CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2930	**Date: April 11, 2014**
	Change Request 8559

SUBJECT: Denial Letters for Religious Nonmedical Health Care Institution Services Not Covered by Medicare

I. SUMMARY OF CHANGES: This Change Request adds instructions regarding requests for denial letters when RNHCIs provide a level of care that is not covered by Medicare.

EFFECTIVE DATE: July 14, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 14, 2014

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	3/170.1.1/Requirement for RNHCI Election

III. FUNDING:
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

Business Requirements

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I. GENERAL INFORMATION

A. Background: RNHCI facilities sometimes provide services to Medicare beneficiaries that do not qualify for Medicare coverage and for which the beneficiary may seek payment from another insurer. The other insurer may require a denial from Medicare before making payment for these services. Medicare systems require submission of a Notice of Election (NOE) before any RNHCI claims can be processed. In order for a claim requesting a denial notice to be processed, the RNHCI would need to inappropriately submit an NOE, since the beneficiary is not requesting Medicare coverage of RNHCI services.

In order to avoid this, the RNHCI may request in writing a denial notice from the Medicare Administrative Contractor. In response, the MAC will provide the RNHCI with a manual denial letter. This letter may then be submitted to a secondary insurer as evidence of a prior Medicare denial**.**

B. Policy: Medicare contractors will issue denial letters for services provided by RNHCIs that do not qualify for Medicare coverage.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8559.1	The contractor shall issue denial letters to RNCHIs when the contractor receives written requests that indicate the RNHCI has provided services that could never be covered by the Medicare RNHCI benefit.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
8559.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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).

VI. FUNDING

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

170.1.1 - Requirement for RNHCI Election

(Rev. 2930, Issued: 04-11-14, Effective: 07-14-14, Implementation: 07-14-14)

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.

Occasionally, a Medicare beneficiary may seek services at a RNHCI that do not qualify for Medicare coverage and for which the beneficiary may seek payment from another insurer. The beneficiary is not required to make an election of RNHCI benefits in this case.

If the other insurer requires a denial from Medicare before making payment for these services, a denial notice cannot be processed by Medicare claims processing systems. Medicare systems require submission of a Notice of Election (NOE) before any RNHCI claims, including claims for denial, can be processed.

The RNHCI may request in writing a denial notice from the Medicare contractor. The written request must describe the reason the beneficiary does not qualify for Medicare coverage. It must also describe the specific services that will be provided to the beneficiary. In response, the contractor will provide the RNHCI with a manual denial letter. This letter may then be submitted to a secondary insurer as evidence of a prior Medicare denial.