

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 11426</b>	<b>Date: May 20, 2022</b>
	<b>Change Request 12613</b>

**Transmittal 11272, dated February 18, 2022, is being rescinded and replaced by Transmittal 11426, dated, May 20, 2022 to revise chapter 32 of the IOM for Pub. 100-04. This correction does not make any revisions to the companion Pub. 100-02 or Pub. 100-03; all revisions are associated with Pub. 100-04. All other information remains the same.**

**SUBJECT: An Omnibus CR Covering: (1) Removal of Two National Coverage Determination (NCDs), (2) Updates to the Medical Nutrition Therapy (MNT) Policy, and (3) Updates to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) Conditions of Coverage**

**I. SUMMARY OF CHANGES:** The purpose of this Omnibus change request is to make Medicare contractors aware of the update to remove two National Determination NCDs, updates to the Medical Nutritional Therapy (MNT) policy and updates to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) resulting from changes specified in the calendar year 2022 Physician Fee Schedule (PFS) final rule published on November 19, 2021.

**EFFECTIVE DATE: January 1, 2022 - By Statute**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: July 5, 2022**

***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.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	32/140/Cardiac Rehabilitation (CR) Programs, Intensive Cardiac Rehabilitation (ICR) Programs, and Pulmonary Rehabilitation (PR) Programs
R	32/140/1/CR Program Services Furnished On or Before December 31, 2009
R	32/140/1/1/ Coding Requirements for CR Services Furnished On or Before Dec. 31, 2009
R	32/140/2/CR Program Services Furnished On or After January 1, 2010
R	32/140/2/1/Coding Requirements for CR Services Furnished On or After January 1, 2010
R	32/140/2/2/Claims Processing Requirements for CR and ICR Services Furnished On or After January 1, 2010
R	32/140/2/2/3/Frequency Edits for CR and ICR Claims
R	32/140/3/ICR Program Services Furnished On or After January 1, 2010
R	32/140/3/1/Coding Requirements for ICR Services Furnished On or After January 1, 2010
R	32/140/4/PR Program Services Furnished On or After January 1, 2010
R	32/140/4/1/Coding Requirements for PR Services Furnished On or After January 1, 2010
R	32/140/4/2/5/Edits for PR Services Exceeding 72 Sessions
R	4/300/1/ General Conditions and Limitations on Coverage
R	4/300/2/Referrals for MNT Services
R	4/300/4/Payment for MNT Services
R	32/140/2/2/4 Edits for CR Services Exceeding 36 Sessions
R	4/300/Medical Nutrition Therapy (MNT) Services
R	4/300/3/Dieticians and Nutritionists Performing MNT Services
R	4/300/5/General Claims Processing Information
R	4/300/5/1/Rural Health Centers (RHCs)/Federally Qualified Health Centers (FQHCs) Special Billing Instructions
R	4/300/6/Common Working File (CWF) Edits

### **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: 11426	Date: May 20, 2022	Change Request: 12613
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**EFFECTIVE DATE: January 1, 2022 - By Statute**

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**IMPLEMENTATION DATE: July 5, 2022**

## **I. GENERAL INFORMATION**

### **A. Background:**

**Updates to Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Conditions of Coverage:**

Section 144(a) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for PR, CR, and ICR programs. The statute specified certain conditions for coverage of these services and an effective date of January 1, 2010. Conditions of coverage for PR, CR, and ICR consistent with the statutory provisions of section 144(a) of MIPPA were codified in 42 Code of Federal Regulations (CFR) sections 410.47 and 410.49, respectively, through the Calendar Year (CY) 2010 Medicare Physician Fee Schedule (MPFS) Final Rule (FR) with comment period (74 FR 61872-61886 and 62002-62003 (PR) 62004-62005 (CR/ICR)).

In 2014, the Centers for Medicare & Medicaid Services (CMS) expanded coverage of CR through the National Coverage Determination (NCD) process (NCD 20.10.1, Cardiac Rehabilitation Programs for Chronic Heart Failure (CHF)).

