CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4229	**Date: February 1, 2019**
	Change Request 11022

SUBJECT: Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)—Clarification of Payment Rules and Expansion of International Classification of Diseases Tenth Edition (ICD-10) Diagnosis Codes

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform the Medicare Administrative Contractors (MACs) that on May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) to cover SET for beneficiaries with Intermittent Claudication (IC) for the treatment of symptomatic PAD.

EFFECTIVE DATE: May 25, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 19, 2019 for of CR for MAC local editing; July 1, 2019

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
R	32/Table of Contents
R	32/390/Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)
R	32/390.2/Coding Requirements for SET for PAD
R	32/390.3/Special Billing Requirements for Professional Claims
R	32/390.4/Special Billing Requirements for Institutional Claims
R	32/390.5/Common Working File (CWF) Requirements
N	32/390.6/Applicable Medicare Summary Notice (MSN), Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Code (CARC) Messaging

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4229	Date: February 1, 2019	Change Request: 11022

SUBJECT: Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)—Clarification of Payment Rules and Expansion of International Classification of Diseases Tenth Edition (ICD-10) Diagnosis Codes

EFFECTIVE DATE: May 25, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 19, 2019 for of CR for MAC local editing; July 1, 2019

I. GENERAL INFORMATION

A. Background: SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from Intermittent Claudication (IC), the most common symptom experienced by people with PAD. Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (i.e., endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs.

B. Policy: On May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Medicare will cover up to 36 sessions over a 12-week period if all of the following components of a SET program are met:

The SET program must:

- consist of sessions lasting 30-60 minutes comprising a therapeutic exercise-training program for PAD in patients with claudication;
- be conducted in a hospital outpatient setting, or a physician's office;
- be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD; and,
- be under the direct supervision of a physician (as defined in 1861(r)(1) of the Social Security Act (the Act)), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in 1861(aa)(5) of the Act), who must be trained in both basic and advanced life support techniques. Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments. Medicare Administrative Contractors (MACs) have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions (up to 72 sessions) over an extended period of time. Contractors shall accept the inclusion of the -KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician

NOTE: Please consult Change Request (CR) 10295 for the initial SET for PAD instructions:

CR10295, Pub.100-03, Rev.207, Filename: R207NCD.pdf

Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)

R207NCD.pdf

CR10295, Pub.100-04, Rev.4049, Filename: R4049CP.pdf

Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)

R4049CP.pdf

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11022.1	Effective for claims with dates of service on or after May 25, 2017, contractor shall deny claims for SET in Place of Service (POS) other than 11, office using the following messages: Medicare Summary Notice (MSN) 15.20: "The following policies National Coverage Determination 20.35 (NCD) were used when we made this decision." Spanish Version: "Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión." 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) N386: "This decision was based on a NCD 20.35. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.		X						X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractors shall use Group CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.									
11022.1.1	Contractors shall not pay claim lines for SET services containing Current Procedural Terminology (CPT) 93668 with revenue codes 096X, 097X, or 098X when billed on Type of Bill (TOB) 85X Method II.	X				X			X	
11022.1.1.1	Contractors shall deny line items on claims for SET services (CPT code 93668) when provided on other than TOBs 13X and 85X using: MSN 15.20: “The following policies National Coverage Determination 20.35 (NCD) were used when we made this decision.” Spanish Version: “Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión.” 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 N386: “This decision was based on a NCD 20.35. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	X				X				
11022.1.1.1.1	Continuation of Business Requirement (BR) 11022.1.1.1) Contractors shall use Group CO (Contractual Obligation) assigning financial liability to the	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	provider, if a claim is received with a GZ modifier indicating no signed ABN is on file. (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version: Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1800-633-4227). NOTE: Due to system requirement, Fiscal Intermediary Shared System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.									
11022.2	Contractors shall deny claim lines for SET using CPT 93668 unless accompanied by one of the following ICD-10 diagnosis codes that should be used in addition to the codes identified in CR 10295: I70.411 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, right leg I70.412 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, left leg I70.413 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, bilateral legs	X	X			X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	I70.418 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, other extremity I70.511 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, right leg I70.512 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, left leg I70.513 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, bilateral legs I70.518 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, other extremity									
11022.2.1	When denying a line-item on the claim per BR 11022.2 contractors shall use the following messages: MSN 15.20: “The following policies National Coverage Determination 20.35 (NCD) were used when we made this decision.” Spanish Version: “Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión.” CARC 167: This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N386: “This decision was based on a NCD 20.35. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 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.									
11022.2.1.1	(Continuation of BR 11022.2.1) (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version: Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1800-633-4227). NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.	X	X							
11022.3	Contractors shall not research and adjust any SET claims (CPT 93668) prior to the implementation of this change request. However, contractors may adjust claims bought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11022.4	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Patricia Brocato-Simons, 410-786-0261 or Patricia.BrocatoSimons@cms.hhs.gov (Coverage and Analysis) , Teira Canty, 410-786-1974 or Teira.Canty@cms.hhs.gov (Supplier Claims) , Yvette Cousar, 410-786-2160 or Yvette.Cousar@cms.hhs.gov (Professional Claims) , Charles Nixon, 410-786-9183 or Charles.Nixon@cms.hhs.gov (Institutional Claims) , David Dolan, 410-786-3365 or David.Dolan@cms.hhs.gov (Coverage and Analysis) , Wanda Belle, 410-786-7491 or Wanda.Belle@cms.hhs.gov (Coverage and Analysis)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev.4229, Issued: 02-01-19)

