Pre-Test

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Religious Nonmedical Health Care Institute (RNHCI) 2019

Presented by:
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JJ Part A Provider Outreach and Education Department
Disclaimer

The content in this presentation is intended for JJ providers and is current as of September 1, 2019. Any changes or new information superseding this information is provided in articles with publication dates after September 1, 2019, at:


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Who is Palmetto GBA?
Palmetto GBA

- Medicare Administrative Contractor (MAC)
- Founded in 1965
- Headquartered in Columbia, South Carolina
- More than 1,500 associates in offices in Alabama, Georgia and South Carolina
- Creates value for government and commercial customers every day
Finance and accounting
Claims processing
Contact center operations
Enrollment
Medical review and medical policy
65.3 BILLION dollars in benefits paid

184 MILLION claims processed

11.5* MILLION beneficiaries served (*unduplicated)

2.9 MILLION customer inquiries answered

2,025 employees working across five operation sites

81 ranking on Information Week’s list of 500 most innovative companies

Calendar year ended December 31, 2018
Jurisdictions M and J
Leadership

W. Joe Johnson
President & COO

Nella Bishop
CIO & Vice President
Systems & Support

Neal Burkhead
Vice President
Shared Services

Debbie Dickson
Vice President
Jurisdiction J
A/B MAC Operations

Elaine Garrick
Vice President
Support Operations

Ken Lewis
Vice President & CFO

Tim Masheck
Vice President
Information Technology Services

Ed Sanchez
Vice President
Jurisdiction M
A/B MAC Operations
Provider Outreach and Education (POE)

Mission
To provide Medicare providers with the timely and accurate information they need to understand the fundamentals of the billing and documentation requirements of the Medicare program and be informed about changes to those regulations in order to reduce the prevalence of billing and documentation errors.

Vision
To establish relationships with providers and their associations and societies in order to be recognized as a reliable resource for Medicare education.
Provide education for providers who are new to the Medicare program

Provide education tailored to small providers

Provide education through various channels

Utilize data analysis in order to identify areas of focus for the education

Measure the effectiveness of the education provided
Methods:

- **Global Education:** General Medicare billing and documentation requirement education will be offered to providers at large.

- **Targeted Education:** Providers will be identified through data analysis and provided education specific to them and their needs.
Religious Nonmedical Health Care Institute (RNHCl) 2019
Policy Overview

Presented by:
Vinsetta Montgomery Sr. Provider Relations Representative
JJ Part A Provider Outreach and Education Department
Agenda

- RNHCl
- Costs
- Basics
- Elections
- Billing
- Claims Processing
- Tips
- Resources
What is a RNHCI?

A Religious Nonmedical Health Care Institution is a facility that provides nonmedical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be not be consistent with their religious beliefs.

The RNHCI benefit is for Part A only.
RNHCI Locations
RNHCI Costs

- Reimbursements
- Funds
- Payments
RNHCIs – Total Costs

$46.3 MILLION

XVIII Pt A
Medicare Reimbursement by Facility

TOTAL
$4,310,603

AVERAGE
$270,000
Sources of Funds

- Routine and Ancillary Charges
- Contributions/Grants
- Investments
RNHCIs are paid on TEFRA

Can receive reimbursement for

- Nursing and Allied Health (and Managed Care payment)
- Organ Acquisition (if approved as Certified Transplant Center)
- Physician Services in a Teaching Hospital
- Medicare Bad Debts
Payment Methodology

- Based on discharges (including deaths)
- Times target amount per discharge (as computed by MAC)
  - This establishes a limitation on allowable rates of increase for inpatient operating costs
- The difference between costs and calculated target determines payments including bonus and relief payments
Two “Add-On” Payments

- Bonus Payment
- Relief Payment
Bonus Payment

1. Cost per Discharge < Target per Discharge
   AND

2. Hospital has received PPS exempt payments for three or more previous cost reporting periods
   AND

3. Operating Costs < target, expected, or trended costs
   THEN

   • Bonus payment is lesser of:
     • 15% of Difference in operating costs and target amount
     OR
     • 2% of Target amount
Relief Payment

1. Actual Inpatient Operating Cost > Target Amount AND

2. Total Program Inpatient Operating Costs (excluding capital/CRNA/Med Ed) > 110% of Target Amount THEN

• Relief payment is the Lesser of:
  • 50% of Difference between amounts in #2 above OR
  • 10% of Target Amount
RNHCI Basics

- Coverage
- Benefit Periods
- Facility
RNHCI Basics – Coverage

- **Certification:** The RNHCI is currently certified to participate in Medicare.

- **Utilization Review:** The RNHCI utilization review committee agrees that the beneficiary would require hospital or SNF care even if he/she was not in the RNHCI.

- **Written Election:** The beneficiary has a written election on file.

- **Non-medical health care items/services:** A RNHCI is a facility that provides non-medical health care items/services to beneficiaries who qualify for hospital or skilled nursing facility care. Religious beliefs of these beneficiaries prohibit conventional and unconventional medical care.

- **Deductible:** The beneficiary is also responsible for applicable Part A deductible/coinsurance costs.
RNHCI services are only available if a beneficiary’s beliefs prohibit their use of conventional and unconventional medical care. Services include:

- **Room and Board**
  - 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.

