CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 357

Department of Health & Human Services

Center for Medicare & Medicaid Services

Date: NOVEMBER 5, 2004

Change Request 3529

SUBJECT: Implementation of Coverage of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home, MMA section 706.

I. SUMMARY OF CHANGES: Implementation of Coverage of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home, MMA section 706.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 1, 2005

IMPLEMENTATION DATE : April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:

R = REVISED, N = NEW, D = DELETED – ***Only One Per Row.***

R/N/D	Chapter / Section / Subsection / Title
R	1/ 60.4 – Noncovered Charges on Outpatient Bills
R	3/ Table of Contents
N	3/170/Billing and Payment of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home

III. FUNDING:

Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 357	Date: November 5, 2004	Change Request 3529

SUBJECT: Implementation of Coverage of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home, MMA section 706.

I. GENERAL INFORMATION

A. Background: Prior to the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Medicare program's Religious Nonmedical Health Care Institution (RNHCI) benefit was limited to inpatient services provided in an RNHCI facility. Section 706 of MMA extends coverage to RNHCI items and services that are provided in a beneficiary's home and that are comparable to items and services provided by a home health agency that is not a RNHCI. Beneficiaries elect the RNHCI benefit if they are conscientiously opposed to accepting most medical treatment, since accepting such services would be inconsistent with their sincere religious beliefs. The Medicare home health benefit provides skilled nursing, physical therapy, occupational therapy, speech language pathology and home health aide services to eligible beneficiaries under a physician's plan of care. The home health benefit also provides medical supplies, a covered osteoporosis drug and durable medical equipment (DME) while under a plan of care (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 7).

B. Policy: Medicare will cover specified durable medical equipment and intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. The remainder of the services covered under the Medicare home health benefit are medical in nature and must be provided under the order of a physician. As such, these services conflict with RNHCI beneficiaries' conscientious opposition to medical care. The specified DME items include canes, crutches, walkers, commodes, a standard wheelchair, hospital beds, bedpans, and urinals (see new Pub. 100-02, Benefit Policy Manual, Chapter 1, §130 for list of codes). Those RNHCIs offering home services may order these items and services without a physician order and without compromising the beneficiary's election for RNHCI care. The RNHCI shall establish a payment arrangement with one or more DME suppliers to obtain any of the specified DME items. The RNHCI shall provide RNHCI nursing services directly. The RNHCI shall submit claims for these items and services only to the RNHCI specialty FI.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3529.1	The RNHCI specialty intermediary shall accept for processing RNHCI outpatient claims for specified DME and for nursing visits.									RNHCI FI
3529.2	The RNHCI specialty intermediary shall instruct RNHCI providers to submit claims for specified DME and for nursing visits using type of bill 43x.									RNHCI FI
3529.2.1	The RNHCI specialty intermediary shall instruct RNHCI providers that claim for specified DME and for nursing visits will be accepted no earlier than April 4, 2005.									RNHCI FI
3529.3	The RNHCI specialty intermediary shall instruct RNHCI providers to submit claims for specified DME using revenue codes 0291 (rental), 0292 (purchase- new) or 0293 (purchase- used) only.									RNHCI FI
3529.4	The RNHCI specialty intermediary shall ensure that RNHCI providers submit claims for nonmedical DME reporting a HCPCS code, units and a date of service for each line item.									RNHCI FI
3529.4.1	The RNHCI specialty intermediary shall publish to RNHCI providers the list of billable nonmedical DME HCPCS codes provided in Pub. 100-02, Benefit Policy Manual, chapter 1, section 130.									RNHCI FI
3529.5	The RNHCI specialty intermediary shall allow payment on type of bill 43x only for the specified DME HCPCS listed in the Benefit Policy Manual, chapter 1, section 130.									RNHCI FI
3529.6	The RNHCI specialty intermediary shall maintain fees on its system only for the specified DME HCPCS listed in the Benefit Policy Manual, chapter 1, section 130.									RNHCI FI

