Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – As a result of Section 6404 of the Patient Protection and Affordable Care Act (PPACA), claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at *http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf* on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: MM6850
Related Change Request (CR) #: 6850
Related CR Release Date: May 21, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R1974CP, R126BP, R339PI, and R170FM
Implementation Date: October 4, 2010

Cardiac Rehabilitation and Intensive Cardiac Rehabilitation

Provider Types Affected

This article is for physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, and Part A/B Medicare Administrative Contractors (A/B MAC)) for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) program services provided to Medicare beneficiaries.

What You Need to Know

CR 6850, from which this article is taken, announces that, effective January 1, 2010, Medicare Part B pays for CR and ICR programs, and related items and services if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which is it administered, and the physician administering the program. Please see the Background section, below, for details.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for CR and ICR programs. The Centers for Medicare & Medicaid Services (CMS) implemented the MIPPA CR and ICR statutory coverage provisions through rule making, in the calendar year (CY) 2010 Physician Fee Schedule (PFS), by adding 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 regulation at 42 CFR 410.49 includes 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.

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* on the Internet. The Final Rule was published in the Federal Register on November 25, 2009, and is available on pages 62004-62005.

ICR services means a physician-supervised program that furnishes the same items/services under the same conditions as a CR program but must also demonstrate through peer-reviewed published research that it improves patients' cardiovascular disease through specific outcome measurements that are described in 42 CFR 410.49(c).

CR 6850 provides specific criteria for CR/ICR programs, outlined as follows:

CR/ICR Program Beneficiary Coverage Requirements (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 (PTCA) or coronary stenting;
- A heart or heart-lung transplant; or,
- Other cardiac conditions as specified through a national coverage determination (NCD) (CR only).

CR/ICR Program Component Requirements:

Covered CR and ICR programs must include the following components:

- Physician-prescribed exercise - This physical activity includes aerobic exercise combined with other types of exercise (i.e., strengthening, stretching) as determined to be appropriate for individual patients by a physician each day CR/ICR items/services are furnished.
- Cardiac risk factor modification - This includes education, counseling, and behavioral intervention, tailored to the patients' individual needs.

- Psychosocial assessment - This assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation. It should include: (1) an assessment of those aspects of the individual's family and home situation that affects the individual's rehabilitation treatment, and, (2) a psychosocial evaluation of the individual's response to, and rate of progress under, the treatment plan.
- Outcomes assessment - These should include: (i) minimally, assessments from the commencement and conclusion of CR/ICR, based on patient-centered outcomes which must be measured by the physician immediately at the beginning and end of the program, and, (ii) objective clinical measures of the effectiveness of the CR/ICR program for the individual patient, including exercise performance and self-reported measures of exertion and behavior.
- An individualized treatment plan - This plan should be written and tailored to each individual patient and include (i) a description of the individual's diagnosis; (ii) the type, amount, frequency, and duration of the CR/ICR items/services furnished; and (iii) the goals set for the individual under the plan. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

Frequency Limitations:

CR sessions are limited to a maximum of 2 one-hour sessions per day (up to 36 sessions, over a period of up to 36 weeks), with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under section 1862(a)(1)(A) of the Social Security Act.

ICR sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

CR/ICR Program Setting Requirements:

CR/ICR services must be furnished in a physician's office or a hospital outpatient setting (for ICR, the hospital outpatient setting must provide ICR using an approved ICR program). All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items/services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26, and for hospital outpatient services as specified at 42 CFR 410.27.

CR/ICR Program Physician Requirements:

Physicians responsible for CR/ICR programs are identified as medical directors who oversee or supervise the CR/ICR program at a particular site. The medical director, in consultation with staff, is involved in directing the progress of

individuals in the program. The medical director, as well as physicians acting as the supervising physician, must possess all of the following: (1) expertise in the management of individuals with cardiac pathophysiology, (2) cardiopulmonary training in basic life support or advanced cardiac life support, and (3) license to practice medicine in the state in which the CR/ICR program is offered. Direct physician supervision may be provided by a supervising physician or the medical director.

ICR Program Approval Requirements:

All prospective ICR programs must be approved by CMS through the NCD process. To be approved, an ICR program must demonstrate through peer-reviewed, published research that it:

- Accomplished one or more of the following for its patients: (i) positively affected the progression of coronary heart disease, (ii) reduced the need for coronary bypass surgery, or, (iii) reduced the need for percutaneous coronary interventions; and,
- Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services: (i) low density lipoprotein, (ii) triglycerides, (iii) body mass index, (iv) systolic blood pressure, (v) diastolic blood pressure, and, (vi) the need for cholesterol, blood pressure, and diabetes medications.