Transmittals for Chapter 32

390 Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease *(PAD)*

(Rev.4229, Issued: 02-01-19, Effective: 05-25-17, Implementation: 03-19-19)

Effective for claims with dates of service on or after May 25, 2017, the Centers for Medicare and Medicaid Services (CMS) will cover supervised exercise therapy (SET) for beneficiaries with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if all of the following components of a SET program are met:

The SET program must:

- consist of sessions lasting 30-60 minutes comprising a therapeutic exercise-training program for PAD in patients with claudication;
- be conducted in a hospital outpatient setting, or a physician's office;
- be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD; and,
- be under the direct supervision of a physician (as defined in *section* 1861(r)(1) of the Social Security Act (the Act), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in section 1861(aa)(5) of the Act) who must be trained in both basic and advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

Please refer to the National Coverage Determinations *(NCD)* Manual (Publication 100-03, Section 20.35) for more information.

390.1 General Billing Requirements

(Rev.4229, Issued: 02-01-19, Effective: 05-25-17, Implementation: 03-19-19)

Effective for claims with date of services on or after May 25, 2017, contractors shall pay claims for SET for beneficiaries with IC for the treatment of symptomatic PAD, with a referral from the physician responsible for PAD treatment.

Medicare Administrative Contractors (MACs) have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. Contractors shall accept the inclusion of the -**KX** modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy.

390.2 Coding Requirements for SET *for PAD*

(Rev.4229, Issued: 02-01-19, Effective: 05-25-17, Implementation: 03-19-19)

- **CPT 93668** ***Peripheral arterial disease (PAD) rehabilitation, per session***
- **ICD-10 Codes**

I70.211 *Atherosclerosis of native arteries of extremities with intermittent claudication,* right leg
I70.212 *Atherosclerosis of native arteries of extremities with intermittent claudication,* left leg
I70.213 *Atherosclerosis of native arteries of extremities with intermittent claudication,* bilateral legs
I70.218 *Atherosclerosis of native arteries of extremities with intermittent claudication,* other extremity

I70.311 *Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication,* right leg
I70.312 *Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication,* left leg
I70.313 *Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication,* bilateral legs
I70.318 *Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication,* other extremity

I70.411 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, right leg
I70.412 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, left leg
I70.413 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, bilateral legs
I70.418 Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, other extremity

I70.511 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, right leg
I70.512 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, left leg
I70.513 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, bilateral legs
I70.518 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, other extremity

I70.611 *Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication,* right leg
I70.612 *Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication,* left leg
I70.613 *Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication,* bilateral legs
I70.618 *Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication,* other extremity

I70.711 *Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication,* right leg
I70.712 *Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication,* left leg
I70.713 *Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication,* bilateral legs
I70.718 *Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication,* other extremity

390.3 Special Billing Requirements for *Professional Claims*

(Rev.4229, Issued: 02-01-19, Effective: 05-25-17, Implementation: 03-19-19)

Professional claim services for SET are only allowed in place of service (POS) 11. All other POS for SET will be denied. See section 390.4 for hospital outpatient center billing requirements.

