CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1974	**Date: May 21, 2010**
	Change Request 6850

SUBJECT: Cardiac Rehabilitation and Intensive Cardiac Rehabilitation

I. SUMMARY OF CHANGES: The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for cardiac rehabilitation (CR) programs and intensive cardiac rehabilitation (ICR) programs. The Centers for Medicare and Medicaid Services (CMS) decided to implement the statutory provisions through rule making, in the calendar year (CY) 2010 Physician Fee Schedule (PFS). To implement MIPPA CR and ICR coverage provisions CMS added section 410.49, Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage, to the Public Health Code of Federal Regulations (42 CFR). The CR and ICR coverage provisions included in new section 42 CF R 410.49 are effective January 1, 2010.

EFFECTIVE DATE: January 1, 2010
IMPLEMENTATION DATE: October 4, 2010

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	26/10.8.3/Physician Specialty Codes
R	32/Table of Contents
N	32/140.2.2/Claims Processing Requirements for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished on or After January 1, 2010
N	32/140.2.2.1/Correct Place of Service (POS) Codes for CR and ICR Services on Professional Claims
N	32/140.2.2.2/Requirements for CR and ICR Services on Institutional Claims
N	32/140.2.2.3/Frequency Edits for CR and ICR Claims
N	32/140.2.2.4/Edits for CR Services Exceeding 36 Sessions

N	32/140.2.2.5/Edits for ICR Services Exceeding 126 Days and 72 Sessions
N	32/140.2.2.6/Supplier Specialty Code 31 Requirements for ICR Claims

III. FUNDING:

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

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

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: 1974	Date: May 21, 2010	Change Request: 6850

SUBJECT: Cardiac Rehabilitation and Intensive Cardiac Rehabilitation

Effective Date: January 1, 2010
Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for cardiac rehabilitation (CR) programs and intensive cardiac rehabilitation (ICR) programs. The Centers for Medicare and Medicaid Services (CMS) decided to implement the statutory provisions through rule making, in the calendar year (CY) 2010 Physician Fee Schedule (PFS). On October 30, 2009, the CY 2010 PFS Final Rule with Comment was finalized and put on display and is available at http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf). The Final Rule was published in the Federal Register on November 25, 2009, and is available on pages 62004 - 62005.

To implement MIPPA CR and ICR coverage provisions CMS added section 410.49, *Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage*, to the Public Health Code of Federal Regulations (42 CFR). The CR and ICR coverage provisions included in new section 42 CF R 410.49 were effective January 1, 2010.

B. Policy: Effective January 1, 2010, Medicare Part B covers CR and ICR program services for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty or coronary stenting;
- A heart or heart-lung transplant; or,
- Other cardiac conditions as specified through a national coverage determination (NCD) (CR only).

ICR programs must be approved by CMS through the NCD process and must meet certain criteria for approval. Individual sites wishing to provide ICR services via an approved ICR program must enroll with their local Medicare contractor or MAC as an ICR program supplier using CMS 855B. Contractors and MACs must ensure that claims submitted from individual ICR sites are submitted by enrolled ICR program sites.

NOTE: Per the NCD process, the coverage analyses of the first ICR programs under evaluation will be completed no later than August 15, 2010. CMS anticipates future analyses of additional ICR programs. ICR programs that are approved through the NCD process will be identified in the NCD manual (Pub. 100-03), on the CMS Web site and in the Federal Register. Once ICR programs are approved through the NCD process, sites wishing to furnish ICR services via an approved ICR program may begin to enroll as ICR program suppliers using CMS 855B.

Regulations at 42 CFR 410.49 include all coverage provisions for CR and ICR items and services, identifies definitions, covered indications, settings, physician supervision requirements and physician standards, required CR and ICR components, limitations to the number of sessions covered, and the period of time over which the sessions may be covered.

CR and ICR programs must include the following components: 1) physician-prescribed exercise each day CR and ICR items and services are furnished; 2) cardiac risk factor modification; 3) psychosocial assessment; 4) outcomes assessment; and 5) an individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed and signed by a physician every 30 days.

