CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2654	**Date: February 8, 2013**
	Change Request 8186

SUBJECT: Updates to Claims Processing Instructions Regarding Religious Nonmedical Health Care Institutions (RNHCI)

I. SUMMARY OF CHANGES: This Change Request updates instructions regarding RNHCI billing to reflect changes in Medicare contracting as well as changes in the UB-04 claim form and code sets. It also provides clarification regarding coding RNHCI claims when the beneficiary has exhausted their inpatient benefit days.

EFFECTIVE DATE: May 9, 2013
IMPLEMENTATION DATE: May 9, 2013

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/170.1.1/Requirement for RNHCI Election
R	3/170.1.2/Revocation of RNHCI Election
R	3/170.1.3/Completion of the Notice of Election for RNHCI
R	3/170.1.4/Common Working File (CWF) Processing of Elections, Revocations and Cancelled Elections
R	3/170.2.1/When to Bill for RNHCI Services
R	3/170.2.2/Required Data Elements on Claims for RNHCI Services
R	3/170.3/RNHCI Claims Processing By the Medicare Contractor With RNCHI Specialty Workload
R	3/170.3.1/RNHCI Claims Not Billed to Original Medicare
R	3/170.4/Informing Beneficiaries of the Results of RNHCI Claims Processing
D	3/170.5/Billing and Payment of RNHCI Items and Services Furnished in the Home
R	3/180/Processing Claims For Beneficiaries With RNHCI Elections by Contractors Without RNHCI Specialty Workloads
R	3/180.1/Recording Determinations of Excepted/Nonexcepted Care on Claim Records
R	3/180.2/Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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: 2654	Date: February 8, 2013	Change Request: 8186

SUBJECT: Updates to Claims Processing Instructions Regarding Religious Nonmedical Health Care Institutions (RNHCI)

EFFECTIVE DATE: May 9, 2013

IMPLEMENTATION DATE: May 9, 2013

I. GENERAL INFORMATION

A. Background: Several sections of Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-04) relating to Religious Nonmedical Health Care Institution (RNHCI) claims had not been updated since 2006. Since that time, the processing of RNHCI claims was shifted from a specialty fiscal intermediary to a specialty workload under one Medicare Administrative Contractor (MAC) jurisdiction. There were also changes to the UB-04 code sets, including the transition of utilization day fields to value codes. This Change Request (CR) updates the sections to ensure they reflect the current environment.

Additionally, it has come to CMS's attention that certain RNHCIs may need additional education regarding how to code claims in situations where the beneficiary's inpatient benefits have been exhausted. To support educational efforts in this area, this CR also clarifies coding instructions for these situations.

B. Policy: This CR contains no new policy.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8186.1	Medicare contractors shall be aware of the revisions to Chapter 3 of Pub. 100-04 contained in this Change Request.	X										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8186.2	MLN Article: 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 sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's 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						

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

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

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev.2654, Issued: 02-08-13)

170.1.1 - Requirement for RNHCI Election

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

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 single Medicare contractor as a specialty workload*. *Currently, this specialty workload is part of Medicare Administrative Contractor Jurisdiction 10.* The completed election form must be filed with the 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 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.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

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 *their Medicare 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 Notice of Election for RNHCI

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Elections, revocations and cancellations of elections may be submitted to the contractor via the *paper* UB-04 *claim form* 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.

This section gives detailed information only for items required for the notice of election and related transactions. The RHNCI does not need to complete items not listed.

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.

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 contractor for processing.

Patient's Name

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

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.

Patient's Birth Date

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

Patient's Sex

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

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.

National Provider Identifier

Required – *The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN).* RNHCI *CCNs* are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

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 *Medicare* 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.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is, the RNHCI enters the patient's HICN. The RNHCI enters the number as it appears on the patient's *Medicare* Card, Social Security Award Certificate, Utilization Notice, *Medicare Summary Notice*, Temporary Eligibility Notice, etc., or as reported by the *Social Security Office*.

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

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

The *Medicare contractor with RNHCI specialty workload* submits all RNHCI election, revocations and cancelled elections to CWF for approval. The CWF will notify the 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.

170.2.1 - When to Bill for RNHCI Services

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

RNHCIs submit claims to *their Medicare* 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* for instructions regarding *reporting of utilization days*.

170.2.2 - Required Data Elements on Claims for RNHCI Services

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

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 RNHCI claims 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-04 (Form CMS-1450) *paper claim* form.

Both the electronic claim transaction and the *paper claim* 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.