- **Items or services that do not require a doctor’s order or prescription, such as:**
  - Un-medicated wound dressings
  - Use of a simple walker
RNHCI Basics – Non-Covered Services

Non-Covered Services include:

- The religious portion of care
- The training of personnel that provide that care
- Charges or costs for training of nonmedical personnel
- Supplies that require a physician order (e.g., specialty dressings, compression stockings, alternating pressure mattress pads)
- Religious items such as 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
- 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)
Part A 2019 (each benefit period):

- Deductible = $1,364;
- Day 1–60 = $0 Co-insurance/Per Day
- Day 61–90 = $341 Co-insurance/Per Day
- Day 91–150 = $682 Co-insurance/Per Day (Lifetime Reserve Days)
The Boston Regional Office has the primary responsibility for the approval and certification process to ensure and verify a RNHCI conforms to the specific Conditions of Coverage and all of the Conditions of Participation. To qualify as a Medicare or Medicaid RNHCI, an institution must meet all ten of the following requirements:

10 requirements to qualify as a Medicare RNHCI

- Is described in subsection (c)(3) of §501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection 501(a);
- Is lawfully operated under all applicable federal, state, and local laws and regulations;
- Furnishes only nonmedical nursing items and services to beneficiaries who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical services would be inconsistent with their religious beliefs;
- Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients;
- Furnishes nonmedical items and services to inpatients on a 24-hour basis;
Continued...

- Does not furnish, on the basis of religious beliefs, through its personnel or otherwise, medical items and services for its patients;

- Is not owned by, under common ownership with, or has an ownership interest of 5 percent or more in, a provider of medical treatment or services and is not affiliated with a provider of medical treatment or services or with an individual who has an ownership interest of 5 percent or more in a provider of medical treatment or services;

- Has in effect a utilization review plan that meets the requirements of §403.720(a)(8);

- Provides information CMS may require to implement §1821 of the Act, including information relating to quality of care and coverage determinations; and

- Meets other requirements CMS finds necessary in the interest of the health and safety of the patients who receive services in the institution.
Elections

➤ Requirements
➤ Submission
➤ Revocation
For the RNHCI to receive payment under the Medicare Program, the beneficiary must make a written election to receive benefits.

**Attestation Statement/Election Form**
- The beneficiary must attest that he/she is opposed to acceptance of nonexcepted (voluntary) medical treatment. An acceptance of this type of treatment would be inconsistent with the beneficiary’s religious beliefs.
- The completed election form must be filed with the specialty contractor (Palmetto GBA) and retained by the RNHCI provider.
- If a Medicare covered level of care is needed after the form is signed, Medicare will then pay the RNHCI for the non-medical care, unless there is a revocation.
Election Requirements

(1) The election must be a written statement that must include the following statements:
   (i) The beneficiary is conscientiously opposed to acceptance of nonexcepted medical treatment.
   (ii) The beneficiary acknowledges that the acceptance of nonexcepted medical treatment is inconsistent with his or her sincere religious beliefs.
   (iii) The beneficiary acknowledges that the receipt of nonexcepted medical treatment constitutes a revocation of the election and may limit further receipt of services in an RNHCI.
   (iv) The beneficiary acknowledges that the election may be revoked by submitting a written statement to CMS.
   (v) The beneficiary acknowledges that revocation of the election will not prevent or delay access to medical services available under Medicare Part A in facilities other than RNHCIs.

(2) The election must be signed and dated by the beneficiary or legal representative.

(3) The election must be notarized.

(4) The RNHCI must keep a copy of the election statement on file and submit the original to CMS with any information obtained regarding prior elections or revocations.

(5) The election becomes effective on the date it is signed.

(6) The election remains in effect until revoked.
Election Submission

The CMS form (UB-04) or Direct Data Entry (DDE) must be used for submitting elections, revocations and cancellations. It must include the following:

- Provider name, address, and telephone number

- Type of Bill (TOB):
  - 4XX, Religious nonmedical health care institution
  - 41X, Inpatient Part A
  - 41A, Election Notice — also use to correct a previously submitted date
  - 41B, Revocation Notice
  - 41D, Cancellation — use to submit notice of revocation when submitted in error

- Patient’s name, address, date of birth and sex
  - If date of birth cannot be obtained after a reasonable effort, the field will be filled in with zeros

- Admission date and NPI
  - Report RNHCI name and NPI in attending physician field to satisfy HIPAA reporting requirements
Election Revocation

When can an election be revoked?
- Written request to cancel the election is submitted to Palmetto GBA
- Patient receives non-excepted medical care for Medicare payment
  
  Once an election has been revoked, Medicare payment cannot be made to a RNHCI unless another valid election is filed

How are RNHCI benefits affected?
- Multiple revocations may affect the beneficiary’s ability to access the RNHCI benefit in the future:
  - Once — no waiting period before Medicare will pay for RNHCI care again.
  - Twice — 1 year waiting period before Medicare will pay for RNHCI care again.
  - Three Times — 5 year waiting period before Medicare will pay for RNHCI care again.
Billing

- Types
- Codes
A RNHCI submits claims to Palmetto GBA in the following situations:

- At the time of beneficiary discharge or death
- At the time beneficiary benefits are exhausted
- On an interim basis monthly

A RNHCI must also submit a claim even where the charges do not exceed the beneficiary’s deductible. The Medicare Claims Processing Manual (Chapter 3, Section 40) provides more information on the report of utilization days.
**Type of Bill (TOB)**

**Type of Bill**

Required: This three-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:

<table>
<thead>
<tr>
<th>1st Digit</th>
<th>Identifies type of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>RNHCI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd Digit</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3rd Digit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>RNHCI election notice</td>
</tr>
<tr>
<td>B</td>
<td>RNHCI revocation notice</td>
</tr>
<tr>
<td>D</td>
<td>RNHCI cancellation</td>
</tr>
<tr>
<td>0</td>
<td>Non-payment/zero Claims</td>
</tr>
<tr>
<td>1</td>
<td>Admit through Discharge</td>
</tr>
<tr>
<td>2</td>
<td>Interim-First Claim</td>
</tr>
<tr>
<td>3</td>
<td>Interim-Continuing Claim</td>
</tr>
<tr>
<td>4</td>
<td>Interim-Last Claim</td>
</tr>
<tr>
<td>7</td>
<td>Replacement of Prior Claim</td>
</tr>
<tr>
<td>8</td>
<td>Vold/Cancel of Prior Claim</td>
</tr>
</tbody>
</table>
Type of Admission (TOA)

TYPE OF ADMISSION CODES

• 3 — Elective: The Beneficiary’s Condition Permitted Adequate Time to Schedule the Availability of a Suitable Accommodation

• 9 — Information Not Available: Self-explanatory
Condition Codes

The RNHCI may enter any number of condition codes to describe conditions that apply to the billing period. 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.

