interim basis monthly.*

RNHCIs submit a claim even where the charges do not exceed the beneficiary's deductible. See section 40.1.1 for instructions regarding inpatient no payment billing.

170.2.2 - Required Data Elements on Claims for RNHCI Services

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

Both the electronic claim transaction and the hardcopy form are suitable for use in billing multiple third party payers. This section details only those data elements required for Medicare billing. When RNHCIs are billing multiple third parties, they complete all items required by each payer who is to receive a claim for the services.

Form Locator (FL) l - (Untitled) Provider Name, Address, and Telephone Number

Required - The RNHCI must enter their name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using

standard post office abbreviations. Five or 9-digit zip codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone/Fax numbers are desirable.

FL 3 - Patient Control Number

Optional - The RNHCI may report a beneficiary's control number if they assign one and need it for association and reference purposes.

FL 4 - Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this claim in this particular episode of care. It is a "frequency" code.

Valid codes for RNHCI claims:

lst Digit-Type of Facility

4 - Religious Nonmedical Health Care Institution

2nd Digit Classification (Except Clinics and Special Facilities)

1 - Inpatient (Part A)

3rd Digit-Frequency	***Definition***
0-Nonpayment/zero claims	*Use when you do not anticipate payment from the payer for the bill but are merely informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Nonpayment bills are required only to extend the "spell of illness." See code 71 FL 36 below.*
l-Admit Through Discharge Claims	*Use for a bill encompassing an entire inpatient confinement for which you expect payment from the payer or for which Medicare utilization is chargeable.*
2-Interim-First Claim	*Use for the first of an expected series of payment bills for the same confinement or course of treatment for which Medicare utilization is chargeable.*
3-Interim-Continuing Claim	*Use when a payment bill for the same confinement or course of treatment has been submitted, further bills are expected to be submitted and Medicare utilization is chargeable.*

4-Interim-Last Claim	*Use for a payment bill which is the last of a series for this confinement or course of treatment when Medicare utilization is chargeable. The "Through" date of this bill (FL 6) is the discharge date for this confinement.*
7-Replacement of Prior Claim	*Use to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.*
8-Void/Cancel of a Prior Claim	*This code indicates the bill is an exact duplicate of an incorrect bill previously submitted. Enter a code "7" (Replacement of Prior Claim) showing the correct information.*

FL 6 - Statement Covers Period (From - Through)

Required - The RNHCI must enter the beginning and ending dates of the period covered by this bill as (MM-DD-YY). Enter the date of discharge or the date of death in the space provided under "Through." The statement covers period may not span 2 accounting years.

FL 7 - Covered Days

Required - The RNHCI must enter the total number of covered days during the billing period, including lifetime reserve days elected for which Medicare payment is requested. Covered days exclude any days classified as noncovered as defined in FL 8, the day of discharge, and the day of death.

Covered days are always in terms of whole days rather than fractional days. As a result, the covered days do not include the day of discharge, even where the discharge was late.

The RNHCI does not deduct any days for payment made under workers' compensation, automobile medical, no-fault, liability insurance, or an EGHP for an ESRD beneficiary or employed beneficiaries and spouses age 65 or over. The specialty contractor will calculate utilization based upon the amount Medicare will pay and will make the necessary utilization adjustment.

FL 8 - Noncovered Days

Required - The RNHCI must enter the total number of noncovered days in the billing period for which the beneficiary will not be charged utilization for Part A services. Noncovered days include:

- *Days not falling under the guarantee of payment provision. See section 40.1. E. Occurrence code "20" (Date Guarantee of Payment Began) is used in FLs 32-35 in this case;*

- *Days for which no Part A payment can be made because benefits are exhausted. This means that either lifetime reserve days were exhausted or the beneficiary elected not to use them. Occurrence code "23" (Benefits Exhausted) is used in FLs 32-35 in this case;*

- *Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the VA. (Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 50.);*
- *Days after the date covered services ended, such as noncovered level of care;*
- *Days for which no Part A payment can be made because the beneficiary was on a leave of absence and was not in the RNHCI. See section 40.2.6. Occurrence span code "74" (Leave of Absence) is used in FL 36 in this case;*
- *Days for which no Part A payment can be made because an RNHCI whose provider agreement has terminated may only be paid for covered inpatient services during the limited period following such termination. All days after the expiration of this period are noncovered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 10.6.4;*

The RNHCI must enter in FL 84, "Remarks" a brief explanation of any noncovered days not described in the occurrence codes. Show the number of days for <u>each</u> category of noncovered days (e.g., "5 leave days").

