CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1966	**Date: May 7, 2010**
	Change Request 6823

SUBJECT: Pulmonary Rehabilitation (PR) Services

I. SUMMARY OF CHANGES: Effective January 1, 2010, for claims processed on or after October 4, 2010, contractors shall pay claims containing HCPCS code G0424 when billing for PR services, including exercise and monitoring, as described in Pub. 100-02, Chapter 15, § 231, Pub. 100-04, Chapter 32, § 140, and CR 6751, TR 1871, dated December 11, 2009.

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	32/Table of Contents
N	32/140.4/ Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010
N	32/140.4.1/ Coding Requirements for Pulmonary Rehabilitation (PR) Services Furnished On or After January 1, 2010
N	32/140.4.2/ Claims Processing Requirements for Pulmonary Rehabilitation (PR) Services Furnished On or After January 1, 2010
N	32/140.4.2.1/Correct Place of Service (POS) Codes for PR Services on Professional Claims
N	32/140.4.2.2/Requirements for PR Services on Institutional Claims
N	32/140.4.2.3/Daily Frequency Edits for PR Claims
N	32/140.4.2.4/Edits for PR Services Exceeding 36 Sessions
N	32/140.4.2.5/Edits for PR Services Exceeding 72 Sessions

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: 1966	Date: May 7, 2010	Change Request: 6823

SUBJECT: Pulmonary Rehabilitation (PR) Services

Effective Date: January 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: Pulmonary Rehabilitation (PR) is a multi-disciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy and an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities.

In September 2007, the Centers for Medicare and Medicaid Services (CMS), in its final decision memorandum for PR Services, announced there was no basis for a national coverage determination at that time. Specifically, this decision was based on a determination by CMS that the Social Security Act did not expressly define a comprehensive PR program as a Part B benefit, and the evidence was not adequate to draw conclusions on the benefit of the individual components of PR. CMS does, however, cover the respiratory services in the Comprehensive Outpatient Rehabilitation Facility regulation (42 CFR 410.100), as well as those services determined covered by local contractors who retain discretion to allow coverage of components of PR.

The Medicare Improvements for Providers and Patients Act of 2008 (MIPPA) added payment and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law provides a single PR program, which was codified in the Physician Fee Schedule final rule at 42 CFR 410.47.

B. Policy: Effective January 1, 2010, MIPPA provisions added a physician–supervised, comprehensive PR program which includes mandatory components: (1) physician-prescribed exercise, (2) education or training, (3) psychosocial assessment, (4) outcomes assessment, and (5) an individualized treatment plan. See the Benefit Policy Manual (BP), Pub. 100-02, chapter 15, § 231, the Claims Processing Manual (CP), Pub. 100-04, chapter 32, § 140, for detailed policy and claims processing instructions. As specified at 42 CFR 410.47(f), pulmonary rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if medically necessary. Contractors shall accept the inclusion of the KX modifier on the claim lines as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond the 36 sessions is medically necessary up to a total of 72 sessions for that beneficiary.