If non-covered days are reported because the beneficiary’s inpatient benefits were exhausted, the RHNCI must indicate whether the beneficiary elects to use lifetime reserve (LTR) days.

- The RNHCI must indicate that the beneficiary chose to use LTR days on the claim by reporting condition code 68
- If a beneficiary elects NOT to use LTR days, the RNHCI must report condition code 67
Occurrence Codes and Dates
Conditional - The RNHCI may enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. Occurrence codes are 2 alphanumeric digits, and are reported with a corresponding date.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>If non-covered days are reported due to days not falling under the guarantee of payment provision</td>
</tr>
<tr>
<td>A3</td>
<td>If non-covered days are reported because the beneficiary’s inpatient benefits were exhausted,</td>
</tr>
</tbody>
</table>

Occurrence Span Code and Dates
Conditional - The RNHCI may enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and through dates for the period described by the code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>74</td>
<td>If non-covered days are reported because the beneficiary was on a leave of absence and was not in the RNHCI</td>
</tr>
</tbody>
</table>
**Value Codes**

The RNHCl must report utilization days using the value codes described below.

| Covered Days | The RNHCl must use value code 80 to 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. |
| Non-covered Days | The RNHCl must use value code 81 to 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. |
| Coinsurance Days | The RNHCl must use value code 82 to enter the number of covered inpatient days occurring after the 60th day and before the 91st day for this billing period. |
| Lifetime Reserve (LTR) Days | The RNHCl must use value code 83 to enter the number of LTR days the beneficiary elected to use during this billing period. LTR days are not charged where the average daily charge is less than the LTR 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. |
Revenue Codes

Identify specific accommodation charges; takes the place of fixed line item descriptions. The four digits explain each charge:

- All other revenue codes can be submitted with non-covered charges only
- Do not repeat revenue codes on the same claim to the extent possible
- RNHCI must enter the number of days for accommodations revenue codes

<table>
<thead>
<tr>
<th>0001</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0120</td>
<td>Semi-Private Room</td>
</tr>
<tr>
<td>0270</td>
<td>Supplies (non-religious, as covered by Medicare)</td>
</tr>
</tbody>
</table>
Reason codes are five-digit codes that direct the result of a claim edit or process. The figure below shows the different positions of the online reason code.

<table>
<thead>
<tr>
<th>First Digit</th>
<th>Type of Edit</th>
<th>Digits 2 - 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consistency Edit</td>
<td>0125-9999</td>
</tr>
<tr>
<td>3</td>
<td>FISS DDE Edit</td>
<td>0000-9799</td>
</tr>
<tr>
<td>4</td>
<td>File Maintenance</td>
<td>Alpha 001 – Alpha 899</td>
</tr>
<tr>
<td>5</td>
<td>Medical Review</td>
<td>0001-9999</td>
</tr>
<tr>
<td>7</td>
<td>Site Specific</td>
<td>0001-9999</td>
</tr>
<tr>
<td>A-Z</td>
<td>CWF (Except W)</td>
<td>Current CWF 4-digit Error Code</td>
</tr>
<tr>
<td>W</td>
<td>OCE/MCE &amp; Grouper</td>
<td>0001-2999</td>
</tr>
</tbody>
</table>
# Reason Codes – Common Denials

<table>
<thead>
<tr>
<th>REASON CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>39503</td>
<td>Occurrence Codes and Leave Days Do Not Match</td>
</tr>
<tr>
<td>U5211</td>
<td>DOD Discrepancy</td>
</tr>
<tr>
<td>7FINP</td>
<td>Missing Occurrence Code A3 to Report the Date Benefits Exhausted</td>
</tr>
</tbody>
</table>
Claims Processing

Rejections
Denials
Return to Provider (RTP)
Non-covered Days
Lifetime Reserve Days
Claims Processing

Upon claim receipt, Palmetto GBA confirms the claim is consistent with CMS instructions.

If appropriate for payment, the claim is processed through the Fiscal Intermediary Standard System (FISS) and submitted to the Common Working File (CWF) for approval.

If not appropriate for payment, the claim is returned to the RNHCI for correction.

Palmetto GBA will then process the claim to completion upon receipt of payment approval or rejection from CWF.
Claim Rejections

What can cause a claim to reject?

- No election is on file
- Submitted dates do not match
- Revocation date is prior to election
- Election already revoked or cancelled
- Claims with a P.O. Box in the billing provider address will reject
- Claims submitted with the group number instead of the individual provider number will be rejected
- Non-sequential billing
Claim Denials

What can cause a claim to deny?

- Services to Medicare beneficiaries that do not qualify for Medicare coverage

- Auto Denial — Requested Records Not Submitted. The services billed were not covered because the claim was not submitted or not submitted timely in response to an Additional Documentation Request (ADR). When an ADR is generated, the provider has 45 days from the date the ADR was generated to respond with medical records.
Return to Provider (RTP)

Claim Correction

The Return to Provider (RTP) status occurs when information necessary to process the claim is missing. The claim can be corrected or resubmitted. The claim correction process only applies to RTP claims.