Day of discharge or death is not counted as a noncovered day. All hospital inpatient rules for billing non-covered days apply to RNHCI claims.

FL 9 - Coinsurance Days

Required - The RNHCI must enter in this field the number of covered inpatient days occurring after the 60th day and before the 9lst day for this billing period.

FL 10 - Lifetime Reserve Days

Required - The RNHCI must enter the number of lifetime reserve days the beneficiary elected to use during this billing period. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68 in FLs 39-41.

Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The RNHCI must notify the beneficiary of their right to elect not to use lifetime reserve days before billing Medicare for services furnished after the 90th day in the spell of illness. The determination to elect or withhold use of lifetime reserve days should be documented and kept on file at the provider.

FL 12 - Patient's Name

Required - The RNCHI must enter the beneficiary's last name, first name, and middle initial, if any.

FL 13 - Patient's Address

Required - The RNCHI must enter the beneficiary's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14 - Birthdate

Required - The RNCHI must enter the month, day, and year of birth (MM-DD-YYYY) of the beneficiary.

FL 15 - Sex

Required - The RNCHI must enter an "M" for male or an "F" for female.

FL 17 - Admission Date

Required - The RNCHI must enter the date the beneficiary was admitted for inpatient care.

(MM-DD-YY).

FL 19 - Type of Admission

Required - The RNCHI must enter the code indicating the priority of this admission.

Valid codes for RNHCI claims:

3 Elective	*The beneficiary's condition permitted adequate time to schedule the availability of a suitable accommodation.*
9 Information Not Available	*Self-explanatory*

FL 20 - Source of Admission

Required - The RNHCI must enter the code indicating the source of this admission. The RNHCI may use any valid source of admission code that applies to the particular admission. See chapter 25, section 60.1, instructions for FL 20 for the complete list of valid codes.

FL 22 - Patient Status

Required - The RNHCI must enter the code indicating the patient's status as of the "Through" date of the billing period (FL 6). The RNHCI may use any valid patient status code that applies to the discharge. See chapter 25, section 60.2, instructions for FL 22 for the complete list of valid codes.

FLs 24, 25, 26, 27, 28, 29, and 30 - Condition Codes

Conditional - The RNHCI may at their option enter any number of condition codes to describe conditions that apply to the billing period. There is no requirement for specific condition codes to appear on all RNHCI claims. If the RNHCI is submitting an adjustment or a cancellation claim, an applicable condition code from the 'claim change reason' series (D0 through D9 or E0) must be used. See Chapter 25, section 60.2, instructions for FL 24 for the definition of these codes and for the complete list of valid codes.

FLs 32, 33, 34, and 35 - Occurrence Codes and Dates

Conditional - The RNHCI may at their option enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. There is no requirement for specific occurrence codes to appear on all RNHCI claims. Occurrence codes are 2 alphanumeric digits, and dates are shown as 6 numeric digits (MM-DD-YY). See chapter 25, section 60.3, instructions for FL 32 for the complete list of valid codes.

Fields 32A-35A must be completed before fields 32B-35B are used.

When FLs 36 A and B are fully used with occurrence span codes, FLs 34 A and B and 35 A and B may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

FL 36 - Occurrence Span Code and Dates

Conditional - The RNHCI may at their option enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. There is no requirement for specific occurrence span codes to appear on all RNHCI claims. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and through dates for the period described by the code. Dates are shown as 6 numeric digits (MM-DD-YY). See chapter 25, section 60.3, instructions for FL 32 for the complete list of valid codes.

FL 37 - Internal Control Number (ICN)/ Document Control Number (DCN)

Conditional - The RNHCI must complete this field on adjustment requests (Bill Type, FL 4 = 417). An RNHCI requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted. Payer A's ICD/DCN must be shown on line "A" in FL 37. Similarly, the ICD/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

FLs 39, 40 and 41 - Value Codes and Amounts

Conditional - The RNHCI may at their option enter any number of value codes and related dollar amount(s) to identify data of a monetary nature necessary for the processing of this claim. There is no requirement for specific value codes to appear on all RNHCI claims. Value codes are 2 alphanumeric digits, and each value allows up to 9 numeric digits (0000000.00). Negative amounts are never shown. If more than one value code is shown for a billing period, the RNHCI must show codes in ascending numeric sequence. There are two lines of data, line "a" and line "b." The RNHCI uses FLs 39a through 41a before FLs 39b through 41b (i.e., use the first line before the second line). See chapter 25, section 60.3, instructions for FL 39 for the complete list of valid codes.

