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Related Change Request (CR) #: 4218

Related CR Release Date: February 10, 2006

Effective Date: May 11, 2006

Related CR Transmittal #: R35GI, R45BP, and R851CP

Implementation Date: May 11, 2006

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

Note: This article was updated on October 23, 2012, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers who may treat Medicare patients who have elected RNHCI care and bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHs), carriers, and durable medical equipment regional carriers (DMERCs) for those services.

Provider Action Needed



STOP – Impact to You

This change request (1) replaces the current process that develops claims via telephone inquiry for beneficiaries with RNHCI elections with a letter using “yes” or “no” questions; (2) places into the *Medicare Claims Processing Manual* RNHCI claims processing instructions; (3) restructures much of the existing RNHCI manual material to be more complete and accessible; (4) defines the RNHCI; and (5) lists the qualifying criteria for RNHCI benefits.

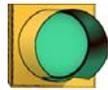


CAUTION – What You Need to Know

Note the business requirements in this CR that apply to your billing area.

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GO – What You Need to Do

For providers other than RNHCI, use the letter issued by your contractor that asks questions key to determining excepted versus nonexcepted care. For RNHCI, incorporate the new claims submission instructions into your billing procedures.

Background

The 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. However, the transmittal revises 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 intent of PM AB-03-145 was to simplify the development process.

Since the issuance of PM AB-03-145, a number of Medicare contractors (i.e., carriers and fiscal intermediaries) other than the RNHCI specialty contractor have expressed sufficient concerns about the telephone contact process to cause the Centers for Medicare & Medicaid Services (CMS) to revise that process.

Non-specialty contractors with high volumes of RNHCI-related claims reported difficulty contacting providers. In addition, they reported beneficiaries were not willing or able to supply the necessary information to enable the contractor to determine 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 listed below that will be incorporated into the letter issued to providers.

Briefly, if you bill Medicare for services provided to a patient who has elected RNHCI coverage, the following requirements of CR4218 will apply.

Requirements of CR4218

Development Letters for Providers Other than RNHCI

Upon receipt of a claim rejected by Medicare systems due to an RNHCI election on file for that Medicare beneficiary, contractors must issue a development letter designed to determine whether care was excepted or nonexcepted.

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Contractors must 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; and
- Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.

The letters will phrase questions in RNHCI to be answered with a Yes or No response. The wording and format of this letter will be based on the experience of your contractor in effectively communicating with their community of providers.

Determinations Based on Development Letter

- Contractors will make determinations of excepted or nonexcepted care based on provider responses to development letters.
- Contractors will make determinations within 30 days of receipt of the provider's response.
- Contractors will make determinations of excepted care when a provider responds 'Yes' to any of the questions in the letter.
- Contractors will make determinations of nonexcepted care when a provider responds 'No' to all of the questions in the letter.
- Contractors will make an excepted/nonexcepted determination based on the evidence presented by the claim itself if the provider does not reply in a timely manner to the development letter.
- For claims for which no timely response was received, contractors will make a determination of nonexcepted care if the claim contains durable medical equipment or prosthetic/orthotic devices.
- For claims for which no timely response was received, contractor staff with a clinical background will use the diagnoses and procedures reported on the claim to make their best determination whether the services were excepted or nonexcepted care.
- For claims for which no timely response was received, contractors will make determinations of excepted or nonexcepted care within 30 days of the end of the timely response period.

For RNHCI Providers

CR4218 provides complete instructions for completion of claims to Medicare. RNHCIs should review the instructions in CR4218 and ensure their current billing

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processes are consistent with these instructions. The "Related Instructions" section of this article provides information on accessing the transmittals that comprise CR4218.

Related Instructions

For a beneficiary to receive benefits under §1821 of the Social Security Act (the Act) and payment under the Medicare program upon admission to a RNHCI and prior to the RNHCI billing for services, the beneficiary must make a written election.

The document detailing the process for a beneficiary to elect RNHCI care or to terminate that election is attached to transmittal R45BP of CR4218. CR4218 may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R45BP.pdf> on the CMS website.

The ten qualifying provisions that must be met for a provider to be defined as an RNHCI, as contained in Section 1861 (ss) (1) of the Act for RNHCI, are defined in transmittal R35GI of CR4218. The transmittal may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R35GI.pdf> on the CMS website.

Chapter 3 of the *Medicare Claims Processing Manual*, Inpatient Hospital Billing, was also completely revised and is contained in transmittal R851CP of CR4218. Transmittal R851CP is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R851CP.pdf> on the CMS website.

Additional Information

The official instructions issued to the RNHCI intermediary regarding this change can be found in three parts, i.e., the transmittals parts as shown in the web addresses provided above.

If you have questions, please contact your carrier/intermediary/DMERC at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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