- To access RTP claims in the DDE Claims Correction screen, select option 03 (Claims Correction) from the Main Menu and the appropriate menu selection under Claims Correction (21 – Inpatient, 23 – Outpatient, 25 – SNF).

- RTP claims remain in this location (TB9997) and are available for correction for 180 days.

- RTP claims are not finalized claims and do not appear on your Remittance Advice (RA). Therefore, you may submit a new (corrected) claim and it will not reject as a duplicate to the original claim. You must submit a new claim if:
  - You do not have access to the DDE system.
  - The RTP claim is not corrected within 180 days (or no longer appears in the Claim Correction screen) and becomes inactive (IB9997).
  - The RTP claim was suppressed in error.
  - The RTP claim is a canceled claim (Type of Bill (TOB) XX8).
Non-Covered Days

Non-covered Days — The RNHCI must use value code 81 to 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. Non-covered days include:

- Days not falling under the guarantee of payment provision. See section 40.1. E
- 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.
- Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the Veterans Administration (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
Non-Covered Days

Continued…

- 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 enters 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.
Lifetime Reserve Days (LTR)

**Lifetime Reserve (LTR) Days**

- If non-covered days are reported because the beneficiary’s inpatient benefits were exhausted, the RNHCI must indicate whether the beneficiary elects to use lifetime reserve (LTR) days. **Do not** use “Remarks” to indicate usage of Lifetime Reserve Days.
  - ✓ If yes, use condition code 68
  - ✓ If no, use condition code 67

- The RNHCI must use value code 83 to enter the number of LTR days the beneficiary elected to use during this billing period. LTR days are not charged where the average daily charge is less than the LTR 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 LTR days before billing Medicare for services furnished after the 90th day in the spell of illness.
Lifetime Reserve Days (LTR)

***UPDATE***

Per the CMS directive, Palmetto GBA will now process claims to allow the usage of LTR days when the RNHCI daily or TEFRA rate is lower than the LTR coinsurance amount. This means:

- The RNHCI must submit or adjust their claims with the word Exception in the Remarks field
- Palmetto GBA cannot mass-adjust the claims
- Palmetto GBA will override untimely claims
- Untimely new or adjusted claims: RNHCI must take into consideration of whether the secondary insurance will also override timeliness. If not, the beneficiary will lose LTR days and be responsible for paying the claim.
Reminders

- **Assistance:** To contact a specific department at Palmetto GBA, please refer to the detailed department listing located at: [https://www.palmettogba.com/palmetto/providers.nsf/cudocs/JJ%20Part%20A?open#reimbursement](https://www.palmettogba.com/palmetto/providers.nsf/cudocs/JJ%20Part%20A?open#reimbursement)

- **Election Revocation:** The Election revocation will automatically occur when the patient voluntarily seeks medical treatment. It is suggested that the RNHCIs ask their patients if they have sought medical treatment prior to admission in case another election has to be discussed.

- **Attending Provider:** RNHCIs submitting claims to original Medicare should report the name and NPI of their director of nursing in the Attending Provider fields on all claims.
Resources

- Medicare Beneficiary Identifier (MBI)
- Forms/Tools
- Education
- Listserv
- Top Links
- Provider Contact Center (PCC)
- Social Media
Medicare Beneficiary Identifier (MBI)

Get It, Use It!
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>Medicare began mailing out new cards and beneficiaries were able to look up their new MBI</td>
</tr>
<tr>
<td>June 2018</td>
<td>Providers enrolled in eServices were able to look up their patient’s MBI</td>
</tr>
<tr>
<td>October 2018</td>
<td>The MBI was returned on Medicare Remittance Advices</td>
</tr>
<tr>
<td>April 2019</td>
<td>Removal of Social Security Numbers (SSNs) from all Medicare cards</td>
</tr>
<tr>
<td>January 1, 2020</td>
<td>Only the MBI will be accepted on claims</td>
</tr>
</tbody>
</table>
Why?
The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 mandates removal of Social Security Number (SSN)-based HICN from Medicare cards to address current risk of beneficiary medical identity theft.

Solution?
Generate MBIs for all beneficiaries, including existing (currently active, deceased or archived) and new beneficiaries.

Who?
CMS initially assigned over 150 million MBIs and will generate a MBI for each new Medicare beneficiary.
Ways you and your office staff can get MBI numbers.

Ask your Medicare patients for the card. Patients can

- Call 1–800–MEDICARE (800–633–4227)
- Log into mymedicare.gov to get their MBI

Check your remittance advice. The MBI will be added to the remittance advice when a valid and active HICN is present, until end of transition period.

Look up your patient’s MBIs via the eServices MBI Lookup Tool.
MBI Lookup Tool

**MBI Lookup**

Medicare Administrative Contractor (MAC) Provider Medicare Beneficiary Identifier (MBI) Lookup Tool

Starting in April 2018, to make it easier for health care providers and those working on their behalf to get Medicare patients’ MBIs when they don’t or can’t give them, providers can use a MAC’s secure portal to look up MBIs. To find MBIs through the portal, providers must key the Medicare patient’s first name, last name, date of birth, and SSN.

**Beneficiary Information**

<table>
<thead>
<tr>
<th>Beneficiary Last Name:*</th>
<th>Beneficiary First Name:*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiary Name</th>
<th>Beneficiary Date Of Birth:*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffix:</td>
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</tr>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Beneficiary Social Security Number:*</th>
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</table>
Do You Have Feedback for Us - 2019 MAC Satisfaction Indicator (MSI) Survey Is Available Now!

