Pulmonary Rehab FAQ’s

1) **Q:** Is the 36 session PR program once in a lifetime or per calendar year or per event?

**Answer:** CMS does not limit to one PR “course” to a calendar year. The number of sessions would be based on medical necessity, up to 36 per “course” with a lifetime limit of 72 sessions. That provides incentive to provide the patient with only the number of sessions necessary to get the patient to a maintenance level of functioning.

2) **Q:** Can CR and PR patients exercise in the same class? Example: 4 CR patients and 6 PR patients in the 9am class?

**Answer:** Although not recommended for obvious clinical reasons, the former federal restriction of space set aside “exclusively for CR” has been removed. The J-15 MAC, Cigna Government Services (CGS), is adhering to the NCD in which there is no stipulation of dedicated clinical space for the disciplines.

3) **Q:** Are we allowed to include COPD and non-COPD patients in our PR program?

**Answer:** Yes, as long as you are adhering to the differences between delivery and coding/billing rules for each.

- **Billing Code = G0424** for moderate, severe and very severe COPD Diagnosis (GOLD guidelines).

  **Non-COPD Diagnoses:**
  - **Billing Code = G0239** “Group Exercise”
  - **Billing Code = G0238** “Individual Exercise q15min”
  - **Billing Code = G0237** “Individual Education q15min”

4) **Q:** Given the new CMS payment schedule for the bundled COPD billing code G0424, if the patient also has a qualifying non-COPD diagnoses can we use non-COPD codes?

**Answer:** Yes, as long as you have substantial documentation of the coexisting non-COPD diagnoses. A word of “caution”…frequent use will no doubt prompt an audit therefore, only use when the documentation is irrefutable!

5) **Q:** May we use CPT (93799, 99211, etc) to bill for PR assessment?

**Answer:** No. CMS has clearly stated that initial assessment provided by the PR staff is considered part of the comprehensive service and is not separately billable when using the pulmonary rehab procedure code G0424.
6) **Q:** If the patient comes to PR, but is unable to exercise due to a medical situation (high BP, high glucose, symptoms that contraindicate exercise that day, etc!), how do we bill for the time spent with that patient?

**Answer:** A patient must exercise during each day that PR session(s) are received. If there is no exercise provided, it would be inappropriate to bill the patient for PR services that day.

7) **Q:** Can the physician’s PR referral order be part of the ITP?

**Answer:** CMS is silent on how the documentation should look for individual programs. If components of the ITP are on the order sheet for the physician to input, they should be included as part of the comprehensive ITP. There should be an identifiable time order to these processes…

1st MD orders PR
2nd PR staff assists MD (referring or Medical Director) in the development of initial ITP
3rd PR Medical Director signs ITP “prior to initiation of PR”

8) **Q:** May we bill separately for smoking cessation?

**Answer:** No, “Brief smoking cessation” is included as part of a comprehensive PR program. [There are two CPT codes available for physicians (CPT 99406 and 99407) that are available outside services included in a comprehensive PR program.]

9) **Q:** Is there any coverage for Phase III (IV, maintenance) PR?

**Answer:** No, Medicare has never paid for maintenance PR. Phase III-IV-Maintenance is a self-pay program not subject to CMS rules.

10) **Q:** Can Physical Therapy bill for a non-COPD patient evaluation?

**Answer:** Physical Therapy codes and G 0237-39 code utilization rules remain in effect for all Non-COPD diagnosed patients currently eligible for respiratory therapy services. For patients with moderate, severe or very severe COPD, the new coverage rules and billing code G0424 apply.

11) **Q:** Is there a requirement for PFTs prior to beginning PR services?