In 2018, §51004 of the Bipartisan Budget Act (BBA of 2018) expanded coverage of ICR to include CHF. Section 410.49 was updated to codify this expansion of coverage through the CY 2020 MPFS final rule (84 FR 62897-62899 and 63188).

In the CY 2022 MPFS final rule (86 FR 65244 dated November 19, 2021) CMS finalized revisions to §§ 410.47 and 410.49 to improve consistency and accuracy across the PR and CR/ICR conditions of coverage, removed the PR requirement for direct physician-patient contact, and expanded coverage of PR for beneficiaries with confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four (4) weeks.

### **NCD Removal:**

CMS is removing two NCDs from Publication (Pub.) 100-03, NCD Manual, as a result of the NCD removal process through rulemaking in the CY 2022 MPFS (86 FR 65244 dated November 19, 2021).

### **Medical Nutritional Therapy (MNT):**

Section 1861(s)(2)(V) of the Social Security Act (the Act) authorizes Medicare Part B coverage of MNT for certain beneficiaries who have diabetes or a renal disease, effective for services furnished on or after January 1, 2002. Regulations for MNT were established at 42 CFR §§410.130 – 410.134. This NCD establishes the duration and frequency limits for the MNT benefit and coordinates MNT and Diabetes Outpatient Self-Management Training (DSMT) as an NCD.

In 2002, the regulation at 42 CFR 410.132(c) required that an MNT referral must be made by the ‘treating’ physician. The treating physician was defined as the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease.

## **B. Policy: Updates to PR, CR), and ICR Conditions of Coverage:**

Under § 410.47(b), Medicare Part B covers PR for beneficiaries:

- With moderate to very severe COPD (defined as GOLD classification II, III, and IV), when referred by the physician treating the chronic respiratory disease;
- Who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least 4 weeks (effective January 1, 2022).
- Additional medical indications for coverage for PR program services may be established through an NCD.

CMS has not expanded coverage of PR further using the NCD process.

Under § 410.49(b), Medicare Part B covers CR and ICR 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;
- Stable, CHF defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, on or after February 18, 2014, for CR and on or after February 9, 2018, for ICR; or,
- Other cardiac conditions as specified through an NCD. The NCD process may also be used to specify non-coverage of a cardiac condition for ICR if coverage is not supported by clinical evidence.

These conditions of coverage are reflected in multiple CMS program manuals. CMS is updating the affected manual language to accurately reflect the updated regulatory text and policy changes finalized in the CY 2022 PFS final rule in §410.47 and 410.49. The updates are to chapter 15, sections 231 and 232 of the Medicare Benefit Policy Manual (Pub. 100-02) and chapter 32, section 140 of the Medicare Claims Processing Manual (Pub. 100-04).

## **NCD Removal:**

The final rule contains a summary of the NCD removal process and explicitly removes the following two NCDs from the NCD Manual:

- NCD 180.2 Enteral/Parenteral Nutritional Therapy
- NCD 220.6 Positron Emission Tomography (PET) Scans

In the absence of an NCD, Medicare Administrative Contractors (MACs) have the authority and discretion to determine whether any Medicare claims for these items/services are reasonable and necessary under §1862(a)(1)(A) of the Act consistent with the existing guidance for making such decisions. Therefore, coverage of the above two NCDs revert to MAC discretion effective for claims with dates of service on and after January 1, 2022.