The 2019 MAC Satisfaction Indicator (MSI), a survey administered by the Centers for Medicare & Medicaid Services (CMS), is available now. The MSI is your opportunity to offer detailed feedback on your interactions with Palmetto GBA over the last year. There are sections of the survey for feedback on Provider Enrollment, EDI and Claims, as well as the Provider Contact Center, eServices online portal and Provider Outreach and Education. The MSI survey is only offered on an annual basis, for a specified window of time, so don’t miss your chance to be heard.

Palmetto GBA has made numerous improvements to our services and have more planned in the coming months. Read our “You Do Make A Difference” page to see all the enhancements implemented as a result of your feedback on our surveys.

Top Links
- CERT Error Rate Map
- Claims Payment Issues Log

Top Forms/Tools
- Medicare Forms
- Charge Denial Rate Calculator

Have Questions About Using eServices?
See our eServices User Guide for answers about registering, logging into, and administering an eServices account - as well as using portal features.
Palmetto GBA Resources

**PCC:**
Contact the PCC for information not available via eServices or the IVR
- Hours: 8 a.m. until 6 p.m. ET
- Contact Number: 877–567–7271

**Interactive Voice Response (IVR):**
Access the IVR to request routine claims, beneficiary eligibility and payment information
- Available 24 hours a day, 7 days a week
- 877–567–7271, then follow the prompts

**eServices:**
The eServices portal is a resource available to access or check eligibility, claim status, remittances, financial information, etc.
- Go to [www.palmettogba.com](http://www.palmettogba.com), select Jurisdiction J Part A MAC, then eServices Portal from the home page
Social Media

- Follow us on Twitter
  - https://twitter.com/PalmettoGBA

- Find out more about us on LinkedIn
  - https://www.linkedin.com/company/palmetto-gba

- Look us up on Facebook
  - https://www.facebook.com/PalmettoGBA

- View our YouTube education
  - https://www.youtube.com/user/palmettogba

- Register to receive email updates
  - LISTSERV

- Subscribe to our RSS feed
  - www.palmettogba.com/JJA HOME PAGE
Religious Nonmedical Health Care Institute (RNHCl) 2019
Nursing Aspects

Presented by:
Sandra Booker, Sr. Provider Education Consultant
JJ Part A Provider Outreach and Education Department
Agenda

- The Christian Science Nurse
- Excepted and Non-Excepted Medical Care
- In-Home Care
- Differences Between Christian Science and Hospice
- Top Errors and Tips on How to Avoid Them
Christian Science Nursing

- Carried out with prayer
- Wisdom
- Skill
- Supports the patient’s decision that rely on Christian Science healing
Christian Science Nursing

Care includes:

- Accepting a case with the expectancy of complete and quick healing
- Giving care that is consistent with the theology and ethics of Christian Science
- Loving reassurance of God's tender care, ever-presence, and omnipotence; faithfully and consistently acknowledging each individual’s spiritual perfection
- Christian encouragement of a patient's appropriate expression of activity and vitality
- Reading to or with an individual from the Bible, Science and Health with Key to the Scriptures and other writings by Mary Baker Eddy, and additional literature published by The Christian Science Publishing Society
Communication: maintaining an ethical, moral and loving manner in all communications with the patient, family, friends, Christian Science practitioner and others; observing ethical and legal requirements with regard to private information about the patient.

Surroundings: maintaining an atmosphere that is conducive to spiritual healing and supportive of harmonious care.

Personal care and bathing: assisting with all necessary care to meet the needs of cleanliness and comfort.

Mobility: assisting with mobility including assisting with standing, walking, moving, and settling with or without mobility aids or comfort items.

Nourishment: preparing and modifying food, assisting with feeding, giving appropriate encouragement to eat.

Cleansing/bandaging: cleansing, covering and bandaging, to provide for cleanliness, protection, support, and comfort.

Instructing the patient or others in providing care for meeting individual needs.

Being obedient to the laws of the land.
Christian Science Nursing Does Not Cover

- Making a medical diagnosis or prognosis
- Assuming responsibility for making healthcare decisions for the patient
- Administering medication, drugs, or using medicated, herbal, or vitamin-based products and remedies
- Using and administering medically oriented techniques or technology; including, but not limited to, administering food or liquids with medical equipment, e.g., intravenous feeding
- Manipulation, massage, physical therapy
- Assuming responsibility for a patient's financial or household business transactions
- Intruding on the private relationship between the patient and the Christian Science practitioner, or between the patient and his or her family
- Giving personal advice and counsel
Christian Science nursing care must meet very specific criteria to qualify for Medicare reimbursement. For Medicare purposes, the nursing care must require the judgment, skill, oversight, observation, or direct care of a Journal-listed Christian Science nurse. Generally, the nursing need must include at least one of the following:

- Full care in bed
- The full assistance of one or more nurses to walk
- The dressing and bandaging of a wound
- Assistance to ensure proper and adequate nourishment
Conditions Not Reimbursable

- Inability to stay at home alone
- Anxiety or depression
- Incontinence
- Mental confusion

The cost is not reimbursable by Medicare.
Medical Care

Medical care or treatment means health care furnished by or under the direction of a licensed physician that can involve:

- Diagnosing
- Treating
- Preventing disease and other damage to the mind and body

Medical care may involve:

- The use of pharmaceuticals
- Diet
- Exercise
- Surgical intervention and/or
- Technical procedures
Excepted or Non-Excepted Medical Care

- Note that the terms “excepted” and “non-excepted” care represent mutually exclusive conditions under §1821 of the Social Security Act.