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 to verify provider identity. Phone/Fax numbers are desirable.

Patient Control Number/Medicare Record Number

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

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:

1st 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 is the discharge date for this confinement. Nonpayment bills are required only to extend the "spell of illness." See code 71 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 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.

Statement Covers Period (From - Through)

Required - The RNHCI must enter the beginning and ending dates of the period covered by this bill. 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.

Patient's Name

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

Patient's Address

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

Patient's Birth Date

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

Sex

Required - The RNHCI must enter an “M” for male or an “F” for female.

Admission Date

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

(MM-DD-YY).

Type of Admission

Required - The RNHCI 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

Point of Origin **for Admission**

Required - The RNHCI must enter the code indicating the *beneficiary's point of origin*. The RNHCI may use any valid *point of origin* code that applies to the particular admission.

Patient Discharge Status

Required - The RNHCI must enter the code indicating the patient's status as of the "Through" date of the billing period. The RNHCI may use any valid patient status code that applies to the discharge.

Condition Codes

Conditional - The RNHCI may enter any number of condition codes to describe conditions that apply to the billing period. 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.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RHNCI must indicate whether the beneficiary elects to use lifetime reserve days. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68. If the beneficiary elects not to use lifetime reserve days, the RNHCI must report condition code 67.

Occurrence Codes and Dates

Conditional - The RNHCI may enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. Occurrence codes are 2 alphanumeric digits, *and are reported with a corresponding date*.

If non-covered days are reported due to days not falling under the guarantee of payment provision, the RNHCI reports occurrence code 20.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RNHCI reports occurrence code A3.

Occurrence Span Code and Dates

Conditional - The RNHCI may enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and through dates for the period described by the code.

If non-covered days are reported because the beneficiary was on a leave of absence and was not in the RNHCI, the RNHCI reports occurrence span code 74.

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.

Value Codes and Amounts

Required – The RNHCI must report utilization days using the value codes described below.

Covered Days *- The RNHCI must use value code 80 to 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 non-covered, 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.

Non-covered Days *- The RNHCI must use value code 81 to enter the total number of non-covered days in the billing period for which the beneficiary will not be charged utilization for Part A services. Non-covered days include:*

- *Days not falling under the guarantee of payment provision. See section 40.1. E.*
- *Days not approved by the utilization review committee when the beneficiary does not meet the need for Part A services;*
- *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.*
- *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 non-covered 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.;*
- *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 non-covered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 10.6.4;*

The RNHCI enters in "Remarks" a brief explanation of any non-covered days not described in the occurrence codes. Show the number of days for each category of non-covered days (e.g., "5 leave days").

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

Coinsurance Days *- The RNHCI must use value code 82 to enter the number of covered inpatient days occurring after the 60th day and before the 9lst day for this billing period.*

Lifetime Reserve Days *- The RNHCI must use value code 83 to enter the number of lifetime reserve days the beneficiary elected to use during this billing period.*

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.

Conditional - The RNHCI may at their option enter any number of other value codes and related dollar amount(s) to identify data necessary for the processing of this claim. Value codes are 2 alphanumeric digits, and *a corresponding value amount.* 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.

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 explains each charge. 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. *On paper claims, the* RNHCI must enter revenue code "000l" *to report a total of the charges on the claim.*

The RNHCI 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.

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 non-covered charge and you can bill the beneficiary if that is your usual practice and if the beneficiary is given proper notice of their liability. In this instance, the RNHCI will enter the additional charge in non-covered charges.

Total Charges

Required - The RHNCI must sum the total charges (covered and non-covered) for the billing period by revenue code and enter them on the adjacent line. *On paper claims, the* last revenue code entered in revenue

code "000l" represents the grand total of all charges billed. For all lines, the total charges minus any associated non-covered charges represent the covered charges.

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

When submitting charges (covered/non-covered):

- Medicare is restricted by law and court order from paying for the religious portion of care or the training of personnel that provide that care. Additionally Medicare does not pay either based on charges or costs for training of nonmedical personnel. RNHCIs do not receive full Medicare payment for a beneficiary's stay since the beneficiary is fiscally responsible for the religious aspects of care. Therefore, the original Medicare or Medicare health plan rate may be significantly lower than the RNHCI private pay rate that includes religious charges.