**MNT:**

Effective January 1, 2022, the regulations at 42 CFR §§ 410.130 and 410.132 will be consistent with the language of the statute and Medicare will cover MNT services with a referral by a physician (as defined in section 1861(r)(1) of the Act). Basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR §410.130 is three (3) hours. Basic coverage in subsequent years for renal disease or diabetes is two (2) hours. The dietitian/nutritionist may choose how many units are performed per day as long as all of the other requirements in the NCD and 42 CFR §§410.130-410.134 are met. Pursuant to the exception at 42 CFR §410.132(b)(5), additional hours are considered to be medically necessary and covered if the physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

If the physician determines that receipt of both MNT and DSMT are medically necessary in the same episode of care, Medicare will cover both DSMT and MNT initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service. The dietitian/nutritionist may choose how many units are performed per day as long as all of the other requirements in the NCD and 42 CFR §§410.130-410.134 are met. Pursuant to the exception at 42 CFR 410.132(b)(5), additional hours are considered to be medically necessary and covered if the physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

NOTE: Effective January 1, 2022, the regulations at 42 CFR §§410.130 and 410.132 are consistent with the language of the statute. Medicare will cover MNT services with a referral by a physician (as defined in section 1861(r)(1) of the Social Security Act). To align with the conforming changes of this regulation, the Claims Processing Manual, chapter 4, section 300, has been updated to remove the requirement that the medical nutrition therapy referral be made by the “treating” physician.

**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	
12613 - 04.1	Contractors shall determine coverage for the following two 2 NCDs effective for claims with dates of service on and after January 1, 2022: <ul style="list-style-type: none"> <li>NCD 180.2 Enteral/Parenteral Nutritional Therapy</li> </ul>	X	X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	<ul style="list-style-type: none"> <li>NCD 220.6 Positron Emission Tomography (PET) Scans (NOTE: This change does not impact any PET-related NCDs currently covered or non-covered under NCD 220.6.)</li> </ul>									
12613 - 04.2	Contractors shall be aware of the policy changes made to chapter 32, section 140 of the Medicare Claims Processing Manual (Pub. 100-04) effective January 1, 2022.	X	X							
12613 - 04.2.1	<p>Contractors shall install edits in their systems and process any PR-related claims with dates of service on and after January 1, 2022. The changes are as follows:</p> <ul style="list-style-type: none"> <li>Process PR claims for patients who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least 4 weeks effective January 1, 2022.</li> <li>Process PR claims that include CPT codes 94625 and 94626 effective January 1, 2022.</li> <li>New CPT 94625 and 94626 are to apply the same edits as for G0424 for edit U539Q.</li> </ul>	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	<p>NOTE: For the 2 new HCPCS codes 94625 and 94626 CWF shall not apply the 72 session cap edit in U539R.</p> <p>NOTE: FISS shall end-date FISS RCs 39938-39943 effective for claims with dates of service on and after January 1, 2022.</p>									
12613 - 04.3	Contractors shall be aware that valued new PR Current Procedural Terminology (CPT) codes 94625 ( <i>Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)</i> ) and 94626 ( <i>Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)</i> ) are effective for use when billing for PR.	X	X							
12613 - 04.3.1	Contractors shall add POS 19 to existing POS 11 and 22 for Pulmonary Rehabilitation effective January 1, 2022.		X							
12613 - 04.4	Contractors shall be aware that PR Healthcare Common Procedure Coding System (HCPCS) code G0424 ( <i>Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day</i> ) is deleted effective December 31, 2021.	X	X							
12613 - 04.5	Contractors shall be aware that the qualifier 'treating' has been removed from 'physician' in the criteria for MNT services	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	effective for claims with dates of service on and after January 1, 2022.									
12613 - 04.6	Contractors shall not search for claims related to the above policy changes prior to the implementation of this CR but should adjust claims that are brought to their attention.	X	X						X	

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12613 - 04.7	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	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):** Wanda Belle, 14107867491 or wanda.belle@cms.hhs.gov (Coverage and Analysis) , Patricia Brocato-Simons, 14107860261 or Patricia.BrocatoSimons@cms.hhs.gov (Coverage and Analysis) , Rachel Katonak, Rachel.Katonak@cms.hhs.gov (Coverage and Analysis) , Sarah Fulton, Sarah.Fulton@cms.hhs.gov (Coverage and Analysis) , Heather Hostetler, Heather.Hostetler@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**

## **140 - Cardiac Rehabilitation (CR) Programs, Intensive Cardiac Rehabilitation (ICR) Programs, and Pulmonary Rehabilitation (PR) Programs**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

Cardiac rehabilitation (CR) means a physician-supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Intensive cardiac rehabilitation (ICR) program means a physician-supervised program that furnishes CR and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements described in 42 CFR 410.49(c). Effective January 1, 2010, Medicare Part B pays for CR/ICR if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which it is administered, and the physician administering the program.