- Medicare contractors may use the examples previously stated in making determinations of excepted and non-excepted care.
Excepted Medical Care

- Excepted medical care is defined as medical care or treatment that is received involuntarily or required under federal, state, or local laws.

- This identifies the kinds of medical services that can be provided to a beneficiary with an election for RNHCI services without revoking the election.
Examples of excepted medical care include, but are not limited to, the following:

- A beneficiary that receives vaccinations required by a state or local jurisdiction. This is compliant behavior to meet government requirements and not considered as voluntarily seeking medical care or services.

- A beneficiary who is involved in an accident and receives medical attention at the accident scene, or in transport to the hospital, or at the hospital before being able to make their beliefs and wishes known.

- A beneficiary who is unconscious and receives emergency care and is hospitalized before regaining consciousness or being able to locate his or her legal representative.
Non-Excepted Medical Care

- Non-excepted medical care is defined as medical care other than excepted medical care.

- This term is intended to define the kinds of medical services that, if received by a beneficiary who has previously elected religious non-medical health care institution services, would revoke the individual’s election of services.
Non-Excepted Medical Care

Examples of non-excepted medical care could include but are not limited to the following:

- A beneficiary receiving medical diagnosis and/or treatment for persistent headaches and/or chest pains
- A beneficiary in an RNHCI who is transferring to a community hospital to have radiological studies and the reduction of a fracture
- A beneficiary with intractable back pain receiving medical, surgical, or chiropractic services
- A beneficiary who has requested a physician to prescribe a wheelchair or other durable medical equipment item
In Home Care

In the case where a RNHCI chooses to provide home services then only care on an intermittent basis, which is provided to an eligible beneficiary who is confined to their home for health reasons, will be covered under the home benefit.

Similar to the inpatient RNHCI benefit, the physician role in certifying and ordering the home benefit is replaced with the use of the RNHCI utilization review committee to review the need for care and plan for initial and continued care in the home setting.
The home benefit will also require a prompt review of admission to the home service, since the patient must be fully eligible (have a health condition that keeps them confined to the home (42CFR409.42(a), have health needs that can be met with intermittent care, and have a valid election) before billable services can be rendered and Medicare payment requested.

The utilization review committee is responsible for review and approval of care plans and orders for DME items, and review of the need for the continuation of services.
Durable Medical Equipment (DME)
Medicare covers a defined list of nonmedical DME items for RNHCCI home services that are comparable to items used in the inpatient RNHCCI setting and could be provided by an HHA such as:

- canes
- crutches
- walkers
- commodes
- a standard wheelchair
- hospital beds
- bedpans
- urinals
DME

The need for each item of DME ordered must be supported by the RNHCI patient’s plan of care for the home setting and the RNHCI nurses’ notes for home services.

It must be noted that the benefit is applicable only to what we shall refer to as “nonmedical DME items” and does not include any of the related services provided by RNHCI staff members.
The RNHCI shall establish a payment arrangement with one or more DME suppliers to obtain any of the items on the DME list (below) they may require for a beneficiary.

The supplier will provide the items and related instructions on use to the beneficiary/family/care giver. The RNHCI will submit claims for these DME items to the RNHCI specialty FI.

The RNHCI must stress to suppliers that DME claims are not to be submitted to the DMERC because this will cause the beneficiary’s election for RNHCI care to be revoked.
# RNHCl Care vs. Hospice Care

## RNHCl Care
- A set of beliefs and practices belonging to the metaphysical family of new religious movements.
- View that disease is a mental error rather than physical disorder, and that the sick should be treated not by medicine, but by a form of prayer.
- Medication is not used.
- Medicare will also only cover the inpatient non-religious, non-medical items and services (room and board and any items or services that don’t require a doctor’s order or prescription, including un-medicated wound dressings).
- Addresses symptom management, coordination of care, communication and decision making, clarification of goals of care, and quality of life.

## Hospice Care
- Medical care to help someone with a terminal illness live as well as possible for as long as possible, increasing quality of life.
- Involves an interdisciplinary team of professionals to address physical, psychosocial, and spiritual distress focused on both the dying person and their entire family.
- Addresses symptom management, coordination of care, communication and decision making, clarification of goals of care, and quality of life.
- Uses medication to manage and control pain.
- The patient has 6 months or less to live, according to a physician.
Top Errors

- Overlapping DOS
- Date of death does not match
- MBI/HIC combo doesn’t match
- Incorrect utilization codes
- Billing dates do not match
- Duplicate claims submitted
- Lifetime Reserve Days
Tips to Avoid Errors
PROACTIVE
Being Proactive

- Create checklists
- Verify dates of service (DOS) billed
- Check the beneficiary’s eligibility
- Verify no one else is working the same claim and no other claims are processing
- Verify the MBI/HIC numbers
- Verify where the beneficiary went after discharge
- Verify that the beneficiary wants to use LTR days
Reminders

- You can only adjust finalized claims
- **Do not** suppress your claims (counts towards your total claim count)
- You have to have a value code to show no covered dates
- Check the beneficiary’s eligibility prior to submitting the claim (shows date of death and if the beneficiary has other insurance)
- Verify the MBI number; Verify the HICN number
- Verify the number of LTR days the beneficiary has
- If services aren’t covered make sure the beneficiary has received a ABN and has received an explanation of the ABN
- Date of discharge and date of death cannot count as non-covered or covered days
FISS Claim Examples
**FISS Claim Example #1**

**Occurrence Codes and Leave Days Do Not Match**

<table>
<thead>
<tr>
<th>MAP 1231</th>
<th>JJ A/B MAC TN #10311</th>
<th>ACPMA411 08/23/19</th>
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**Narrative**

**Standard Narrative:**

**Type Bill:** INPATIENT/SNF

Considered noncovered days based on the occurrence codes and leave days on the claim do not match the noncovered days on the claim.

