CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2285	Date: August 26, 2011
	Change Request 7542

SUBJECT: Attending Physician Identifiers on Religious Nonmedical Health Care Institution Claims

I. SUMMARY OF CHANGES: This Change Request instructs Religious Nonmedical Health Care Institutions to report their own facility identifiers as the attending physician on claims.

EFFECTIVE DATE: November 28, 2011
IMPLEMENTATION DATE: November 28, 2011

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	3/170.2.2/Required Data Elements on Claims for RNHCI Services

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Not Applicable.

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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2285	Date: August 26, 2011	Change Request: 7542

SUBJECT: Attending Physician Identifiers on Religious Nonmedical Health Care Institution Claims

Effective Date: November 28, 2011

Implementation Date: November 28, 2011

I. GENERAL INFORMATION

A. Background: Covered health care providers, including Religious Nonmedical Health Care Institutions (RNHCIs), have been required to use the National Provider Identifier (NPI) on electronic claim transactions since May 23, 2008. Medicare billing instructions have historically required RNHCI claims to report the RNHCI's own NPI but have not required RNHCI's to report an attending physician NPI. Due to the non-medical nature of RNHCI services, beneficiaries electing the RNHCI benefit do not have an attending physician.

As long as RNHCIs submit their claims to Medicare using the Direct Data Entry (DDE) system, the absence of an attending physician is not a problem. Medicare edits of DDE claims do not require an attending physician on type of bill 41x. However, CMS has learned that the absence of an attending physician presents a barrier to RNHCIs seeking to submit claims using the HIPAA-standard 837 Institutional claim standard.

The 837 Institutional claim requires an attending provider name and NPI to be reported in the 2310A loop, NM1 segment for all claims that contain any services other than unscheduled transportation. If RNHCIs do not report this segment, they will be rejected by HIPAA-compliant translator edits. By providing instructions to report this segment, CMS will enable RNHCIs to submit 837 Institutional claims.

B. Policy: RNHCIs submitting claims to Medicare will duplicate the institution's own name and NPI as the attending physician data on their claims.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A / B MAC	D M E MAC	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	
7542.1	Contractors shall instruct RNHCIs to duplicate their facility name and NPI in the Attending Physician NPI field on all claims.										J10 MAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	A / B MAC	D M E MAC	F I	C A R R I E R	R H H I	FISS	MCS	VMS	CWF	Other
							Shared-System Maintainers				
7542.2	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 MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										J10 MAC

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, 410-786-6148, wilfried.gehne@cms.hhs.gov (claims processing), Michelle Cruse, 410-786-7540, michelle.cruse@cms.hhs.gov (payment policy)

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

VI. FUNDING

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

N/A

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 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.

170.2.2 - Required Data Elements on Claims for RNHCI Services
(*Rev.*2285, Issued: 08-26-11, Effective: 11-28-11, Implementation 11-28-11)

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.
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 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.
9	Information	Self-explanatory
	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 "000l". 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 RHNCI 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 "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.

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.

Attending Physician

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

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.