FL 42 - Revenue Code

Required - The RNHCI must enter the appropriate revenue codes to identify specific accommodation and/or ancillary charges. This code takes the place of fixed line item descriptions. The 4-digit numeric revenue code on the adjacent line in FL 42 explains each charge in FL 47. The following revenue codes and associated descriptions are used where there are charges billed as covered by Medicare:

Code	*Description*
0001	*Total Charges*
0120	*Semi-Private Room*
0270	*Supplies (non-religious, as covered by Medicare)*

Any other revenue codes may be submitted with non-covered charges only.

Additionally, there is no fixed "Total" line in the charge area. The RNHCI must enter revenue code "000l" instead in FL 42. The adjacent charge entry in FL 47 is the sum of charges billed.

The RNCHI should list revenue codes other than revenue code "0001" in ascending numeric sequence and should not repeat revenue codes on the same claim to the extent possible. To limit the number of line items on each claim, the RNHCI should sum revenue codes at the "zero" level to the extent possible.

FL 46 - Units of Service

Required - The RNHCI must enter the number of days for accommodations' revenue codes.

Accommodation days are always in terms of whole days rather than fractional days. The accommodation days do not include the day of discharge, even where the discharge was late. Where a charge was made because the beneficiary remained in the RNHCI after checkout time for his own convenience, it is a noncovered charge and you can bill the beneficiary if that is your usual practice and if beneficiary is given proper notice of their liability. In this instance, the RNHCI will enter the additional charge in FL 48.

For supplies or patient convenience items, the RNHCI must enter a number units corresponding to the number of items provided to the beneficiary.

FL 47 - Total Charges

Required - The RHNCI must sum the total charges (covered and non-covered) for the billing period by revenue code (FL 42) and enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 "000l" represents the grand total of all charges billed. For all lines, the total charges minus any associated non-covered charges in FL 48 represent the covered charges.

Each line allows up to 9 numeric digits (0000000.00).

FL 48 - Non-Covered Charges

Required - The RHNCI must enter the total non-covered charges pertaining to the related revenue code in FL 42, if any (e.g., religious items/services or religious activities performed by nurses or other staff).

FLs 50A, B, and C - Payer Identification

Required - If Medicare is the primary payer, the RNHCI must enter "Medicare" on line A. If Medicare is entered on line 50A, this indicates that the RNHCI has developed for other insurance and has determined that Medicare is the primary payer.

All additional entries across line A (FLs 50-54) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the RNHCI may identify the primary payer on line A and enter Medicare information on line B or C as appropriate.

FLs 51A, B, and C - Provider Number

Required - The RNHCI must enter the 6-digit number assigned by Medicare. RNHCI provider numbers begin with a 2-digit state code and are followed by a number in the range

1990 through 1999. The specialty contractor will not accept RNHCI claims with provider numbers outside this range.

FLs 60A, B, and C - Certificate/Social Security Number/HI Claim/Identification Number

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50, the RNHCI must enter the beneficiary's Medicare Health Insurance Claim Number. The RNHCI must show the number as it appears on the beneficiary's Medicare Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

FL 67 - Principal Diagnosis Code

Required - While coding of a principal diagnosis is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI may report ICD-9 code 799.9 (defined "other unknown and unspecified cause") in FL 67.

FLs 68-75 - Other Diagnosis Codes

Required - While coding of diagnoses is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI may report ICD-9 code V62.6 (defined "refusal of treatment for reasons of religion or conscience") in FL 68. The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other form locators (FLs 76 through 81) relating to medical diagnoses and medical procedures.

FL 84 - Remarks

Conditional - The RNHCI may enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

FL 85-6 - Provider Representative Signature and Date

Required – If using the hard copy claim, an RNHCI representative makes sure the claim record is complete and accurate before signing Form CMS-1450. A stamped signature is acceptable on Form CMS-1450.

170.3 - RNHCI Claims Processing by RNHCI Specialty Contractor

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Upon submission of a claim for RNHCI services, the specialty contractor ensures that the submission contains the complete set of required data elements according to the instructions in §170.2. The specialty contractor ensures that the submission does not contain data that is invalid, internally inconsistent or is not otherwise submitted in error. If the submission is not found to be consistent with CMS instructions, it is returned to the RNHCI for correction.