Reason code modified with CR8896/C2015200.

---

**Process Completed --- No More Data This Type**

Press PF3-Exit PF5-Scroll BKWD PF6-Scroll FWD PF8-Next
FISS CLAIM EXAMPLE #1

OCCURRENCE CODES AND LEAVE DAYS DO NOT MATCH

CONDITION CODES 01 68 02 03 04 05 06 07 08 09 10
VERIFY NC DT THRU HMO REL/OR CD HMO AUTH
BENE EXHAUST DATE SET QUALIFYING STAY DATES SET BDL CHK OVR
PROV FLT DAYS LTR RATE BYPASS TECH PROV; DAYS CHARGES
PA REDUCT BYPASS ZPIC

OCCURRENCE CDS AND DATES 01 A3 102617 02 03 04
05 06 07 08 09 10
CARR/LOC:

OCCURRENCE SPAN CDS AND DTS (FROM / THRU)
1 2 3 4
5 6 7 8
9 10

AD DCN

VALUE CODES - AMOUNTS - ANSI MSP APP IND
01 80 0.00 02 81 26.00 03
04 05
07 08
39503

<== REASON CODES
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
FISS CLAIM EXAMPLE #2
SERVICE DATES THAT OVERLAP

MAP1231 JJ A/B MAC TN #10311 ACPHA411 08/23/19
VY20115 SC REASON CODES INQUIRY A20193CP 09:09:51
MNT: XE41126 04/16/14

PLAN REAS NARR EFF MSN EFF TERM CMS EMC HC/PRO PP CC USER
IND CODE TYPE DATE REAS DATE DATE STD ST/LOC ST/LOC LOC IND ACT
1 38017 S 122289 7.1 120105 A R R
TPTP A X B X NP CD A N B N HD CPY A 9 B 9 NB ADR CAL DY C/L C
JUSTIFICATION EFFECTIVE DATE
-----------------------------NARRATIVE-----------------------------

STANDARD NARRATIVE:
THIS INPATIENT CLAIM TOB 11X, 18X, 41X CONTAINS SERVICE DATES
THAT OVERLAP A PREVIOUS INPATIENT CLAIM TOB 11X, 18X, 41X.

THIS EDIT IS BYPASSED:
A- IF THE INCOMING OR HISTORY CLAIM HAS A NON-PAY CODE OF
   'N' OR 'B'.
B- IF THE INCOMING OR HISTORY CLAIM IS A LTCH PPS CLAIM.
   LTCH PPS CLAIMS ARE IDENTIFIED AS PROVIDER NUMBERS IN THE
   RANGE XX2000-XX2299 WITH A PPS INDICATOR OF 'Y'.
C- IF THE INCOMING OR HISTORY IRF CLAIM (XX3025 TO XX3099 OR
   XXTXXX, OR XXXX X) HAS A 74 SPAN (INTERRUPTED STAY), AND THE
   PROCESS COMPLETED --- PLEASE CONTINUE

PRESS PF3-EXIT PF5-SCROLL BKWD PF5-SCROLL FWD PF8-NEXT
# FISS Claim Example #3

## Date of Death Does Not Match

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**Standard Narrative:***

The statement from/thru date is greater than the date of death on beneficiary master record.

This edit is bypassed when:

- The claim action code is equal to '2', '4', or '6'.
- The claim is denied, either on the line or on the whole claim.
- Edit '5211' is present in the header and override with dates of service on or after 01/01/2011. T in the header override and the line
- The patient relationship equals '39'. Sent.

Process completed --- Please continue

Press PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT
### FISS Claim Example #3

**Date of Death Does Not Match**

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**Value Codes - Amounts - ANSI MSP APP IND**

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--- NARRATIVE ---

STANDARD NARRATIVE: THE COINSURANCE RATE FOR LIFE TIME
RESERVE DAYS EXCEEDS THE AVERAGE DAILY CHARGE, AND LTR RATE
BYPASS IS NOT SET TO 'Y'; OR LTR RATE BYPASS IS A 'Y', AND
THE RATE ENTERED FOR VALUE CODE 08 (LTR YEAR 1 RATE) OR
VALUE CODE 10 (LTR YEAR 2 RATE) IS MORE THAN THE HCFA SET
LTR RATE FOR THAT YEAR.

THIS REASON CODE IS BYPASSED FOR THE FOLLOWING CONDITION:
11X TOB WITH DATES OF SERVICE 7/1/06 AND GREATER FOR PROVIDER
RANGES XX-0001 THRU XX-0999, XX-1300 THRU XX-1399, AND XX-3300
THRU XX-3399 AND THE SUM OF THE COVERED (INCLUDING COINS AND
LTR) AND NON-COVERED DAYS ARE EQUAL TO ONE.

***********************

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT
FISS CLAIM EXAMPLE #4
(LTR DAYS)

CONDITION CODES
01 02 03 04 05 06 07 08 09 10
VERIFY NC DT THRU HMO REL/OR CD HMO AUTH
BENE EXHAUST DATE SET QUALIFYING STAY DATES SET BDL CHK OVR
PROV FLT DAYS LTR RATE BYPASS TECH PROV: DAYS CHARGES
PA REDUCT BYPASS ZPIC

OCCURRENCE CDS AND DATES
01 02 03 04 05 06 07 08 09 10
A3 102617 03 04

CARR/LOC:

OCCURRENCE SPAN CDS AND DTS (FROM / THRU)
1 2 3 4
5 6 7 8
9 10

AD. DCN

VALUE CODES - AMOUNTS - ANSI MSP APP IND
01 02 03
80 81 26.00
04 05 06
07 08 09
39507

PRESS PF3-EXIT PF5-SCROLL BKWD PF5-SCROLL FWD PF7-PREV PF8-NEXT

<== REASON CODES
FISS CLAIM EXAMPLE #5
(BENEFITS EXHAUSTED)

TYPE OF BILL: 11X
BENEFITS ARE EXHAUSTED ON AN INPATIENT CLAIM FOR SERVICES SUBJECT
TO BENEFIT PERIOD DETERMINATIONS.