390.4 *Special Billing Requirements for Institutional Claims*

(Rev.4229, Issued: 02-01-19, Effective: 05-25-17, Implementation: 03-19-19)

Contractors shall pay claims for SET services containing CPT code 93668 on Types of Bill (TOBs) 13X under OPPS and 85X based on reasonable cost.

Contractors shall *not* pay claims for SET services containing CPT 93668 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II.

390.5 *Common Working File (CWF) Requirements*

(Rev.4229, Issued: 02-01-19, Effective: 05-25-17, Implementation: 03-19-19)

CWF shall create a new edit for CPT 93668 to reject claims when a beneficiary has reached 36 SET sessions within 84 days after the date of the first SET session and the -KX modifier is not included on the claim, or to reject any SET session provided after 84 days from the date of the first session and the -KX modifier is not included on the claim.

CWF shall determine the remaining SET sessions.

The CWF determination, to parallel claims processing, shall include all applicable factors including:

- Beneficiary entitlement status
- Beneficiary claims history
- Utilization rules

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.

CWF shall display the remaining SET sessions on all CWF provider query screens.

The Multi-Carrier System Desktop Tool (MCSDT) shall display the remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

390.6 Applicable Medicare Summary Notice (MSN), Remittance Advice Remark Codes *(RARCs),* and Claim Adjustment Reason Code *(CARC)* Messaging

(Rev.4229, Issued: 02-01-19, Effective: 05-25-17, Implementation: 03-19-19)

- *Effective for claims with dates of service on or after May 25, 2017, contractor shall deny claims for SET in Place of Service (POS) other than 11, office using the following messages:*

Medicare Summary Notice (MSN) 15.20: "The following policies National Coverage Determination 20.35 (NCD) were used when we made this decision."

Spanish Version: "Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión."

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) N386: "This decision was based on a NCD 20.35. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Contractors shall use Group CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.

- Contractors shall deny claims for SET when services are provided on other than TOBs 13X and 85X using the following messages:

MSN 15.20: "The following policies NCD 20.35 were used when we made this decision."

Spanish Version: "Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión."

(Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD."

Spanish Version: "Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1800-633-4227)."

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 N386: This decision was based on a National Coverage Determination (NCD) 20.35. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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.

For professional claims only, contractors shall deny line items on claims for SET services performed in POS other than POS 11 and use the following messages:

MSN 15.20: "The following policies NCD 20.35 were used when we made this decision."

Spanish Version: "Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión."

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 N386: "This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this

policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Contractors shall use Group 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.

- Contractors shall deny/reject claim lines for CPT 93668 without one of the diagnosis codes listed in section 390.2 above and use the following messages:

MSN 15.20: "The following policies NCD 20.35 were used when we made this decision."

Spanish Version: "Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión."

(Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version: "Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1800-633-4227)."

CARC 167: "This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

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 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.

- Contractors shall reject claims with CPT 93668 which exceed 36 sessions within 84 days from the date of the first session when the -KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the -KX modifier is not included on the claim and use the following messages:

CARC 96: "Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC N640: "Exceeds number/frequency approved/allowed within time period."

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file and occurrence code 32 is not present).

- Contractors shall deny/reject claim lines with CPT 93668 when *73* sessions have *been* reached using the following messages:

MSN 15.20: “The following policies NCD 20.35 were used when we made this decision.”

Spanish Version: “Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión.”

(Part A only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version: “Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1800-633-4227).”

CARC 119: “Benefit maximum for this time period or occurrence has been reached.”

RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without a GA modifier or a claim-line is received with a GA modifier indicating a signed ABN is on file)

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file and occurrence code 32 is not present

- Contractors shall deny claim line-items for SET, CPT 93668, when *73* sessions have *been* reached with or without the -KX *m*odifier present using the following messages:

MSN 15.20: “The following policies NCD 20.35 were used when we made this decision.”

Spanish Version: “Las siguientes políticas NCD 20.35 fueron utilizadas cuando se tomó esta decisión.”

(Part A only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version: “Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800- MEDICARE (1800-633-4227).”

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Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file and occurrence code 32 is not present).