*Pulmonary rehabilitation (PR) means a physician-supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Effective January 1, 2010, Medicare Part B pays for PR if specific criteria are met by the Medicare beneficiary, the PR program itself, the setting in which it is administered, and the physician administering the program, as outlined below.*

### **140.1 – CR Program Services Furnished On or Before December 31, 2009**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

Medicare covers **CR** exercise programs for patients who meet the following criteria:

- Have a documented diagnosis of acute myocardial infarction (**MI**) within the preceding 12 months; or
- Have had coronary bypass surgery; or,
- Have stable angina pectoris; or,
- Have had heart valve repair/replacement; or,
- Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or,
- Have had a heart or heart-lung transplant.

Effective for dates of services on or after March 22, 2006, services provided in connection with a CR exercise program may be considered reasonable and necessary for up to 36 sessions. Patients generally receive 2 to 3 sessions per week for 12 to 18 weeks. The contractor has discretion to cover **CR** beyond 18 weeks. Coverage must not exceed a total of 72 sessions for 36 weeks.

**CR** programs shall be performed incident to physician's services in outpatient hospitals, or outpatient settings such as clinics or offices. Follow the policies for services incident to the services of a physician as they apply in each setting. For example, see Pub. 100-02, Chapter 6, §2.4.1, and Pub. 100-02, Chapter 15, §60.1. (Refer to Publication 100-03, §20.10 for further coverage guidelines.)

#### **140.1.1 - Coding Requirements for CR Services Furnished On or Before December 31, 2009**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

The following are the applicable *Healthcare Common Procedure Coding System (HCPCS)* codes:

93797 - Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session); and

93798 - Physician services for outpatient cardiac rehabilitation; with continuous ECG

monitoring (per session).

Effective for dates of service on or after January 1, 2008, and before January 1, 2010, providers and practitioners may report more than one unit of CPT code 93797 or 97398 for a date of service if more than one *CR* session lasting at least 1 hour each is provided on the same day. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the *CR* provided on a given day total 1 hour and 50 minutes, then only one session should be billed to report the *CR* provided on that day.

## **140.2 – *CR* Program Services Furnished On or After January 1, 2010** ***(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)***

As specified at 42 CFR 410.49, Medicare *Part B* covers *CR* for beneficiaries who have experienced one or more of the following:

- An acute *MI* within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- PTCA or coronary stenting;
- A heart or heart-lung transplant;
- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, on or after February 18, 2014; or,
- Other cardiac conditions as specified through a national coverage determination (NCD).

*CR* must include all of the following *components*:

- Physician-prescribed exercise each day *CR* items and services are furnished.
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to *the* individual's needs.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

*Medicare Part B* pays for *CR* 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 times *when* items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27.

As specified at 42 CFR 410.49(f)(1), *the number of CR* sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare *Administrative Contractor (MAC)*.

### **140.2.1 – Coding Requirements for *CR* Services Furnished On or After January 1, 2010** ***(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)***

The following are the applicable *Current Procedural Technology (CPT)* codes for *CR* services:

**93797** Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (Per Session)

**93798** Physician or other qualified care health professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (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 **CR** in a day, the duration of treatment must be at least 31 minutes. Two sessions of **CR** 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 **CR** 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 **CR** in the day, no **CR** session may be reported because less than 31 minutes of services were furnished.

