

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1612	Date: OCTOBER 3, 2008
	Change Request 5383

Subject: Revision of Interim Payment Methodology for Religious Nonmedical Health Care Institution (RNHCI), Clarifying Existing Policy on Training of Religious Nonmedical Nursing Personnel, Claims Not Billed to the RNHCI Specialty Contractor, and Statutory End of Coverage for RNHCI Items and Services Furnished in the Home

I. SUMMARY OF CHANGES: This transmittal revises how interim payments to RNHCI are computed. It also clarifies coverage limitations (e.g., religious nonmedical nursing personnel, supplies, and training of religious nonmedical nursing personnel) and the information provided to involved parties in the claims processing manual. Additionally, it provides for training on the new material and on some existing requirements. It also removes coverage related information regarding RNHCI services in the home, which by statute (Medicare Modernization Act of 2003, Section 706) ended December 31, 2006.

New / Revised Material

Effective Date: January 5, 2009

Implementation Date: January 5, 2009

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	3/170.2.2/Required Data Elements on Claims for RNHCI Services
N	3/170.3.1/Claims Not Billed to the RNHCI Specialty Contractor
R	3/170.5/Billing and Payment of RNHCI Items and Services Furnished in the Home

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

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

SECTION B: For Medicare Administrative Contractors (MACs):

Not Applicable.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1612	Date: October 3, 2008	Change Request: 5383
-------------	-------------------	-----------------------	----------------------

SUBJECT: Revision of Interim Payment Methodology for Religious Nonmedical Health Care Institution (RNHCI), Clarifying Existing Policy on Training of Religious Nonmedical Nursing Personnel, Claims Not Billed to the RNHCI Specialty Contractor, and Statutory End of Coverage for RNHCI Items and Services Furnished in the Home

Effective Date: January 5, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background:

Section 1821(a)(2) of the Social Security Act (the Act) and 42 Code of Federal Regulations (CFR) sections 403.720(d) and 403.724(a) provide that Medicare beneficiaries, who are eligible for care in a hospital or skilled nursing facility, may elect to receive nonmedical care in a RNHCI as a result of their religious beliefs. However, payment for nonmedical care is subject to the requirements for reasonableness and necessity as described in §1862(a)(1)(A) of the Act. Religious nonmedical nursing personnel do not engage in any activities that are medical in nature. Additionally, the nonmedical RNHCI setting eliminates the need for charges of supplies and equipment (i.e., 42 CFR 403.720(a)(4) and (6)). Allowable supplies and equipment are only those available without a prescription and these items are included in the provider's interim payment or per diem. Therefore, billing the revenue code 0270 - Supplies, is only an option for submitting non-covered charges.

This Change Request will revise the Claims Manual by: (1) revising the methodology for interim payments and related clarification of billing instructions; (2) clarifying existing policy on training of religious nonmedical nursing personnel; (3) clarifying policy on claims not billed to the RNHCI specialty contractor; and (4) finalizing the statutory end of the home services benefit.

1. Revision of Interim Rate Methodology for RNHCI's and Related Clarification of Billing Instructions

In recent years, RNHCI's have experienced a disparity between their interim payments and final TEFRA year-end settlement amounts. As a result, we have modified the interim payment rate calculation to a per diem that more closely approximates each RNHCI's year-end allowable TEFRA payment limit. The RNHCI's billing is clarified and streamlined in the Claims Manual.

2. Clarifying Existing Policy on Training of Religious Nonmedical Nursing Personnel

We are aware that religious nonmedical nursing education costs have been submitted and paid as "pass through costs" on the annual TEFRA cost report and overpayment recovery steps have been initiated. Additionally, we are aware of several RNHCI's providing religious nonmedical nursing education that have not indicated the activity on their cost report. Medicare does not pay either based on charges or costs for training of nonmedical personnel.

3. Home Services Benefit:

Section 706 of the Medicare Modernization Act authorized coverage for a time limited home service benefit for RNHCI's. This benefit expired on December 31, 2006, pursuant to section 1861(aaa)(2)(B)(ii) of the Social Security Act and the companion regulation at 42 CFR 403.764(b).

B. Policy: The RNHCI specialty contractor must convert interim payments made on RNHCI claims to an adjusted per diem payment based upon the RNHCI's annual TEFRA limit. Interim payments on a per diem

basis will allow the Medicare program to more efficiently and accurately pay RNHCIs subject to their TEFRA limits.