CR sessions are limited to a maximum of 2 1-hour sessions per day up to 36 sessions furnished over a period of up to 36 weeks, with the option for an additional 36 sessions at Medicare contractor discretion over an extended period of time. ICR sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

NOTE: Once a beneficiary begins CR, he or she may not switch to ICR and once a beneficiary begins ICR, he or she may not switch to CR. Upon completion of a CR or ICR program, beneficiaries must experience another indication in order to be eligible for coverage of more CR or ICR. Should a beneficiary experience more than one indication simultaneously, he or she may participate in a single series of CR or ICR sessions (i.e., a patient who had a myocardial infarction within 12 months and currently experiences stable angina is entitled to one series of CR sessions, up to 36 1-hour sessions with contractor discretion for an additional 36 sessions; or one series of ICR sessions, up to 72 1-hour sessions over a period up to 18 weeks).

Contractors shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond 36 sessions of CR up to a total of 72 sessions meets the requirements of the medical policy or, for ICR, that any further sessions beyond 72 sessions within a 126 day period counting from the date of the first session or for any sessions provided after 126 days from the date of the first session meet the requirements of the medical policy.

See Pub. 100-06, Medicare Financial Management Manual, chapter 6, section 420, and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 232, and Pub. 100-08, Medicare Program Integrity Manual, chapter 10, section 2.2.8 for detailed information regarding CR and ICR policy and claims processing.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	CR Specific Requirements:										
6850.1	Effective for claims with dates of service on and after January 1, 2010, contractors shall pay claims containing HCPCS 93797 for CR services without continuous monitoring and HCPCS 93798 for CR services with continuous monitoring.	X		X	X		X				
6850.1.1	Contractors shall pay claims for HCPCS 93797 and 93798 only when services are provided for place of service (POS) 11 or 22.	X			X						
6850.1.2	Contractors shall deny claims for CR services for POS other than 11 or 22 using the following:	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings." **NOTE:** This is a new MSN message. Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." Claim Adjustment Reason Code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **NOTE:** Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present. Remittance advice remark code (RARC) N428: "Service/procedure not covered when performed in this place of service." Contractors shall use Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
6850.1.3	Contractors shall pay claims for CR services containing HCPCS 93797 and 93798 with revenue code 0943 on Types of Bill (TOBs) 13X under OPPS and 85X on reasonable cost.	X		X			X				
6850.1.4	Contractors shall pay for CR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis, TOB 13X, in accordance with the terms of the Maryland waiver.	X		X			X				
6850.1.5	Contractors shall deny claims for CR services (HCPCS 93797 and 93798) when services are provided on other than TOBs 13X and 85X using: MSN 21.25: "This service was denied because Medicare only covers this service in certain settings." **NOTE:** This is a new MSN message.	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **NOTE:** Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present. RARC N428: "Service/procedure not covered when performed in this place of service." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
6850.2	Contractors shall pay HCPCS codes 93797 and 93798 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II under MPFS.	X		X			X				
6850.3	Effective for claims with dates of service on and after January 1, 2010, contractors shall deny CR services that exceeded 2 units on the same date of service.	X		X	X		X				
6850.3.1	Contractors shall deny CR services that exceed 2 units on the same date of service using: CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N362: "The number of days or units of service exceeds our acceptable maximum." MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
6850.3.2	Contractors shall not research and adjust any CR claims (HCPCS 93797 and 93798) paid for more than 2 units per date of service processed prior to the implementation of this Change Request. However, contractors may adjust claims brought to their attention.	X		X	X						
6850.4	Effective for claims with dates of service on and after January 2, 2010, contractors shall pay CR claims (HCPCS 93797 and 93798) which exceed 36 sessions when the KX modifier is included on the claim.	X		X	X						
6850.4.1	CWF shall create a new edit for HCPCS 93797 and 93798 to reject to contractors when a beneficiary has reached 37 CR sessions and the KX modifier is not included on the claim line.									X	
6850.4.2	Contractors shall deny claims with HCPCS 93797 and 93798 which exceeded 36 sessions when a KX modifier is not included on the claim line using the following: CARC 151: "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services." RARC N435: "Exceeds number/frequency approved/allowed within time period without support documentation." MSN 23.17: "Medicare won't cover these services because they are not considered medically necessary." Spanish Version: "Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