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3529.7	The RNHCI specialty intermediary shall instruct RNHCI providers to submit claims for RNHCI nursing visits using revenue code 57x.									RNHCI FI
3529.8	The RNHCI specialty intermediary shall ensure that RNHCI providers submit claims for RNHCI nursing visits reporting each visit as a separate line item reporting HCPCS code G0156, units and a date of service for each line item.					X				RNHCI FI
3529.9	The RNHCI specialty intermediary shall instruct RNHCI providers to report service units associated with HCPCS code G0156 in 15-minute increments.									RNHCI FI
3529.10	Medicare systems shall make payment on claims reporting revenue code 57x with dates of service in calendar year 2005 using the table of MSA-specific per-visit rates in the attachment.					X				
3529.11	Medicare systems shall not calculate coinsurance or deductible for nursing services on type of bill 43x.					X				
3529.12	On April 4, 2005, the RNHCI specialty intermediary shall ensure that revenue codes 291, 292, 293 and 57x are valid for processing on type of bill 43x effective for dates of service on or after January 1, 2005.									RNHCI FI
3529.13	Medicare systems shall ensure that annual calendar year payments for all claims with type of bill 43x do not exceed $700,000.					X				
3529.13.1	Medicare systems shall maintain and display a single total of payments made for 43x claims for services in each calendar year, increasing the total based on each claim paid to any provider.					X				
3529.13.2	Medicare systems shall compare all claims with type of bill 43x to the total of payments made for 43x claims in the applicable calendar year.					X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3529.13.3	If the $700,000 annual limit is reached in a calendar year, the RNHCI specialty intermediary shall reject all further receipts of 43x claims with dates of service within that calendar year.					X				
3529.13.3.1	If the $700,000 annual ceiling is reached in a calendar year, the RNHCI specialty intermediary shall reject claims as a beneficiary liability using reason code 45.					X				RNHCI FI
3529.13.3.2	If the $700,000 annual ceiling is reached in a calendar year, the RNHCI specialty intermediary shall reject claims using Medicare Summary Notice message 16.10.					X				RNHCI FI
3529.13.4	The RNHCI specialty intermediary shall periodically monitor the total of payments made for 43x claims for services in each calendar year									RNHCI FI
3529.13.5	The RNHCI specialty intermediary shall notify providers when spending for RNHCI outpatient claims is nearing the annual limit, informing providers that future claims may be rejected when the limit is met.									RNHCI FI

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3529.5	All current coverage requirements and standards for DME apply to these services.
3529.5, 3529.6	Systems changes to allow type of bill 43x and to calculate payments for DME items on this type of bill were implemented in Transmittal 104, January 3, 2005.
3529.12	Only the RNHCI specialty intermediary shall make these changes to their revenue code file. All other FIs shall continue to ensure that no revenue codes are valid for type of bill 43x, as required by Transmittal 104.
3529.13.3.1	Reason code 45 is defined "Charges exceed your contracted/ legislated fee arrangement."

3529.13.3.2	MSN message 16.10 is defined "Medicare does not pay for this item or service."

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: These instructions will create an entirely new workload for the RNHCI specialty intermediary. RNHCI outpatient claims have never before been accepted and processed at this intermediary or by any other agent of the Medicare program.

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Wil Gehne, 410-786-6148, wgehne@cms.hhs.gov (claims processing) or Jean-Marie Moore, 410-786-3508, jmoore2@cms.hhs.gov (payment policy) **Post-Implementation Contact(s):** Regional Offices	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

Attachment

Attachment – Facility Specific Per-Visit Rates for RNHCI Nursing Services for Services Provided in Calendar Year 2005.

Facility MSA Area	2005 Wage Index Value	Facility Wage-Adjusted Labor Portion	Facility Non-Labor Portion	Total Facility Per-Visit Rate
1123	1.1290	31.04	8.32	39.36
1600	1.0851	29.84	8.32	38.16
1680	0.9626	26.46	8.32	34.78
1840	0.9753	26.81	8.32	35.13
1920	1.0054	27.63	8.32	35.95
2080	1.0904	29.98	8.32	38.30
3480	1.0039	27.60	8.32	35.92
4480	1.1732	32.25	8.32	40.57
5080	1.0076	27.70	8.32	36.02
5600	1.3586	37.36	8.32	45.68
5960	0.9742	26.78	8.32	35.10
7320	1.1267	30.98	8.32	39.30
7360	1.4712	40.45	8.32	48.77
8200	1.1078	30.46	8.32	38.78
8840	1.0971	30.16	8.32	38.48

Notes:

- National base RNHCI nursing rate is $35.81.
- Labor portions are calculated as follows: $35.81 x .76775 x facility's wage index value.
- Non-labor portions are calculated as follows: $35.81 x .23225 = $8.32.
- Facility per-visits rates are the sum of the labor and non-labor portions.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

60.4 - Noncovered Charges on Outpatient Bills

(Rev. 357, Issued: 11-05-04, Effective: 01-01-05, Effective: 04-04-05)

The term "outpatient" is often used very generally. In this section, the term should be applied to benefits that are both: (1) Not exclusively inpatient, and (2) Not Part A TOBs (i.e., not TOBs 11x, 18x, 21x, 41x). Therefore, "outpatient" here includes inpatient Part B (TOBs 12x, 22x) and hospice (TOBs 81x, 82x).

