



News Flash – As a result of the Affordable Care Act (ACA), 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/MLN MattersArticles/downloads/MM6960.pdf> on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: MM6823

Related Change Request (CR) #: 6823

Related CR Release Date: May 7, 2010

Effective Date: January 1, 2010

Related CR Transmittal #: R124BP and R1966CP

Implementation Date: October 4, 2010

Pulmonary Rehabilitation (PR) Services

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs) and/or carriers) for pulmonary rehabilitation (PR) services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6823 which alerts providers that the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added payment and coverage improvements for patients with chronic obstructive pulmonary disease (COPD) and other conditions effective January 1, 2010. As a result, Medicare provides a covered benefit for a comprehensive PR program under Medicare Part B effective for services on or after January 1, 2010. Be certain your billing staffs are aware of these Medicare changes and of the claims processing system changes to handle claims for PR services that must be implemented no later than October 4, 2010.

Background

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.

Pulmonary Rehabilitation (PR) is a multi-disciplinary program of care for patients with chronic respiratory impairment who are symptomatic and often have decreased daily life activities.

.A PR program is individually tailored and designed to optimize physical and social performance and autonomy. The program must provide an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory impairment. In September 2007, the Centers for Medicare & 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 did (and still does) cover medically reasonable and necessary respiratory treatment services in Comprehensive Outpatient Rehabilitation Facilities (CORFs), as well services to patients with respiratory impairments who are not eligible for PR but for whom local contractors determine respiratory treatment services are covered. MIPPA added payment and coverage improvements for patients with COPD and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law authorizes a PR program, which was codified in the Physician Fee Schedule calendar year 2010 final rule at 42 CFR 410.47.

Key Points of CR 6823

Effective January 1, 2010, MIPPA provisions added a physician-supervised, comprehensive PR program. Medicare will pay for up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of PR. The PR program must include the following mandatory components:

1. Physician-prescribed exercise;
2. Education or training;
3. Psychosocial assessment;
4. Outcomes assessment; and
5. An individualized treatment plan.

The following bullet points detail Medicare claims processing requirements for PR services furnished on or after January 1, 2010:

- Effective January 1, 2010, Medicare contractors will pay claims containing Healthcare Common procedure Coding System (HCPCS) code G0424 when billing for PR services, including exercise and monitoring, as described in the Medicare Benefit Policy Manual, Chapter 15, section 231, as revised by CR

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6823, and the Medicare Claims Processing Manual, Chapter 32, Section 140, as revised by CR 6823. These revised documents are attached to CR 6823, which is available at

<http://www.cms.gov/Transmittals/downloads/R124BP.pdf> (Benefit Policy Manual) and <http://www.cms.gov/Transmittals/downloads/R1966CP.pdf> (Claims Processing Manual) on the CMS website.

- Medicare contractors will pay claims for HCPCS code G0424 (PR) only when services are provided in the following places of service (POS): 11 (physician's office) or 22 (hospital outpatient). Medicare will deny claims for HCPCS code G0424 performed in other than, and billed without, POS 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.”
 - Group Code PR (Patient Responsibility) assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file or Group Code CO (Contractual Obligation) assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare contractors will pay claims for PR services containing HCPCS code G0424 and revenue code 0948 on Types of Bill (TOB) 13X and 85X under reasonable cost.
- Contractors will 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.
- Contractors will deny claims for PR services provided in other than TOB 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.”

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- Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Using the Medicare Physician Fee Schedule, Medicare contractors will also pay for PR services billed with HCPCS code G0424 and revenue code 096X, 097X, or 098X on TOB 85X from Method II critical access hospitals (CAHs).
- Medicare will deny PR services that exceed two units on the same date of service and, in doing so, will use 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.”
 - Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare will normally pay for 36 sessions of PR, but may pay up to 72 sessions when the claim(s) for sessions 37-72 includes a KX modifier. Claims for HCPCS code G0424 which exceed 36 sessions without the KX modifier will be denied using the following:
 - CARC 151 – “Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.”
 - Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare contractors will deny claims for HCPCS code G0424 when submitted for more than 72 sessions even where the KX modifier is present. In the denials, contractors will use the following:
 - CARC B5 - “Coverage/program guidelines were not met or were exceeded.”
 - Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

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Additional Information

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

CR6823 was issued to your Medicare MAC, FI, or carrier in two transmittals. One transmittal modifies the Medicare Benefit Policy Manual and that transmittal is available at <http://www.cms.gov/Transmittals/downloads/R124BP.pdf> on the CMS website. The second transmittal modifies the Medicare Claims Processing Manual and that transmittal is at <http://www.cms.gov/Transmittals/downloads/R1966CP.pdf> on the CMS website.

For related detailed policy and claims processing instructions issued December 11, 2009, you may review MM6715 at <http://www.cms.gov/MLNMattersArticles/downloads/MM6751.pdf> on the CMS website.

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