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

**Example:** If the patient receives 70 minutes of **CR** in the morning and 25 minutes of **CR** in the afternoon of a single day, the hospital or practitioner would report two sessions of **CR** under the appropriate CPT code(s) because the total duration of **CR** on that day of 95 minutes exceeds 90 minutes.

**Example:** If the patient receives 70 minutes of **CR** in the morning and 85 minutes of **CR** in the afternoon of a single day, the hospital or practitioner would report two sessions of **CR** under the appropriate CPT code(s) for the total duration of **CR** of 155 minutes. A maximum of two sessions per day may be reported, regardless of the total duration of **CR**.

## **140.2.2 – Claims Processing Requirements for CR and ICR Services Furnished On or After January 1, 2010**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

**NOTE:** A beneficiary may switch from an ICR program to a CR program. The beneficiary is limited to a one-time switch, multiple switches are not allowable. Once the beneficiary switches from ICR to CR he or she will be limited to the number of sessions remaining in the program. For example, a beneficiary who switches from ICR to CR after 12 sessions will have 24 sessions of CR remaining, (i.e., 12 sessions of ICR + 24 sessions of CR = total of 36 sessions). Should a beneficiary experience more than one indication simultaneously, he or she may participate in a single series of CR or ICR sessions (i.e., a patient who had a **MI** within 12 months and currently experiences stable angina is entitled to one series of CR sessions, up to 36 1-hour sessions with contractor discretion for an additional 36 sessions; or one series of ICR sessions, up to 72 1-hour sessions over a period up to 18 weeks). Beneficiaries may not switch from CR to ICR. Upon completion of a CR or ICR program, beneficiaries must experience another indication in order to be eligible for coverage of more CR or ICR.

Contractors shall accept the inclusion of the -KX modifier on the claim line(s) as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond 36 sessions of CR up to a total of 72 sessions meets the requirements of the medical policy or, for ICR, that any further sessions beyond 72 sessions within a 126-day period counting from the date of the first session, or for any sessions provided after 126 days from the date of the first session, meet the requirements of the medical policy. Beneficiaries who switch from ICR to CR may also be eligible for up to 72 combined sessions with contractor discretion for CR sessions after 36 (to include completed ICR sessions prior to switch). In these

cases, and consistent with the information above, the -KX modifier must be included on the claim should the beneficiary participate in more than 36 CR sessions following the switch.

See Pub. 100-06, Medicare Financial Management Manual, chapter 6, section 420, and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 232, and Pub. 100-08, Medicare Program Integrity Manual, chapter 10, section 10.2.2.5 for detailed information regarding CR and ICR policy and claims processing.

### **140.2.2.3 – Frequency Edits for CR and ICR Claims**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

Effective for claims with dates of service on or after January 1, 2010, contractors shall deny all CR claims (both professional and institutional claims) that exceed 2 units per date of service for CR and 6 units per date of service for ICR.

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

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.

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

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

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

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

### **140.2.2.4 – Edits for CR Services Exceeding 36 Sessions**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

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

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

-CARC-) 119 – Benefit maximum for this period or occurrence has been reached.

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

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

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

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

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

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

### **140.3 – *ICR* Program Services Furnished On or After January 1, 2010** **(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)**

As specified at 42 CFR 410.49, Medicare *Part B* covers *ICR* for beneficiaries who have experienced one or more of the following:

- An acute *MI* within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- *PTCA* or coronary stenting;
- A heart or heart-lung transplant;
- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and NYHA class II to IV symptoms despite being on optimal *heart failure* therapy for at least 6 weeks, on or after February 9, 2018; or,
- Other cardiac conditions as specified through an NCD. The NCD process may also be used to specify non-coverage of a cardiac condition for *ICR* if coverage is not supported by clinical evidence.