Once the claim is found to satisfy CMS instructions, the specialty contractor ensures the claim is not a duplicate of previously paid RNHCI services or does not demonstrate grounds for Medicare denial for any other reason. If the claim appears appropriate for payment based on the specialty contractors initial processing, the claim is submitted to the CMS Common Working File (CWF) for approval.

The CWF system compares the claim submitted by the specialty contractor to the eligibility and utilization data for the beneficiary that received the services. The CWF ensures the beneficiary is eligible for Part A for the dates of service (since RNHCI services are exclusively a Part A benefit) and the beneficiary has utilization days remaining in their current inpatient spell of illness. The CWF also compares the RNHCI claim to the beneficiary's file of RNHCI elections and claims. If CWF does not identify any error conditions on the RNHCI claim, an approval message is returned to the specialty contractor.

An RNHCI claim may be rejected by CWF if:

- *No RNHCI election period is present for the dates of service of the claim;*
- *The RNHCI election period to which the claim would apply has been revoked (see section 180 for procedures that lead to revocation of the election);*
- *The RNHCI election period to which the claim would apply has been cancelled; or*
- *The service dates on the claim overlap previously paid claims for RNCHI services or other inpatient services that were processed by a Medicare contractor other than the specialty contractor.*

Claims rejected for these reasons may not be corrected and returned by the RNHCI. If the error condition can be resolved (for instance, by the resubmission of an election period cancelled in error), a new original claim for the services may be submitted by the RNHCI and processed by the specialty contractor.

Upon receipt of payment approval or rejection from CWF, the specialty contractor may then process the claim to completion. If the claim is to be paid, the specialty contractor issues a remittance subject to the Medicare payment floor and the contractor's regular payment cycle. RNHCI claims are paid a daily interim rate as established for each RNHCI provider under TEFRA payment rules (see Pub. 15-2, Provider Reimbursement Manual, chapter 30). The specialty contractor makes RNHCI payments subject to the inpatient hospital cash deductible when applicable and, if services are for the 61st through 90th day of a benefit period or are for lifetime reserve days, subject to coinsurance (see Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, Sections 10.1 and 10.2).

170.4. - Informing Beneficiaries of the Results of RNHCI Claims Processing

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Beneficiaries are informed of all Medicare payment determinations, including those for RNHCI services, via their monthly Medicare Summary Notice (MSN). The complete set of messages used on the MSN can be found in chapter 21, section 50.42 of this manual. The specialty contractor uses special messages on MSNs to reflect determinations specific to the RNHCI benefit

- *If an RNHCI claim is denied because CWF did not find record of an RNHCI election in the beneficiaries record, the specialty contractor uses MSN message 42.3. This message reads: "This service is not covered since you did not elect to receive religious nonmedical health care services instead of regular Medicare services."*

- *If an RNHCI claim is denied because CWF found record of an RNHCI election in the beneficiary's record that had been revoked in writing, the specialty contractor uses MSN message 42.5. This message reads: "This service is not covered because you requested in writing that your election to religious nonmedical health care services be revoked."*
- *If an RNHCI claim is denied because CWF found record of an RNHCI election in the beneficiary's record that had been revoked because the beneficiary received nonexcepted medical care, the specialty contractor uses MSN message 42.4. This message reads: "This service is not covered because you received medical health care services which revoked your election to religious nonmedical health care services."*

170.5 - Billing and Payment of RNHCI Items and Services Furnished in the Home

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Medicare covers specified durable medical equipment and intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section *130.4* regarding this policy. Medicare covers these item sand services for dates of service from January 1, 2005 through December 31, 2006. Total Medicare payments under this benefit for each calendar year during this period are limited to $700,000. During this period, Medicare instructions for billing nonmedical DME by RNCHIs are as follows:

- RNHCIs must submit claims for DME and nursing visits to the RNHCI specialty FI using type of bill 43x.
- RNHCIs must submit claims for DME using revenue codes 291 (rental), 292 (purchase- new) or 293 (purchase- used) only, reporting a HCPCS code, service units, a date of service and a charge for each line item.
- RNHCIs may provide DME items as specified by a list of HCPCS codes published in Pub. 100-02, Medicare Benefit Policy Manual, chapter 1, section *130.4.1* and distributed by their specialty intermediary.
- RNHCIs must submit claims for nursing visits using revenue code 57x, reporting each visit as a separate line item using HCPCS code G0156, service units, a date of service and a charge amount.
- RNHCIs must report service units for nursing visits in increments of 15 minutes, as defined by HCPCS code G0156.