**Answer:** CMS requires a diagnosis of COPD GOLD stages II- IV for coverage of COPD for Pulmonary Rehabilitation under Medicare part B. COPD is diagnosed by PFT or spirometry and therefore would be required for PR services in COPD patients. Medicare does not specify how long before PR the PFT is performed. Medicare is also silent
regarding a requirement for PFT for non-COPD diagnoses. Any PFT requirement and timing of when the testing is to be done for non-COPD patients would come from our Medicare Administrative Contractor (MAC J-15) in the form of Local Coverage Determination, bulletins, articles, or instructions for Pulmonary Rehabilitation and for Respiratory Care Services in our MAC region. CGS our MAC provider has not published regulations for these services, choosing to follow the CMS national regulations effective 1/1/2010 governing Pulmonary Rehabilitation.

12) Q: Is Asthma considered COPD or Non COPD?

Answer: Non-COPD. However, some patients will have components of both with PFTs meeting the GOLD criteria that would qualify them for pulmonary rehab.

13) Q: What does “direct patient contact”, required within each 30 day period, mean?

Answer: A brief (1-2 minute) conversation between the physician and patient, i.e., “eyeballing the patient”, would meet the “direct patient contact” requirement for pulmonary rehab. The Medical director attending the educational session and interacting with the patients would meet the requirement.

14) Q: Is it OK to educate, place pt on the monitor for their Initial Interview, and do a 6 min walk at that time, counting this as the patient's first session?

Answer: Provided that the patient is not billed separately for the 6 min-walk test yes, the 6MWT may serve as the exercise component of the session.

15) Q: Is there a required staff /pt. ratio when using G0424?

Answer: CMS has no staff-patient ratio requirements. Those are AACVPR recommendations in the AACVPR Pulmonary Rehabilitation Guidelines (4th edition) based on expert opinion. CMS does not require that education or exercise be delivered 1:1. It is expected that this service will be provided in a small group setting.

16) Q: Can the 6-minute walk be charged with the initial pulmonary assessment?

Answer: No, it is not separately billable if provided in PR.

17) Q: Is the G0237-39 are still billable for non COPDers, is the ICD-9 list of approved diagnosis that was in place previously, still appropriate?

Answer: Yes.
18) Q: Is there an NCD for pulmonary rehab?

Answer: No, there is no National Coverage Determination (NCD) for PR. It is the prerogative of each MAC provider to determine local coverage’s given the statutes & provisions within Medicare. As of 1/1/2010 a CMS provision took effect to provide for physician–supervised, comprehensive PR programs which include defined mandatory components including: (1) physician-prescribed exercise, (2) education or training, (3) psychosocial assessment, (4) outcomes assessment, and (5) an individualized treatment plan. CGS or MAC provider recognizes these provisions and covers PR programs but has not developed a local coverage determination (LCD).

19) Q: The patient’s pulmonologist overseeing the care is signing the ITP; does the medical director also have to sign ITP?

Answer: The medical director must sign the initial ITP (Federal Register, 11-25-09, pg 61883). The ITP must be signed by a physician who is “involved in the patient’s care and has knowledge related to his or her condition every 30 days” (42 CFR 410.47(c)(5). Although the regulation does not specifically stipulate that the medical director must sign all monthly ITPs, AACVPR recommends that it should be the medical director’s signature on all ITPs because the medical director must be “involved substantially in directing the progress of the individual in the program including direct patient contact related to the periodic review of his/her treatment plan,” (42 CFR 410.47(e)(2).

20) Q: Is there any condition when a COPD Pt can be admitted for a second group of 36 sessions? IE, Going from a Gold Stage II to III.

Answer: It is not a matter of a “condition” that would trigger an additional 36 sessions. If a patient has not reached his/her goals and additional sessions would clearly benefit the patient, then sessions beyond the initial 36 would be warranted. Likewise, if a patient does reach his goals using an initial 30 sessions, that patient still has access to another 42 sessions of pulmonary rehab if another event warrants the rehab, or the patient declines and the physician believes that the patient would indeed benefit from the rehab services.
21) Q: How should we interpret the GOLD guidelines to determine eligibility of Medicare patients for pulmonary rehab?