*ICR* must include all of the following *components*:

- Physician-prescribed exercise each day *CR* items and services are furnished.
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to *the* individual's needs.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

A list of approved *ICR* programs, identified through the *NCD* process, will be listed in the Federal Register *and is available on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/ICR>*. In order to be approved, a program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following for its patients:

- Positively affected the progression of coronary heart disease.
- Reduced the need for coronary bypass surgery.
- Reduced the need for percutaneous coronary interventions.

An *ICR* program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before *CR* services to after *CR* services:

- Low density lipoprotein.
- Triglycerides.

- Body mass index.
- Systolic blood pressure.
- Diastolic blood pressure.
- The need for cholesterol, blood pressure, and diabetes medications.

*Medicare Part B pays for ICR* 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 times *when* items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27.

As specified at 42 CFR 410.49(f)(2), *ICR* sessions are limited to 72 1-hour sessions (*as defined in section 1848(b)(5) of the Act*), up to 6 sessions per day, over a period of up to 18 weeks.

### **140.3.1 – Coding Requirements for *ICR* Services Furnished On or After January 1, 2010**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

The following are the applicable HCPCS codes for *ICR*:

G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session)

G0423 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 6 1-hour sessions per day. In order to report one session of *ICR* in a day, the duration of treatment must be at least 31 minutes. Additional sessions of *ICR* beyond the first session may only be reported in the same day if the duration of treatment is 31 minutes or greater beyond the hour increment. In other words, in order to report 6 sessions of *ICR* on a given date of service, the first five sessions would account for 60 minutes each and the sixth session would account for at least 31 minutes. If several shorter periods of *ICR* 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 *ICR* in the day, no *ICR* session may be reported because less than 31 minutes of services were furnished.

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

**Example:** If the patient receives 70 minutes of *ICR* in the morning and 25 minutes of *ICR* in the afternoon of a single day, the hospital or practitioner would report two sessions of *ICR* under the appropriate HCPCS code(s) because the total duration of *ICR* on that day of 95 minutes exceeds 90 minutes.

**Example:** If the patient receives 70 minutes of *ICR* in the morning and 85 minutes of *ICR* in the afternoon of a single day, the hospital or practitioner would report three sessions of *ICR* under the appropriate HCPCS code(s) because the total duration of *ICR* on that day is 155 minutes, which exceeds 150 minutes and is less than 211 minutes.

## **140.4 – PR Program Services Furnished On or After January 1, 2010** *(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

As specified in 42 CFR 410.47, Medicare *Part B* covers *PR* for beneficiaries:

- *With moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease;*
- *Who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks (effective January 1, 2022);*
- *Additional medical indications for coverage for PR may be established through an NCD.*

*PR must* include all of the following components:

- Physician-prescribed exercise *during each pulmonary rehabilitation session.*
- Education or training *that is* closely and clearly related to the individual's care and treatment which is tailored to the individual's needs *and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life. Education must* include information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

*Medicare Part B pays for PR* in a physician's office or a hospital outpatient setting. All settings must have the *following: (i) A* physician immediately available and accessible for medical consultations and emergencies at all times *when items and services are being furnished* under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27, *and, (ii) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.*

As specified at 42 CFR 410.47(e), *the number of PR* sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions *over up to 36 weeks* with the option for an additional 36 sessions *over an extended period of time* if approved by the *MACs*.

### **140.4.1 – Coding Requirements for PR Services Furnished On or After January 1, 2010** *(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

The following *are* the applicable HCPCS codes for *PR*:

*Effective January 1, 2010 through December 31, 2021*

G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session)

*Effective January 1, 2022*

*94625 (Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session))*

*94626 (Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (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 *PR* in a day, the duration of treatment must be at least 31 minutes. Two sessions of *PR* 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 *PR* 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 *PR* in the day, no *PR* session may be reported because less than 31 minutes of services were furnished.

**Example:** If a patient receives 20 minutes of *PR* in the morning and 35 minutes of *PR* in the afternoon of a single day, the hospital or practitioner would report 1 session of *PR* under 1 unit of HCPCS code/*CPT code* for the total duration of 55 minutes of *PR* 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/*CPT codes* 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/*CPT codes* 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.