Payment to RNHCIs for DME items will be made based on the DME fee schedule. Coinsurance applies to these items. Deductible does not apply to these items. Payment to RNHCIs for nursing visits will be made at 80 percent of the national standard home health aide visit rate used under the home health prospective payment system, subject to wage index adjustment based on the location of the RNHCI facility. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 1, section *130.4.2* for details of the payment calculation. Coinsurance and deductible do not apply to these services.

180 - Processing Claims For Beneficiaries With RNHCI Elections by Contractors Other Than the RNHCI Specialty Intermediary

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

While elections and claims for RNHCI services are processed by a specialty contractor, all Medicare contractors (below 'non-specialty contractors') must understand the nature and purpose of the RNHCI election and the definitions of excepted and non-excepted care defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130. Non-specialty contractors may find it advisable to have an identified specialist (or specialists) familiar with excepted and nonexcepted care used in the review of beneficiaries with RNHCI elections, since this process is so unlike other Medicare claims processes.

Beneficiaries may revoke their RNHCI election by submitting a written revocation request to Medicare, but this is rare. The specialty contractor processes these written revocations. Far more commonly, beneficiaries revoke the election simply by receiving nonexcepted medical services and requesting Medicare payment for those services. Any non-specialty contractor may receive a claim for services for a beneficiary with an RNHCI election currently in place. This section provides instructions to non-specialty contractors for the handling of such claims.

Upon receipt of a claim for payment, non-specialty contractors will not be aware that the beneficiary has an RNHCI election in place and will process the claim normally to the point of transmitting the claim to CWF. The CWF searches beneficiary records for all claims processed to determine whether an RNHCI election is found. If an election is found, CWF takes one of two actions on a claim for non-RNHCI services:

- *If the claim is for DME, or orthotic/prosthetic devices, CWF will accept the DMERC claim and revoke the RNHCI election. All DMERC claims for DME, orthotic/prosthetic devices are treated as nonexcepted medical care.*
- *If the claim is for any other Medicare covered services, CWF initially rejects it to the non-specialty contractor. The non-specialty contractor must determine whether the care was excepted or nonexcepted. The claim must never be automatically denied. The RNHCI election revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of their Medicare coverage.*

The process for non-specialty contractors to follow in responding to this CWF edit is unique among Medicare claims processes. A determination must be made whether the beneficiary's RNHCI election should be revoked. Therefore, unlike other CWF rejects which are processed in an automated fashion, claims rejected by CWF due to the presence of an RNHCI election must be suspended and developed to determine if the beneficiary received excepted care. At differing points in time, this review consisted of a request for medical records or a series of telephone contacts but these methods were found too workload intensive. In response to a CWF reject due to the presence of an RNHCI election, non-specialty contractors must issue a simple development letter asking the provider of services to respond in a yes or no fashion to three questions:

- *Whether the beneficiary paid for the services out of pocket in lieu of requesting payment from Medicare;*
- *Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed; and*

- *Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.*

Each non-specialty contractor may develop the wording and format of this letter based on their experience effectively communicating with their community of providers.

The purpose for this development letter is to determine whether the care received is excepted (leaving the election intact) or whether it is nonexcepted (causing a revocation of the RNHCI election). Provider responses of 'No' to all questions in the letter will determine that the services are found to be non-excepted care. Provider responses of 'Yes' to the questions regarding inability to make beliefs known or regarding required vaccinations will determine that the services are found to be excepted care. Unless reasons to deny these claims are found during the course of claims processing, these claim will normally be paid. A provider response of 'Yes' to the question regarding the beneficiary's paying out of pocket will determine that the services are found to be excepted care, but the claim for payment for medical care must be denied. The claim must be denied because the beneficiary has not made a request for Medicare payment. The beneficiary has accepted liability for these services in order to protect their RNHCI election.

Once the non-specialty contractor makes this determination of whether the care is excepted or nonexcepted, the claim record is annotated accordingly (see section 180.1 below) and returned to CWF. The claim will be approved for payment and if the care was found to be nonexcepted CWF will cause the beneficiary's RNHCI election to be revoked.