6850.4.3	Contractors shall not research and adjust any CR claims (HCPCS 93797 and 93798) paid for more than 36 sessions processed prior to the implementation of this Change Request. However, contractors may adjust claims brought to their attention.	X		X	X						
	ICR Specific Requirements:										
6850.5	Effective for claims with dates of service on and after January 1, 2010, contractors shall pay claims containing HCPCS G0422 for ICR services with exercise and HCPCS G0423 for ICR services without exercise.	X		X	X		X				
6850.5.1	Contractors shall pay claims for ICR services (HCPCS G0422 and G0423) only when services were provided for POS 11 or 22.	X			X						
6850.5.2	Contractors shall deny claims for HCPCS G0422 and G0423 billed without POS 11 or 22 using: MSN 21.25: "This service was denied because Medicare only covers this service in certain settings." **NOTE:** This is a new MSN message. Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **NOTE:** Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present. RARC N428: "Service/procedure not covered when performed in this place of service." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	with a GZ modifier indicating no signed ABN is on file.										
6850.6	Effective for claims with dates of service on and after January 1, 2010, contractors shall pay claims for ICR services containing HCPCS G0422 and G0423 with revenue code 0943 on TOBs 13X under OPPS and 85X under reasonable cost.	X		X			X				
6850.6.1	Contractors shall pay for ICR services for hospitals in Maryland under the jurisdiction of the HSCRC on an outpatient basis, TOBs 13X, in accordance with the terms of the Maryland waiver.	X		X			X				
6850.6.2	Contractors shall deny claims for ICR (HCPCS G0422 and G0423) when services are provided on other than TOBs 13X and 85X using: MSN 21.25: "This service was denied because Medicare only covers this service in certain settings." **NOTE**: This is a new MSN message. Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. RARC N428: "Service/procedure not covered when performed in this place of service." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.	X		X			X				
6850.7	Contractors shall pay HCPCS codes G0422 and G0423 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II under MPFS.	X		X			X				
6850.8	Effective for claims with dates of service on and after January 1, 2010, contractors shall deny ICR services that exceeded 6 units on the same date of service.	X		X	X		X				
6850.8.1	Contractors shall deny ICR services (HCPCS G0422	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	and G0423) that exceed 6 units on the same date of service using: CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N362: "The number of days or units of service exceeds our acceptable maximum." MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
6850.8.2	Contractors shall not research and adjust any ICR claims (HCPCS G0422 and G0423) paid for more than 6 units per date of service processed prior to the implementation of this Change Request. However, contractors may adjust claims brought to their attention.	X		X	X						
6850.9	Effective for claims with dates of service on and after January 1, 2010, contractors shall pay ICR claims (HCPCS G0422 and G0423) which exceed 72 sessions within 126 days from the date of the first session when the KX modifier is included on the claim.	X		X	X						
6850.9.1	CWF shall create a new edit for HCPCS G0422 and G0423 to reject claims when a beneficiary has reached 72 ICR sessions within 126 days after the date of the first ICR session and the KX modifier is not included on the claim or to reject any ICR session provided after 126 days from the date of the first session and the KX modifier is not included on the claim.									X	
6850.9.2	Contractors shall deny ICR claims (G0422 and G0423) that exceed 72 sessions within 126 days after the date of the first ICR session and the KX modifier is not	X		X	X		X	X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	included on the claim or deny any ICR session provided after 126 days from the date of the first session and the KX modifier is not included on the claim using the following: CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N435: "Exceeds number/frequency approved /allowed within time period without support documentation." MSN 20.5 - "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
6850.9.3	Contractors shall not research and adjust any ICR claims (HCPCS G0422 and G0423) paid for more than 72 sessions or where any billed sessions were provided after 126 days from the date of the first session prior to the implementation of this Change Request. However, contractors may adjust claims brought to their attention.	X		X	X						
6850.10	CWF shall determine the remaining CR and ICR sessions.						X			X	
6850.10.1	The CWF determination, to parallel claims processing, shall include all applicable factors including: • Beneficiary entitlement status • Beneficiary claims history • Utilization rules									X	
6850.10.2	CWF shall update the determination when any changes occur to the beneficiary master data or claims data that would result in a change to the calculation.									X	
6850.10.3	CWF shall display the remaining CR and ICR sessions						X			X	MBD