Answer: Medicare requires that a patient meet the COPD GOLD stages II-IV criteria to be eligible for Medicare coverage of pulmonary rehabilitation (i.e., use of CPT code G0424). The stages of COPD are found on the AACVPR web site in the AACVPR Position Papers, Scientific Statements and Guidelines section.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>FEV1/FVC &lt; 0.70</th>
<th>FEV1 50-79% normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>Moderate COPD</td>
<td>FEV1/FVC &lt; 0.70</td>
<td>FEV1 50-79% normal</td>
</tr>
<tr>
<td>III</td>
<td>Severe COPD</td>
<td>FEV1/FVC &lt; 0.70</td>
<td>FEV1 30-49% normal</td>
</tr>
<tr>
<td>IV</td>
<td>Very Severe COPD</td>
<td>FEV1/FVC &lt; 0.70</td>
<td>FEV1 &lt; 30% normal, or &lt; 50% normal with chronic respiratory failure present*</td>
</tr>
</tbody>
</table>

The FEV1 identifies the severity of COPD and the FEV1/FVC ratio is the criteria for COPD Dx. Here is an example of PFT results demonstrating very severe COPD. GOLD standards are to be interpreted that both the FEV1 predicted standard and the FEV1/FVC standard need to be met.

<table>
<thead>
<tr>
<th>Pulmonary Function Test pre-PR</th>
<th>Results</th>
<th>Units</th>
<th>Normal</th>
<th>%Pred</th>
<th>Post BD</th>
</tr>
</thead>
<tbody>
<tr>
<td>FVC</td>
<td>1.79</td>
<td>L</td>
<td>2.29-3.64</td>
<td>60%</td>
<td>62%</td>
</tr>
<tr>
<td>FEV1</td>
<td>0.66</td>
<td>L</td>
<td>1.63-2.76</td>
<td>30%</td>
<td>32%</td>
</tr>
<tr>
<td>FEV1/FVC</td>
<td>37%</td>
<td>% predicted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEF 25-75%</td>
<td>0.17</td>
<td>L/sec</td>
<td>0.4-3.12%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>TLC (single breath)</td>
<td>3.06</td>
<td>L</td>
<td>4.24-6.40</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>TLC (re-breathing)</td>
<td>3.75</td>
<td>L</td>
<td>4.24-6.39</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>TLC (box)</td>
<td>5.52</td>
<td>L</td>
<td>4.24-6.39</td>
<td>104%</td>
<td></td>
</tr>
<tr>
<td>FRC (re-breathing)</td>
<td>2.55</td>
<td>L</td>
<td>2.00-4.13</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>RV/TLC</td>
<td>67%</td>
<td>%</td>
<td>35-57%</td>
<td>145%</td>
<td></td>
</tr>
<tr>
<td>DLCO HGB COR</td>
<td>6.75</td>
<td>ml/mn/mm/HG</td>
<td>18.18-30.38</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>DLCO HGB UnCOR</td>
<td>6.75</td>
<td>ml/mn/mm/HG</td>
<td>18.18-30.38</td>
<td>26%</td>
<td></td>
</tr>
</tbody>
</table>

A post bronchodilator spirometry may be performed to evaluate for asthma or ‘reversibility’. Post bronchodilator flow rates are typically checked (post BD value) to evaluate for significant asthma (change of 200 ml and 12-15%),
It may be the case that the post bronchodilator value is absent, e.g. a patient comes to PR with either simple spirometry (flow rates of FVC, FEV1 and FEV1/FVC ratio) or a PFT with only pre-BD values (which meet CMS requirements for mod – very severe COPD). However, these patients still meet CMS requirements for pulmonary rehabilitation.

Patients who do not meet COPD II-IV criteria on PFT may be covered for another pulmonary diagnosis and eligible for respiratory therapy services, per your local coverage policy (e.g. asthma or bronchiectasis).

22) Q: Does the lifetime benefit for pulmonary only apply to sessions done as of 1-1-2010?

Answer: Correct…the lifetime benefit limitation became effective on January 1, 2010.