#### **140.4.2.5 – Edits for PR Services Exceeding 72 Sessions**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

Effective for claims with dates of service on and after January 1, 2010 *through December 31, 2021*, 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 assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

*Effective for claims with dates of service on and after January 1, 2022, Medicare Contractors shall deny PR claims that exceed 72 sessions only when the -KX modifier is not submitted on the claim line.*

### **300- Medical Nutrition Therapy (MNT) Services**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861(r)(1) of the *Social Security Act (the Act)*. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

The benefit consists of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment (“episode of care”) to assure compliance with the dietary plan. Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR, 410.130 is 3 hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease is 2 hours.

For the purposes of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 36 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) *15–59* ml/min/1.73m<sup>2</sup>). Effective January 1, 2004, *the Centers for Medicare & Medicaid Services (CMS)* updated the definition of diabetes to be as follows: Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar  $\geq$  126 mg/dL on two different occasions; a 2-hour post-glucose challenge  $\geq$  200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

The MNT benefit is a completely separate benefit from the diabetes self-management training (DSMT) benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage *determination*, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, providers are not allowed to bill for both DSMT and MNT on the same date of service for the same beneficiary.

#### **300.1 - General Conditions and Limitations on Coverage**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

##### **A. General Conditions *of* Coverage**

The following are the general conditions of coverage:

- *A physician must make a referral and indicate a diagnosis of diabetes or renal disease. Physician is defined in §1861(r)(1) of the Act.*

- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the physician;
- Services may be provided either on an individual or group basis without restrictions and;
- For a beneficiary with a diagnosis of diabetes, *DSMT* and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. For a beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis, or treatment as stated in 42 CFR 410.132(b)(5).

## **B. Limitations on Coverage**

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under section 1881 of the Act.
- A beneficiary may not receive MNT and DSMT on the same day.

### **300.2 - Referrals for MNT Services**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

Medicare covers 3 hours of MNT in the beneficiary's initial calendar year. No initial hours can be carried over to the next calendar year. For example, if a physician gives a referral to a beneficiary for 3 hours of MNT but a beneficiary only uses 2 hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for 2 follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours.

Referral may only be made by *a* physician when the beneficiary has been diagnosed with diabetes or renal disease.

Documentation must be *noted* by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The *National Provider Identifier (NPI)* number of the referring physician must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The A/B MAC (B) or A/B MAC (A) shall return claims that do not contain the referring *NPI* of the referring physician.

**NOTE:** Additional covered hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132 (a).

### **300.3 - Dietitians and Nutritionists Performing MNT Services**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

#### **A. Professional Standards for Dietitians and Nutritionists**

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a *state* as of December 21, 2000 (they are not required to meet any other requirements); or an individual whom, on or after December 22, 2000:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and,
- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements stated above.

## **B. Enrollment of Dietitians and Nutritionists**

- In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location.
- The A/B MAC (B) shall establish a permanent *NPI* for any new registered dietitian or nutrition professional who is applying to become a Medicare provider for MNT.
- Registered dietitians and nutrition professionals must accept assignment. Since these new providers must accept assignment, the limiting charge does not apply.

## **300.4 - Payment for MNT Services**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

The contractor shall pay for MNT services under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements. Deductible and coinsurance apply. As with the *DSMT* benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

The contractor shall pay the lesser of the actual charge, or 85% of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. As required by statute, use this same methodology for services provided in the hospital outpatient department.

### **A. Payable Codes for MNT with Applicable Instructions**

- 97802 - Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. (**NOTE:** This HCPCS code must only be used for the initial visit.)

This code is to be used only once for the initial assessment of a new patient. The provider shall bill all subsequent individual visits (including reassessments and interventions) as 97803. The provider shall bill all subsequent group visits as 97804.