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	on all CWF provider query screens.										NGD
6850.10.4	The Multi-Carrier System Desktop Tool (MCSDT) shall display the remaining CR and ICR sessions in a format equivalent to the CWF HIMR screen.							X			
6850.11	Contractors shall make all necessary changes to recognize and use the new supplier specialty code 31 as a valid specialty code for ICR.	X			X						PSUP
6850.11.1	The Provider Enrollment, Chain and Ownership System shall make the necessary changes to recognize and use the new supplier specialty code 31 as a valid specialty code for ICR.										PECOS
6850.11.2	The Multi-Carrier System shall add and recognize the new supplier specialty code 31 for ICR.							X			HIGLAS
6850.11.3	Contractors shall only accept for payment ICR claims from providers enrolled as the new supplier specialty code 31.	X			X			X			
6850.11.3.1	Contractors shall deny claims for ICR (HCPCS G0422 and G0423) when received from providers not enrolled as the new supplier specialty code 31: CARC 8: "The procedure code is inconsistent with the provider type/specialty (taxonomy). **NOTE:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present." RARC N95: "This provider type may not bill this service." MSN 21.18 – "This item or service is not covered when performed or ordered by this provider." Spanish Version: "Este servicio no está cubierto cuando es ordenado o rendido por este proveedor." Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file. Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.	X			X			X			
6850.11.4	Contractors shall be aware that individual sites wishing to provide ICR services via an approved ICR program	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	must enroll with their local Medicare contractor or MAC as an ICR program supplier using CMS 855B and supplier type "Other." **NOTE**: Contractors and MACs must ensure that claims submitted from individual ICR sites are submitted by enrolled ICR program sites.										
6850.11.5	Contractors shall accept a CMS 855B submitted for ICR services, with a supplier type of "Other." Each site shall be separately enrolled; therefore, each enrolling ICR supplier may only have one practice location listed on its CMS 855B application.	X			X						
6850.11.6	Contractors shall issue a separate PTAN per ICR site.	X			X						
6850.11.7	Contractors shall only accept and process reassignments to ICR suppliers for physicians defined in 1861(r) (1) of the Act.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6850.12	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.	X		X	X						

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sarah McClain, Coverage, 410-786-2994, sarah.mcclain@cms.hhs.gov, Pat Brocato-Simons, Coverage, 410-786-0261, patricia.brocatosimons@cms.hhs.gov, Michelle Atkinson, coverage, 410-786-2881, michelle.atkinson@cms.hhs.gov, Bill Ruiz, Institutional Claims Processing, 410-786-9283, William.ruiz@cms.hhs.gov , Tom Dorsey, Practitioner Claims Processing, Thomas.Dorsey@cms.hhs.gov, 410-786-7434, Alisha Banks, Provider Enrollment, 410-786-0671, alisha.banks@cms.hhs.gov, Richard Cuchna, CWF Inquiry Screens, 410-786-7239, richard.cuchna@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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.

10.8.3 - Nonphysician Practitioner, Supplier, and Provider Specialty Codes

(Rev.1974, Issued: 05-21-10, Effective: 01-01-10, implementation: 10-04-10)

The following list of 2-digit codes and narrative describe the kind of medicine non-physician practitioners or other healthcare providers/suppliers practice.