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT
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VALUE CODES - AMOUNTS - ANSI MSP APP IND
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7FINP

PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
Q & A
Question #1

**Question:** Is there a step-by-step description of what is needed to efficiently process LTR claims and Benefits Exhausted Claims? What edits are ones that RNHCI claims seem to have trouble bypassing in the order to smoothly go from input to paid claim?

**Answer:**

- **LTR Claims:** Please refer to slide 55
- **Benefits Exhausted Claims:**
  - If non-covered days are reported due to days not falling under the guarantee of payment provision, the RNHCI reports occurrence code 20
  - If non-covered days are reported because the beneficiary’s inpatient benefits were exhausted, the RNHCI reports occurrence code A3 and the date benefits exhausted
  - Refer to FISS example # 5
- **Edits:** RNHCI claims will hit regular claim edits
Question #2

**Question:** I’d be interested to know the relationship between CMS and MC Advantage plans, seen from the CMS side, and how our claims to these insurers could be filed and paid more efficiently. (But perhaps that’s beyond the scope of this meeting?)

**Answer:** This is something that we, as your MAC, don’t handle. You would need to contact your MA vendor.
Question: I’ve been working to correct a claim which has been a bit complicated. Would a review of claims corrections be helpful to the group?

Answer: Claim corrections allow the provider to:
- Correct RTP claims
- Adjust claims
- Cancel claims

Specific details regarding claim corrections are outlined on the Palmetto GBA website (DDE Training Module) at:
**Question 4**

**Question 4-A:** How will Palmetto GBA treat claims where Medicare is a Secondary Payer?

**Answer:** Please refer to the MSP MLN booklet at:


**Question 4-B:** Should a 41A be filed when you are billing the primary payer?

**Answer:** Yes. 41A is the TOB information for the Notice of Election.

**Question 4-C:** How will the EOB’s from the Primary Payer be submitted to Palmetto GBA when Medicare does become responsible to pay on the claim?

**Answer:** Submit any MSP information to Palmetto GBA by using condition codes, occurrence codes and value codes on the claim like any other MSP claim. If the EOB is needed, the provider will be advised.

The Medicare Secondary Payer (MSP) Coding Module can be found at:

**Question #5**

**Question:** Not specific for Palmetto GBA, but I’d love to have a breakout session or round table discussion devoted to billing insurance claims.

**Answer:** Palmetto GBA has educational resources available to assist with billing:

- **RNHCI Overview Module:**

- **RNHCI — Religious Nonmedical Health Care Institutions Article:**

**Concierge Service:** The Provider Contact Center (PCC) offers Concierge Service to assist providers with a large number of claims questions. To request concierge service, simply contact the PCC at 877–567–7271 and a CSR will assist in scheduling the teleconference.

**Subject Matter Experts:** The PCC is in the process of designating RNHCI Subject Matter Experts (SMEs) to route RNHCI provider inquiries. This enhancement should be in process after the first of the year.
Question #6

**Question:** How do you actually submit your insurance claims? Are people using a software program to create the UB04 they submit? Is the submittal done electronically, or are all forms printed and mailed to insurance companies? Is the UB04 submitted virtually a copy of the ones submitted to Palmetto GBA for payment (for supplemental insurance claims), or does the UB04 only have the amount of the insurance claim on it? Do you include some sort of admitting diagnosis code in box 69?

**Answer:** Free software is available to submit claims to Palmetto GBA. PC-ACE Pro32 information is available on the EDI webpage. Below are relevant links:

- [Introduction to PC-ACE Pro32](#)
- [Part A & HHH PC-ACE Pro32 Reference Guide](#)
- [PC-ACE Pro32 Training Modules](#)
- [PC-ACE Pro32 Software User's Manual](#)

Specific details regarding claim billing is outlined on the Palmetto GBA website (DDE Training Module) at: [https://www.palmettogba.com/palmetto/providers.nsf/DocsR/JJ-Part-A~AUXRQX3748](https://www.palmettogba.com/palmetto/providers.nsf/DocsR/JJ-Part-A~AUXRQX3748)
Question: How does Palmetto GBA classify RNHCI in their system? What set of edits are used? Hospitals, rural clinics, hospice?

Answer: RNHCI facilities are classified as entities with Inpatient Hospital edits set for 41x type of bills. RNHCIs are qualified to bill Medicare Part A for nonmedical nursing items and services to beneficiaries who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical services would be inconsistent with their religious beliefs.
**Question**: Any update on being able to see a RNHCI election/revocation online or when we call IVR line?

**Answer**: The system upgrade is currently being worked on.
Resources

https://hospicefoundation.org/Hospice-Care/Hospice-Services

https://www.medicare.gov/coverage/religious-non-medical-health-care-institution-items-services

https://www.christianscience.com/what-is-christian-science

Internet Only Manual Medicare Benefit Policy Manual 100-08, Chapter 1; section 130

Palmetto GBA
www.palmettogba.com

Internet Only Manual Medicare Secondary Payer Chapter 3

MSP MLN Booklet

CMS MSP
Post-Test

Post-Test Link: https://www.surveymonkey.com/r/JLKLNPQ

Survey Link: https://www.surveymonkey.com/r/2FRDN9Q