- As medical procedures are not performed in a RNHCI, the use of high cost medical supplies are not separately payable. Supplies that require a physician order (e.g., specialty dressings, compression stockings, alternating pressure mattress pads) are not separately payable in a RNHCI. The use of diapers, incontinence pads, chux/underpads, feminine hygiene products, tissues, and the materials for simple dressings (cleansing and bandaging) are included in the daily room and board portion of the charges and should not be reported separately as supplies.

- Medical equipment (e.g., wheelchair, walker, crutches) are institution inventory items for beneficiary use in the RNHCI. The use of these items during the beneficiary stay is part of the daily interim payment to the RNHCI. To receive Medicare payment for durable medical equipment (DME) following a RNHCI stay, a beneficiary would need to meet all of the criteria, including medical necessity, and obtain a physician order or prescription. A RNHCI is not authorized as a Medicare supplier and, therefore, may not offer DME items for purchase to beneficiaries.

- Nonmedical nursing personnel, for Medicare payment purposes, perform services (e.g., serving meals, assisting with activities of daily living) that are strictly nonmedical/non-religious. The statute and court order mandates only the coverage and payment under Part A for reasonable and necessary nonmedical/non-religious care.

- Medicare payment for religious/nonmedical nursing personnel in a RNHCI, as other inpatient facilities, is a component of the per diem rate and is not separately payable.

Non-Covered Charges

Required - The RHNCI must enter the total non-covered charges pertaining to the related revenue code, if any (e.g., religious items/services or religious activities performed by nurses or other staff, or convenience items that are not part of the Medicare daily interim payment rate.)

Examples of non-covered charges:

- Non-covered religious items include but are not limited to religious publications, religious recordings, any equipment for the use of those recordings, any reproduction costs for these materials, and attendance at religious meetings.

- Religious sessions with RNHCI staff or outside associates.

- Expenses related to student programs/subsistence, staff education/training, travel, or relocation to be factored into the development of charges for covered patient care services.

- Stays, items, and services that are not substantiated by appropriate documentation in the beneficiary's utilization review file or care record.

- Convenience items (e.g., telephone, computer, beautician/barber).

Payer Identification

Required - If Medicare is the primary payer, the RNHCI must enter "Medicare" on line A. If Medicare is entered, 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 supply information needed by the payer named. 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.

National Provider Identifier

Required – *The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN).* RNHCI *CCNs* are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, 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, *Medicare Summary Notice,* Temporary Eligibility Notice, or as reported by the Social Security Office.

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").

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"). The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other *fields* relating to medical diagnoses and medical procedures.

Attending Provider

Required – While the participation of an attending provider is not consistent with the nonmedical nature of RNHCI services, reporting an attending provider is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI must report the name and NPI of their director of nursing.

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.

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 the *Medicare Contractor with RNCHI Specialty Workload*

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Upon submission of a claim for RNHCI services, the 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 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 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), *the RNHCI may submit* a new original claim for the services.

Upon receipt of payment approval or rejection from CWF, the contractor may then process the claim to completion. 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 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).

170.3.1 – *RNHCI* Claims Not Billed to *Original Medicare*

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Health Plans

A beneficiary covered by a Medicare Advantage plan (e.g., Medicare health maintenance organization, preferred provider organization, competitive medical plan or other health care prepayment plans.) must have prior authorization from their plan before admission to a RNHCI to assure payment for a specified time period. Continued stay reviews must be performed, submitted, and approved at designated intervals identified by the plan to assure coverage by the Medicare health plan.

In the case of billing a Medicare health plan, the RNHCI charges for inpatient services should not exceed the established interim TEFRA per diem payment amount available under Medicare Part A. The Medicare health plan may obtain the current TEFRA per diem rate information by calling the specialty contractor responsible for the involved RNHCI.

Medicaid

The State agency may obtain the current Medicare rate information by calling the *Medicare* contractor responsible for the RNHCI.

170.4 - Informing Beneficiaries of the Results of RNHCI Claims Processing

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

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 *Medicare* contractor *with RHNCI specialty workload* 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 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 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 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."

180 - Processing Claims For Beneficiaries With RNHCI Elections by Contractors *Without* RNHCI Specialty *Workloads*

(Rev.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

While elections and claims for RNHCI services are processed by the *Medicare contractor with RNHCI specialty workload*, 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. 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 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 prosthetic/*orthotic* devices, CWF will accept the *DMEPOS* claim and revoke the RNHCI election. All *DMEPOS* claims 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.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

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 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 contractor *with RNHCI specialty workload* will be not

approved for payment by CWF unless the beneficiary files a new election following the prescribed time intervals between elections.

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.2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

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."