Code	Non-physician Practitioner/Supplier/Provider Specialty
15	Speech Language Pathologists
31	*Intensive Cardiac Rehabilitation*
32	Anesthesiologist Assistant
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
45	Mammography Screening Center
47	Independent Diagnostic Testing Facility (IDTF)
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical supply company with orthotic personnel certified by an accrediting organization
52	Medical supply company with prosthetic personnel certified by an accrediting organization
53	Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization
54	Medical supply company not included in 51, 52, or 53
55	Individual orthotic personnel certified by an accrediting organization
56	Individual prosthetic personnel certified by an accrediting organization
57	Individual prosthetic/orthotic personnel certified by an accrediting organization
58	Medical Supply Company with registered pharmacist

Code	Non-physician Practitioner/Supplier/Provider Specialty
59	Ambulance Service Supplier, e.g., private ambulance companies, funeral homes
60	Public Health or Welfare Agencies (Federal, State, and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62	Clinical Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologist (Billing Independently)
65	Physical Therapist in Private Practice
67	Occupational Therapist in Private Practice
68	Clinical Psychologist
69	Clinical Laboratory (Billing Independently)
71	Registered Dietician/Nutrition Professional
73	Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)
74	Radiation Therapy Centers
75	Slide Preparation Facilities
80	Licensed Clinical Social Worker
87	All other suppliers, e.g., Drug Stores
88	Unknown Supplier/Provider
89	Certified Clinical Nurse Specialist
95	Available
96	Optician
97	Physician Assistant
A0	Hospital

Code	Non-physician Practitioner/Supplier/Provider Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Nursing Facility, Other
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel
B4	Rehabilitation Agency

NOTE: Specialty Code Use for Service in an Independent Laboratory. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use type of supplier code "69".

Medicare Claims Processing Manual
Chapter 32 – Billing Requirements for Special Services

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(Rev.1974, 05-21-10)

140.2.2 – Claims Processing Requirements for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished On or After January 1, 2010

(Rev. 1974, Issued: 05-21-10, Effective: 01-10-10, Implementation: 10-04-10)

140.2.2.1 – Correct Place of Service (POS) Code for CR and ICR Services on Professional Claims

(Rev. 1974, Issued: 05-21-10, Effective: 01-10-10, Implementation: 10-04-10)

Effective for claims with dates of service on and after January 1, 2010, place of service (POS) code 11 shall be used for CR and ICR services provided in a physician's office and POS 22 shall be used for services provided in a hospital outpatient setting. All other POS codes shall be denied. Contractors shall adjust their prepayment procedure edits as appropriate.

The following messages shall be used when contractors deny CR and ICR claims for POS:

Claim Adjustment Reason Code (CARC) 58 - Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

NOTE: *Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.*

Remittance Advice Remark Code (RARC) N428 - Service/procedure not covered when performed in this place of service.

Medicare Summary Notice (MSN) 21.25 - This service was denied because Medicare only covers this service in certain settings.

Group Code PR (Patient Responsibility) - Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

140.2.2.2 –Requirements for CR and ICR Services on Institutional Claims

(Rev. 1974, Issued: 05-21-10, Effective: 01-10-10, Implementation: 10-04-10)

Effective for claims with dates of service on and after January 1, 2010, contractors shall pay for CR and ICR services when submitted on Types of Bill (TOBs) 13X and 85X only. All other TOBs shall be denied.

The following messages shall be used when contractors deny CR and ICR claims for TOBs 13X and 85X:

Claim Adjustment Reason Code (CARC) 58 - Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Remittance Advice Remark Code (RARC) N428 - Service/procedure not covered when performed in this place of service.

Medicare Summary Notice (MSN) 21.25 - This service was denied because Medicare only covers this service in certain settings.

Group Code PR (Patient Responsibility) – Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

140.2.2.3 – Frequency Edits for CR and ICR Claims

(Rev. 1974, Issued: 05-21-10, Effective: 01-10-10, Implementation: 10-04-10)

Effective for claims with dates of service on or after January 1, 2010, contractors shall deny all CR claims (both professional and institutional claims) that exceed 2 units per date of service for CR and six units per date of service for ICR.