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	
6823.1	Effective January 1, 2010, for claims processed on or	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	
	after October 4, 2010, contractors shall pay claims containing HCPCS code G0424 when billing for PR services, including exercise and monitoring, as described in Pub. 100-02, BPM, chapter 15, section 231, Pub. 100-04, CPM, chapter 32, section 140, and CR 6751, TR 1871, dated December 11, 2009.										
6823.2	Contractors shall pay claims for HCPCS code G0424 (PR) only when services are provided for the following place of service (POS): 11 (physician's office) or 22 (hospital outpatient).	X			X						
6823.2.1	Contractors shall deny claims for HCPCS code G0424 performed in other than, and billed without, POS 11 or 22.	X			X						
6823.2.1.1	Contractors shall deny claims for PR services for POS other than 11 or 22 using the following: 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 835 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." Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." **NOTE:** This is a new MSN message. 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.	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	
6823.3	Contractors shall pay claims for PR services containing HCPCS code G0424 and revenue code 0948 on Types of Bill 13X under OPPS and 85X under reasonable cost.	X		X			X				
6823.3.1	Contractors shall update the Revenue Code File to allow revenue code 0948 on the following TOBs: 13X and 85X.	X		X			X				
6823.3.2	Contractors shall pay for PR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission on an outpatient basis, TOB 13X in accordance with the terms of the Maryland waiver.	X		X			X				
6823.3.3	Contractors shall deny claims for PR services provided in other than TOBs 13X and 85X.	X		X			X				
6823.3.3.1	Contractors shall deny claims for PR services billed on TOBs other than 13X and 85X using the following: CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **NOTE:** Refer to the 835 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." Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings." Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." **NOTE:** This is a new MSN message. 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	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	
	provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
6823.3.4	Contractors shall pay claims for PR services containing HCPCS code G0424 and revenue code 096X, 097X, and 098X on TOB 85X Method II under MPFS.	X		X			X				
6823.4	Contractors shall deny PR services that exceed two units on the same date of service.	X			X		X				
6823.4.1	Contractors shall deny claims for PR services (HCPCS G0424) submitted for more than two units on the same date of service using the following: 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 (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.	X		X	X						
6823.4.2	Contractors shall not research and adjust PR claims paid for more than two units on the same date of service processed prior to the implementation of the change request. However, contractors may adjust claims brought to their attention.	X		X	X						
6823.5	Contractors shall pay PR claims which exceed 36 sessions when a KX modifier is included on the claim line. **NOTE:** Contractors shall deny PR claims that exceed 72 sessions in accordance with business requirement 6823.5.6	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	
6823.5.1	CWF shall create a new edit for HCPCS G0424 to reject to contractors when a beneficiary has reached 37 PR sessions and the KX modifier is not included on the claim line									X	
6823.5.2	Contractors shall deny claims with HCPCS G0424 which exceed 36 sessions when a KX modifier is not included on the claim line. CARC 151: "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services." 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 (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.	X		X	X		X				
6823.5.3	Contractors shall not research and adjust PR claims paid for more than 36 sessions processed prior to the implementation of CWF editing. However, contractors may adjust claims brought to their attention.	X		X	X						
6823.5.4	CWF shall reject PR claims that exceed 72 sessions.									X	
6823.5.5	Contractors shall deny PR services that exceed 72 sessions.	X		X	X						
6823.5.6	Contractors shall deny G0424 when submitted for more than 72 services regardless of whether the KX modifier is submitted. CARC B5: "Coverage/program guidelines were not met or were exceeded." MSN 20.5: "These services cannot be paid because	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	
	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 (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.										
6823.5.7	Contractors shall not research and adjust PR claims paid for more than 72 sessions processed prior to the implementation of CWF editing. However, contractors may adjust claims brought to their attention.	X		X	X						
6823.6	CWF shall determine the remaining PR sessions.									X	
6823.6.1	The CWF determination, to parallel claims processing, shall include all applicable factors including: • Beneficiary entitlement status • Beneficiary claims history • Utilization rules									X	
6823.6.2	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	
6823.6.3	CWF shall display the remaining PR sessions.									X	
6823.6.4	The CWF shall display the remaining PR sessions on all CWF provider query screens.						X			X	MBD NGD
6823.6.5	The Multi-Carrier System Desktop Tool (MCSDT) shall display the remaining PR sessions in a format equivalent to the CWF HIMR screen.							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	
6823.7	A provider education article related to this instruction	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	
	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.										

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Roya Lotfi, coverage, 410-786-4072, roya.lofti@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, Cynthia Thomas, 410-786-8169, Practitioner Claims Processing, cynthia.thomas2@cms.hhs.gov, Melissa Dehn, Institutional Claims Processing. 410-786-5721, melissa.dehn@cms.hhs.gov, Bill Ruiz, Institutional Claims Processing, 410-786-9283, bill.ruiz@cms.hhs.gov, Richard Cuchna, Provider Communications Group, 410-786-7239, richard.cuchna@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Project Officer or Contractor Manager

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.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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(Rev.1966, 05-07-10)

140.4 – Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010

(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

As specified in 42 CFR 410.47, Medicare covers pulmonary rehabilitation items and services for patients with moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease.
Pulmonary rehabilitation programs must include the following components:
• Physician-prescribed exercise. Some aerobic exercise must be included in each pulmonary rehabilitation session;

• Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling;

• Psychosocial assessment;

• Outcomes assessment; and,

• An individualized treatment plan detailing how components are utilized for each patient.