Effective January 1, 2007, Medicare no longer provided coverage for the RNHCI home services benefit (including durable medical equipment items). Claims for RNHCI home services rendered prior to December 31, 2006 and appropriately submitted to the RNHCI specialty contractor will continue to be processed for payment.

II. BUSINESS REQUIREMENTS TABLE

“Shall” denotes a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER	
							F I S S	M C S	V M S	C W F		
5383.1	The RNHCI Specialty Contractor shall review prior year cost reports for non-allowable religious nonmedical nursing personnel education costs and remove these costs.											RNHCI Specialty Contractor
5383.2	The RNHCI Specialty Contractor shall calculate interim payments for RNHCI claims on a per diem basis, subject to the revised TEFRA limit.											RNHCI Specialty Contractor
5383.2.1	The RNHCI Specialty Contractor shall make per diem payments effective for dates of service on and after the first day of the month following the calculation of the new interim per diem payment rate.											RNHCI Specialty Contractor

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER	
							F I S S	M C S	V M S	C W F		
5383.3	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 site 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 your next regularly scheduled bulletin. Contractors are free to supplement											RNHCI Specialty Contractor

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

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 (claims processing) 410-786-6148, wilfried.gehne@cms.hhs.gov
Jean-Marie Moore (payment policy) 410-786-3508, jeanmarie.moore@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHCs)*:

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

Section B: For *Medicare Administrative Contractors (MACs)*: N/A

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents *(Rev. 1612, 10-03-08)*

170.3.1 –Claims Not Billed to the RNHCI Specialty Contractor

170.2.2 - Required Data Elements on Claims for RNHCI Services

(Rev. 1612; Issued: 10-03-08; Effective/Implementation Date: 01-05-09)

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) hardcopy form. A table to crosswalk UB-04 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.

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.

1-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 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.

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 non-covered, the day of discharge, and the day of death. Days must be reported using the appropriate value code.

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

Required - The RNHCI must 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. Days must be reported using the appropriate value code. Non-covered 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 this case;

- *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. Occurrence code "A3" (Benefits Exhausted) is used 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 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. Occurrence span code "74" (Leave of Absence) is used 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 non-covered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 10.6.4;

The RNHCI must enter 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

Required - The RNHCI must enter in this field the number of covered inpatient days occurring after the 60th day and before the 91st day for this billing period. Days must be reported using the appropriate value code.

Lifetime Reserve Days

Required - The RNHCI must enter the number of lifetime reserve days the beneficiary elected to use during this billing period. Days must be reported using the appropriate value code. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68.

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.

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 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.
---	----------	---

Not Available

Source of Referral for 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.

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 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.

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).

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).

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

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.

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. The RNHCI must enter revenue code "0001". The adjacent charge entry is the sum of charges billed.

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. To limit the number of line items on each claim, the RNHCI should sum revenue codes at the "zero" level 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 RNHCI must sum the total charges (covered and non-covered) for the billing period by revenue code and enter them on the adjacent line. The last revenue code entered in revenue code "0001" 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 RNHCI 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.

Provider Number

Required - The RNHCI must enter their *National Provider Identifier (NPI)*.

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, Explanation of Medicare Benefits, 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 form locators relating to medical diagnoses and medical procedures.

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.

***170.3.1 – Claims Not Billed to the RNHCI Specialty Contractor
(Rev. 1612; Issued: 10-03-08; Effective/Implementation Date: 01-05-09)***

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 specialty contractor responsible for the RNHCI.

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

(Rev. 1612; Issued: 10-03-08; Effective/Implementation Date: 01-05-09)

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 items and 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 RNHCI are as follows:

- RNHCI must submit claims for DME and nursing visits to the RNHCI specialty FI using type of bill 43x.
- RNHCI 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.
- RNHCI 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 *contractor*.
- RNHCI 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.
- RNHCI must report service units for nursing visits in increments of 15 minutes, as defined by HCPCS code G0156.

Payment to RNHCI 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 RNHCI 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.

Claims for RNHCI home services with dates of service between January 1, 2005, and December 31, 2006, will be accepted for processing subject to the timely filing instructions provided in Chapter 1.