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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

MLN Matters Number: MM11022

Related Change Request (CR) Number: 11022

Related CR Release Date: February 1, 2019

Effective Date: May 25, 2017

Related CR Transmittal Number: R4229CP

Implementation Date: July 1, 2019, shared system edits, March 19, 2019, local MAC edits

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians and providers billing Medicare Administrative Contractors (MACs) for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) provided for Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11022 informs providers that on May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) to cover SET for Medicare beneficiaries with Intermittent Claudication (IC) for the treatment of symptomatic PAD. See the Key Points section of this article and make sure your billing staff is aware of this update.

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 IC, the most common symptom experienced by people with PAD.

KEY POINTS

On May 25, 2017, CMS issued an 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:

- Consist of sessions lasting 30-60 minutes comprising a therapeutic exercise-training program for PAD in patients with claudication
- Conducted in a hospital outpatient setting, or a physician's office
- Delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD

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- 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.

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.

MACs will 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.

Coding Requirements for SET

Providers should use Current Procedural Terminology (CPT) 93668 (Under PAD Rehabilitation) to bill for these services with appropriate ICD-10 Code as follows:

I70.211 – right leg	I70.511 – right leg
I70.212 – left leg	I70.512 – left leg
I70.213 – bilateral legs	I70.513 – bilateral legs
I70.218 – other extremity	I70.518 – other extremity
I70.311 – right leg	I70.611 – right leg
I70.312 – left leg	I70.612 – left leg
I70.313 – bilateral legs	I70.613 – bilateral legs
I70.318 – other extremity	I70.618 – other extremity
I70.411– right leg	I70.711 – right leg
I70.412– left leg	I70.712 – left leg
I70.413 – bilateral legs	I70.713 – bilateral legs
I70.418 – other extremity	I70.718 – other extremity

MACs will deny claim line items for SET (CPT 93668) unless accompanied by ICD-10 codes in the table above, which also includes the codes identified in CR 10295 (see MM10295):

When denying a line-item on those claims, MACS will use the following codes:

- Claim Adjustment Reason Code (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."
- 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.
- 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.

Special Billing Requirements for Professional Claims

Medicare allows professional claim services for SET only in place of service (POS) 11 (office). MACs will deny claims with any other POS for SET on or after May 25, 2017, using the following messages

- 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.
- 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.

Special Billing Requirements for Institutional Claims

Medicare requires institutional claims for SET be submitted on Type of Bills (TOB) 13X or 85X. MACs will deny line items on institutional claims for SET that are not submitted on TOB 13X or 85X using the following messages:

- 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.
- 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.

Note: Effective May 25, 2017, Medicare will **not** pay claims for SET services containing CPT 93668 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II.

MACs will not search and adjust any SET claims (CPT 93668) prior to the implementation of CR 11022. However, they may adjust such claims that you bring to their attention.

ADDITIONAL INFORMATION

The official instruction, CR11022, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4229CP.pdf.

You may review MM10295 for the initial SET of PAD instructions at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10295.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
February 6, 2019	Initial article released.