Pulmonary rehabilitation items and services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time items and 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 therapeutic services as specified at 42 CFR 410.27.

As specified at 42 CFR 410.47(f), pulmonary rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if medically necessary. Contractors shall accept the inclusion of the KX modifier on the claim lines as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond the 36 sessions is medically necessary up to a total of 72 sessions for that beneficiary.

140.4.1 – Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010

(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

The following is the applicable HCPCS code for pulmonary rehabilitation services:
G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 2 1-hour sessions per day. In order to report one session of pulmonary rehabilitation services in a day, the duration of treatment must be at least 31 minutes. Two

sessions of pulmonary rehabilitation services may only be reported in the same day if the duration of treatment is at least 91 minutes. In other words, the first session would account for 60 minutes and the second session would account for at least 31 minutes, if two sessions are reported. If several shorter periods of pulmonary rehabilitation services are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.

***Example:** If the patient receives 20 minutes of pulmonary rehabilitation services in the day, no pulmonary rehabilitation session may be reported because less than 31 minutes of services were furnished.*

***Example:** If a patient receives 20 minutes of pulmonary rehabilitation services in the morning and 35 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report 1 session of pulmonary rehabilitation services under 1 unit of the HCPCS G-code for the total duration of 55 minutes of pulmonary rehabilitation services on that day.*

***Example:** If the patient receives 70 minutes of pulmonary rehabilitation services in the morning and 25 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of pulmonary rehabilitation services under the HCPCS G-code because the total duration of pulmonary rehabilitation services on that day of 95 minutes exceeds 90 minutes.*

***Example:** If the patient receives 70 minutes of pulmonary rehabilitation services in the morning and 85 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of pulmonary rehabilitation services under the HCPCS G-code for the total duration of pulmonary rehabilitation services of 155 minutes. A maximum of two sessions per day may be reported, regardless of the total duration of pulmonary rehabilitation services.*

140.4.2 – Claims Processing Requirements for Pulmonary Rehabilitation (PR) Services Furnished On or After January 1, 2010

(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

140.4.2.1 – Correct Place of Service (POS) Code for PR Services on Professional Claims

(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, 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 pulmonary rehabilitation (PR) 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. Medicare contractors shall adjust their prepayment procedure edits as appropriate.

The following messages shall be used when Medicare contractors deny PR 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 835 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."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

NOTE: *This is a new MSN message.*

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.

140.4.2.2 – Requirements for PR Services on Institutional Claims
(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

Effective for claims with dates of service on and after January 1, 2010, Medicare contractors shall pay for PR services when submitted on a type of bill (TOB) 13X and 85X only, along with revenue code 0948. All other TOBs shall be denied.

The following messages shall be used when Medicare contractors deny PR claims for TOB:

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 835 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."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

NOTE: *This is a new MSN message.*

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.

140.4.2.3 – Daily Frequency Edits for PR Claims
(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

Effective for claims with dates of service on or after January 1, 2010, Medicare contractors shall deny all PR claims (both professional and institutional claims) that exceed two units on the same date of service.

The following messages shall be used when Medicare contractors deny PR claims for exceeding the daily frequency limit:

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 (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.

140.4.2.4 – Edits for PR Services Exceeding 36 Sessions
(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

When a beneficiary has reached 37 PR sessions, CWF shall reject the claims to the contractors if the KX modifier is not included on the claim line. Effective for claims with dates of service on or after January 1, 2010, Medicare contractors shall deny all claims (both professional and institutional claims) that exceed 36 PR sessions without a KX modifier included on the claim line.

The following messages shall be used when Medicare contractors deny PR claims that exceed 36 sessions, without the KX modifier on the claim line:

CARC 151: "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."

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 (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.

140.4.2.5 – Edits for PR Services Exceeding 72 Sessions
(Rev.1966, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

Effective for claims with dates of service on and after January 1, 2010, CWF shall reject PR claims that exceed 72 sessions. Medicare contractors shall deny PR claims that exceed 72 sessions regardless of whether the KX modifier is submitted on the claim line.

The following messages shall be used when Medicare contractors deny PR claims that exceed 72 sessions:

CARC B5: "Coverage/program guidelines were not met or were exceeded."

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 (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.