The following messages shall be used when contractors deny CR and ICR claims for exceeding units per date of service:

Claim Adjustment Reason Code (CARC) 119 - Benefit maximum for this time period or occurrence has been reached.

Remittance Advice Remark Code (RARC) N362 - The number of days or units of service exceeds our acceptable maximum.

MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time.

Spanish Version - Estos servicios no pueden ser pagados porque sus beneficios se han agotado.

Group Code PR (Patient Responsibility) – Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

Contractors shall not research and adjust CR claims (HCPCS 93797 and 93798) paid for more than 2 units on the same date of service processed prior to the implementation of edits. However, contractors may adjust claims brought to their attention.

Contractors shall not research and adjust ICR claims (HCPCS G0422 and G0423) paid for more than 6 units on the same date of service processed prior to the implementation of edits. However, contractors may adjust claims brought to their attention.

140.2.2.4 – Edits for CR Services Exceeding 36 Sessions

(Rev. 1974, Issued: 05-21-10, Effective: 01-10-10, Implementation: 10-04-10)

Effective for claims with dates of service on or after January 1, 2010, contractors shall deny all claims with HCPCS 93797 and 93798 (both professional and institutional claims) that exceed 36 CR sessions when a KX modifier is not included on the claim line.

The following messages shall be used when contractors deny CR claims that exceed 36 sessions, when a KX modifier is not included on the claim line:

Claim Adjustment Reason Code (CARC) 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

RARC N435 - Exceeds number/frequency approved/allowed within time period without support documentation.

MSN 23.17- Medicare won't cover these services because they are not considered medically necessary.

Spanish Version - Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas.

Group Code PR (Patient Responsibility) – Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

Contractors shall not research and adjust CR claims paid for more than 36 sessions processed prior to the implementation of CWF edits. However, contractors may adjust claims brought to their attention.

140.2.2.5 – Edits for ICR Services Exceeding 126 Days and 72 Sessions

(Rev. 1974, Issued: 05-21-10, Effective: 01-10-10, Implementation: 10-04-10)

Effective for claims with dates of service on and after January 1, 2010, CWF shall reject ICR claims (G0422 and G0423) that exceed 72 sessions or where any billed sessions were provided after126 days from the date of the first session and a KX modifier is not included on the claim line.

The following messages shall be used when contractors deny ICR claims that exceed 72 sessions or where any billed sessions were received after the 126 days from the date of the first session:

Claim Adjustment Reason Code (CARC) 119 - Benefit maximum for this time period or occurrence has been reached.

RARC N435 - Exceeds number/frequency approved/allowed within time period without support documentation.

MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time.

Spanish Version - Estos servicios no pueden ser pagados porque sus beneficios se han agotado.

Group Code PR (Patient Responsibility) – Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

Contractors shall not research and adjust ICR claims paid for more than 72 sessions or where any billed sessions were received after 126 days from the date of the first session that were processed prior to the implementation of CWF edits. However, contractors may adjust claims brought to their attention.

140.2.2.6 –Supplier Specialty Code 31 Requirements for ICR Claims

(Rev. 1974, Issued: 05-21-10, Effective: 01-10-10, Implementation: 10-04-10)

Effective for claims with dates of service on and after January 1, 2010, contractors shall pay for ICR services when submitted by providers enrolled as the new supplier specialty code 31 for ICR. ICR services submitted by providers enrolled as other than the new supplier specialty code 31 for ICR are to be denied using the following messages:

CARC 8: "The procedure code is inconsistent with the provider type/specialty (taxonomy). ***NOTE:*** *Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."*

RARC N95: "This provider type may not bill this service."

MSN 21.18 – "This item or service is not covered when performed or ordered by this provider."

Spanish Version: Este servicio no está cubierto cuando es ordenado o rendido por este proveedor.

Group Code PR (Patient Responsibility) – Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.