Once an ICR program is approved through the NCD process, all prospective ICR sites that want to furnish ICR items/services via the approved program must enroll with their local Medicare contractor to become an ICR program supplier using the designated forms at 42 CFR 424.510, and report specialty code 31 (single or multispecialty group practice) in order to be identified as an enrolled ICR supplier.

Note: For purposes of appealing an adverse determination concerning site approval, an ICR site is considered a supplier (or prospective supplier) as defined in 42 CFR 498.2.

A list of approved ICR programs, identified through the NCD process, will be posted to the CMS website and listed in the Federal Register.

Claims Processing Requirements

The following requirements all pertain to claims for CR and /or ICR services with dates of service on and after January 1, 2010.

Your carrier or MAC will pay for *professional* claims containing Healthcare Common Procedure Coding System (HCPCS) codes 93797 (Physician services for outpatient cardiac rehabilitation; without continuous electrocardiographic [ECG] monitoring [per session]), 93798 (Physician services for outpatient cardiac

rehabilitation; with continuous ECG monitoring [per session]), G0422 (Intensive Cardiac Rehabilitation; With or Without continuous ECG monitoring, With Exercise, Per Session), and G0423 (Intensive Cardiac Rehabilitation; With or Without continuous ECG monitoring, Without Exercise, Per Session) only when billed with place of service (POS) codes 11 (services provided in a physician's office) or 22 (services provided in a hospital outpatient setting).

They will deny all professional claims for CR/ICR services containing any other POS codes, using:

- Remittance Advice Remark Code (RARC) N428 - "Service/procedure not covered when performed in this place of service,"
- 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," and,
- If the claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN is on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Your FI or MAC will pay *institutional* claims containing HCPCS 93797, 93798, G0422, and G0423 on Types of Bill (TOB) 13X under the Hospital Outpatient Prospective Payment System (OPPS) and 85X on reasonable cost. They will pay for CR/ICR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis (TOBs 13X) in accordance with the terms of the Maryland waiver. Claims for G0422 and G0423 from Method II critical access hospitals should be billed on TOB 85X with revenue codes 96X, 97X, or 98X.

They will deny claims for CR/ICR services (HCPCS codes 93797, 93798, G0422, and G0423) for services that are provided in other than TOBs 13X and 85X using:

- RARC N428 - "Service/procedure not covered when performed in this place of service,"
- 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," and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ

modifier indicating no ABN is on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Your contractors will deny both professional and institutional claims for CR services that exceed two units per date of service, or six units per date of service for ICR, using:

- CARC 119 – "Benefit maximum for this time period or occurrence has been reached,"
- RARC N362 – "The number of days or units exceeds our acceptable maximum," and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Medicare will pay for HCPCS codes 93797 and 93798 for CR services that exceed 36 sessions when the KX modifier is on the claim. However, Medicare contractors will deny claims for over 36 sessions of CR services without the KX modifier and, in doing so, will use 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," and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.
- Your contractors will deny ICR claims (G0422 and G0423) that exceed 72 sessions within 126 days from the date of the first session unless the modifier KX is on the claim. In denying such claims, they will use:
- 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," and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Contractors will only pay for ICR services when submitted by providers enrolled as supplier specialty code 31 (intensive cardiac rehabilitation). ICR services submitted by providers enrolled as other than specialty code 31 will be denied using:

- 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," and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Finally, your contractors will not research and adjust any CR or ICR claims (HCPCS 93797, 93798, G0422, and G0423), processed prior to the implementation of CR 6850; however, they will adjust claims that you bring to their attention.

Additional Information

You can find more information about CR and ICR services by going to CR 6850, which was issued in four transmittals as follows:

- Transmittal R1974CP modified the Medicare Claims Processing Manual and is available at *http://www.cms.gov/Transmittals/downloads/R1974CP.pdf*;
- Transmittal R126BP modified the Medicare Benefit Policy Manual at *http://www.cms.gov/Transmittals/downloads/R126BP.pdf*;
- Transmittal R339PI modifies the Medicare Program Integrity Manual at *http://www.cms.gov/Transmittals/downloads/R339PI.pdf*; and
- Transmittal R170FM modifies the Medicare Financial Management Manual at *http://www.cms.gov/Transmittals/downloads/R170FM.pdf* on the CMS website.

If you have any questions, please contact your FI, carrier, or MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.