In the event that the provider does not reply timely to the development letter, non-specialty contractors must make an excepted/nonexcepted determination based on the evidence presented by the claim itself. Non-specialty contractors shall apply the same timeliness standard to these responses as to all other documentation requests. If the claim contains durable medical equipment or prosthetic/orthotic devices, the non-specialty contractor may make a determination of nonexcepted care on that basis alone. All such claims are treated as nonexcepted care. For all other claims, non-specialty contractor staff with a clinical background must make their best determination based on the diagnoses and procedures reported on the claim whether the services were excepted or nonexcepted care. In cases where the determination cannot be made with certainty but there is some reason to suspect services were nonexcepted care, the non-specialty contractor shall make a determination of nonexcepted care and annotate the claim record accordingly. Determinations must be made within the earlier of 30 days of receipt of the provider's response or 30 days of the end of the timely response period.

The importance of the development of these claims lies in its effect on the beneficiary. If the claim for medical care is denied improperly based on the presence of the RNHCI election, the beneficiary will incur liability in error and may experience financial hardship. Similarly, it is important that the review result in accurate determinations of nonexcepted care since repeated revocations of this benefit can have an impact on the beneficiary's right to access the RNHCI benefit in the future.

180.1 - Recording Determinations of Excepted/Nonexcepted Care on Claim Records

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Once the excepted/nonexcepted care determination is made, the non-specialty contractor resubmits the claim to CWF using the following indicators to record the determination:

- *Indicator "1" - for excepted care; or*
- *Indicator "2" - for nonexcepted care.*

***NOTE**: Indicator 0 (zero) presents no entry.*

The following are the fields and locations for the excepted and nonexcepted indicators on the CWF record types:

Record	***Location***	***Field***	***Size***
HUIP	*84*	*1*	*823*
(IP hospital/SNF Claim)			
HUOP	*64*	*1*	*778*
(Outpatient)			
HUHC	*64*	*1*	*778*
(Hospice)			
HUHH	*64*	*1*	*778*
(Home Health)			
HUBC	*13*	*1*	*57*
(Carrier/Part B Claim)			

The screen field corresponding to these CWF fields may vary depending on the Medicare shared system in use at a contractor's location. Non-specialty contractors may contact their shared system maintainer if necessary to determine the correct screen location to use for excepted/nonexcepted care indicators.

*If a claim is resubmitted with a "0" excepted care indicator in error, CWF will again reject the claim. Upon receipt of the resubmitted claim with a valid "1" or "2" entry, CWF will approve it for payment (by generating a disposition "01") and revoke the beneficiary's election if the care received was nonexcepted. CWF will **not** notify either the specialty contractor or the non-specialty contractor of any revocations as a result of claims received for nonexcepted care. Any subsequent RNHCI claims processed at the specialty contractor will be not approved for payment by CWF unless the beneficiary files a new election following the prescribed time intervals between elections.*

Once the excepted/nonexcepted care determination is made, the non-specialty contractor annotates the claim and the associated remittance advice with the following indicators to record the determination:

If development to make the excepted/nonexcepted care determination discovered that the beneficiary paid out of pocket for the services and the claim for payment for medical care must be denied as a result, annotate the claim and the associated remittance advice with the following codes:

- *Claim adjustment reason code 125, defined "Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate."*
- *Remittance advice remark code MA47, defined "Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment."*

180.2 - Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Beneficiaries are informed of all Medicare payment determinations, including those for RNHCI services, via their monthly Medicare Summary Notice (MSN). The complete set of messages used on the MSN can be found in chapter 21, section 50.42 of this manual. Non-specialty contractors use special messages on MSNs to reflect determinations specific to excepted or nonexcepted care.

- *If a determination of excepted care is made, the non-specialty contractor uses MSN message 42.1. This message reads: "You received medical care at a facility other than a religious nonmedical health care institution but that care did not revoke your election to receive benefits for religious nonmedical health care."*
- *If a determination of nonexcepted care is made, the non-specialty contractor uses MSN message 42.2. This message reads: "Since you received medical care at a facility other than a religious nonmedical health care institution, benefits for religious nonmedical health care services has been revoked for these services unless you file a new election."*
    - *If development to make the excepted/nonexcepted care determination discovered that the beneficiary did not request Medicare payment, but instead paid for the services out of pocket, the non-specialty contractor uses MSN message 16.41. This message reads: "Payment is being denied because you refused to request reimbursement under your Medicare benefits."*