TABLE 6:

Definition of Fee-for-Service (Traditional or Original) Medicare Inpatient and Outpatient Services by Bill Type

Concise/General Policy Description: An inpatient service requires a beneficiary reside in a specific institutional setting during treatment. An outpatient service is provided by an institutional provider, but beneficiaries are not necessarily confined to a specific institution for periods of 24 hours or more.

Concise/General Claims/Systems Definition: The use of the category terminology is understood to reference the specific listed bill types, EXCEPT general use of the term outpatient is generally understood as all bill types EXCEPT those defined as inpatient Part A. Specific trust fund payment is associated with these bill types. Note an "x" represents a varying third digit in the bill type not needed to identify the benefit.

Category	Medicare FFS Bill Types (All Types Listed)	Trust Fund Payment
Inpatient Part A	11x – Hospital 18x – Swing Bed 21x – Skilled Nursing Facility (SNF) 41x – RNHCI – Religious Non-Medical Health Care Institution – *inpatient*	Part A only
Inpatient	12x – Hospital	Part B only
Part B*	22x – SNF	
In/Outpatient Part A*	81x, 82x – Hospice	Part A only
Outpatient*	13x, 14x – Hospital	Part B only

[1]Subject to Ambulatory Surgery Center (ASC) payment limits

Category	Medicare FFS Bill Types (All Types Listed)	Trust Fund Payment
	23x – SNF 34x – Home Health (not prospective payment (PPS)) *43x – RNHCI outpatient* 71x – RHC – Rural Health Clinic 72x – RDF – Renal Dialysis Facility 73x – FQHC – Federally Qualified Health Center 74x – ORF – Outpatient Rehabilitation Facility 75x – CORF – Comprehensive ORF 76x – CMHC – Community Mental Health Center 83x – Hospital Outpatient Surgery[1] 85x – Critical Access Hospital (CAH) = 32x, 33x – Home Health (PPS) = 89x – NOE[2] for Coordinated Care Demonstration	= = = = = = = = Parts A and B = = = = = = = = No payment

* Treated as outpatient in processing unless instructions specify otherwise. Note that for inpatient Part B claims, since 10/2003 HIPAA requires that, when transmitted, these claims conform to inpatient requirements for the institutional 837 claim transaction, though Medicare systems will still process these claims like outpatient transactions when received.

[2] Notice of Election, which creates a benefit period in Medicare systems (Common Working File) against which utilization or payment can be tracked; this is the only type of NOE that requires a specific character in the second digit of the bill type, aside from requirements for the frequency cod (third digit).

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 357, 11-05-04)

170 – Billing and Payment of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home

(Rev. 357, Issued: 11-05-04, Effective: 01-01-05, Effective: 04-04-05)

Medicare covers specified durable medical equipment and intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. See Pub. 100-02, Benefit Policy Manual, chapter 1, section 130 regarding this policy.

Medicare covers these item sand services for dates of service from January 1, 2005 through December 31, 2006. Total Medicare payments under this benefit for each calendar year during this period are limited to $700,000. During this period, Medicare instructions for billing nonmedical DME by RNCHIs are as follows:

- *RNHCIs must submit claims for DME and nursing visits to the RNHCI specialty FI using type of bill 43x.*

- *RNHCIs must submit claims for DME using revenue codes 291 (rental), 292 (purchase- new) or 293 (purchase- used) only, reporting a HCPCS code, service units, a date of service and a charge for each line item.*

- *RNHCIs may provide DME items as specified by a list of HCPCS codes published in Pub. 100-02, Benefit Policy Manual, chapter 1, section 130 and distributed by their specialty intermediary.*

- *RNHCIs must submit claims for nursing visits using revenue code 57x, reporting each visit as a separate line item using HCPCS code G0156, service units, a date of service and a charge amount.*

- *RNHCIs must report service units for nursing visits in increments of 15 minutes, as defined by HCPCS code G0156.*

Payment to RNHCIs for DME items will be made based on the DME fee schedule. Coinsurance applies to these items. Deductible does not apply to these items.

Payment to RNHCIs for nursing visits will be made at 80 percent of the national standard home health aide visit rate used under the home health prospective payment system, subject to wage index adjustment based on the location of the RNHCI facility. See Pub. 100-2, Benefit Policy Manual, chapter 1, section 130.2 for details of the payment calculation. Coinsurance and deductible do not apply to these services.