- 97803 - Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

The provider shall bill this code for all reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient (see the heading, Additional Covered Hours for Reassessments and Interventions).

- 97804 - Group (2 or more individual(s)), each 30 minutes

The provider shall bill this code for group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

**NOTE:** The above codes can be paid if submitted by a registered dietitian or nutrition professional who meet the specified requirements; or a hospital that has received reassigned benefits from a registered dietitian or nutritionist. These services cannot be paid "incident to" physician services.

### **B. *Healthcare Common Procedure Coding System (HCPCS)* Codes for MNT When There is a Change in the Beneficiaries Condition (for services effective on or after January 1, 2003)**

The following HCPCS codes shall be used when there is a change in the beneficiary's condition:

- G0270 - Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes.
- G0271 - Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes.

**NOTE:** These G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

## **300.5 - General Claims Processing Information**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

This benefit is payable for beneficiaries who have diabetes or renal disease. Contractors are urged to perform data analysis of these services in your jurisdiction. If you determine that a potential problem exists, you should verify the cause of the potential error by conducting an error validation review as described in the Program Integrity Manual (PIM), Chapter 3, Section 2A. Where errors are verified, initiate appropriate corrective actions found in the PIM, Chapter 3, Sections 3 through 6. If no diagnosis is on the claim, return the claim as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, then deny the claim under Section 1862(a)(1)(A) of the Act.

### **A. Special Requirements for A/B MACs (B)**

- Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in on the claim form.
- The specialty code for "dietitians/nutritionists" is 71.

### **B. Medicare Summary Notices (MSNs)**

- Use the following MNT messages where appropriate. If you locate a more appropriate message, then you should use it.

- If a claim for MNT is submitted with dates of service before January 1, 2002, use MSN 21.11 (This service was not covered by Medicare at the time you received it). The Spanish version is ‘Este servicio no estaba cubierto por Medicare cuando usted lo recibio.’
- If a claim for MNT is submitted by a provider that does not meet the criteria use MSN 21.18 (This item or service is not covered when performed or ordered by this provider). The Spanish version is ‘Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.’

### **C. A/B MAC (A) Special Billing Instructions**

MNT Services can be billed to A/B MACs (A) when performed in an outpatient hospital setting. The Hospital outpatient departments can bill for the MNT services through the A/B MAC (A) if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments the nutritionists and the registered dietitians will have to bill the Medicare A/B MAC (B) under their own provider number or the hospital will have to bill the Medicare A/B MAC (B).

NOTE: Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.

The only applicable bill types are 13X, 14X, 23X, *34X*, and 85X.

### **300.5.1 – *Rural Health Centers (RHCs)/Federally Qualified Health Centers (FQHCs)* Special Billing Instructions**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

Detailed billing instructions for *MNT* services provided *in Rural Health Clinics* and *Federally Qualified Health Centers* can be found in Chapter 9, section 182 of this manual.

### **300.6 - Common Working File (CWF) Edits**

*(Rev. 11426; Issued: 05-20-22; Effective: 01-01-22; Implementation: 07-05-22)*

The *Common Working File (CWF)* edit will allow 3 hours of therapy for MNT in the initial calendar year. The edit will allow more than 3 hours of therapy if there is a change in the beneficiary’s medical condition, diagnosis, or treatment regimen and this change must be documented in the beneficiary’s medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the beneficiary to receive more than 3 hours of therapy. Another edit will allow 2 hours of follow up MNT with another referral in subsequent years.

#### **Advance Beneficiary Notice (ABN)**

The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An *Advance Beneficiary Notice (ABN)* should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable.

An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

#### **Duplicate Edits**

Although beneficiaries are allowed to receive training and therapy during the same time period *DSMT* and *MNT* services may not be provided on the same day to the same beneficiary. Effective April 1, 2010 CWF

shall implement a new duplicate crossover edit to identify and prevent claims for DSMT/MNT services from being billed with the same dates of services for the same beneficiaries submitted from institutional providers and from a professional provider.