23) Q: What are the changes in 2011 to CMS rules regarding physician supervision for pulmonary rehab in an on-campus or off-campus setting?

Answer: Per the 2011 Final Hospital Outpatient Prospective Payment System (HOPPS) regulation, whether on or off campus, the supervising physician must be “immediately available” without differentiation between on and off-campus hospital-based PR programs. CMS decided to remove the 2010 requirement for off-campus hospital-based programs that required a physician “in the provider-based department”. This is discussed in greater detail in the Federal Register, 11-24-10, pgs 71998-72013.

24) Q: If a pt. needs more than the initial 36 sessions, are there special procedures taken to get an additional 36 approved so there is not interruption of services?

Answer: The use of a KX modifier is necessary for all patients exceeding 36 sessions i.e. must be included in the billing. The key is sufficiently documented medical necessity for PR beyond the initial 36 sessions. The patient can continue his/her course without interruption given this documentation which should be preformed proactively providing justification data of achievement of outcomes, medical complications, exacerbations etc… This documentation should be signed by managing staff and a physician (Medical Director and/or referring physician). [Our local MAC contractor has total discretion in retroactively denying payment beyond 36 if, in their determination, there was not adequate justification for the extension.]
25) Q: If treating a patient and billing the G0237-39, can the 6 minute walk test be billed separately?

Answer: As of 10-1-10, 6MWT can not be billed with the same patient encounter as G0237, G0238, or G0239 because these codes are considered to include the monitoring provided in a 6MWT.

26) Q: Can the G0424 PR code be used for education if the pt is unable to exercise on any given session?

Answer: No, the patient must exercise at every session in order for that session to be legitimately billable to Medicare.

27) Q: Must PR patients exercise at every session?

Answer: Yes, exercise must be provided in every session for PR per Federal Register, 11-25-10, pg 61886 (see also HCPCS code descriptor for G0424). For cardiac rehab, exercise must be provided every day, but not every session per Federal Register, 11-25-10, pg 61878.

28) Q: What does CMS mean by “immediately available”?

Answer: Per CMS, not defined by time or distance. General definition is “without interval of time” (Federal Register, 11-20-09, pg 60580). Accessible at all times where the services are being furnished; not so physically far away that he/she couldn’t intervene right away; must not be performing another procedure or service that he/she couldn’t interrupt.

29) Q: Is coding/billing the same for the LVRS pt who has a COPD dx code?

Answer: There is a separate Medicare policy for LVRS that includes pulmonary rehab and should be billed in accordance with that policy and the corresponding codes identified in that policy.

30) Q: Does the medical director have to be the same person every day?

Answer: That responsibility may be shared by more than one MD. Proactive documentation (before the fact) needs to take place and can take a number of forms. Can CORFs provide pulmonary rehab programs?
31) Q: Can CORFs provide pulmonary rehab programs?

Answer: No, as of January, 2010, CORFs may no longer provide pulmonary rehabilitation. The rationale for this is explained in the Federal Register, 2010 Physician Fee Schedule, published November 25, 2009, on page 61883. (You will find this document posted in the members-only Regulatory & Legislative Resources section of the AACVPR web site.)

32) Q: For an off-campus hospital satellite pulmonary rehab program, in order to comply with the physician supervision regulation, does the physician have to be in the dept or just in the building?

Answer: CMS does not refer to a specific location or a specific response time, other than “immediately available”. This is true for both on-campus and off-campus settings.

33) Q: Is a modifier “59” necessary when two pulmonary rehabilitation sessions are provided in one day?

Answer: No, it is NOT necessary to use modifier “59” when two pulmonary rehabilitation sessions (COPD diagnoses = procedure code G0424) are provided on a given day. CMS coding edits were put in place when the new G code was implemented in January, 2010 so that the modifier is not required for this new service. **Modifier -59 continue to be necessary for respiratory therapy/care services (non-COPD diagnoses for G0237, G0238, or G0239)**,
Contractors shall accept the inclusion of the KX modifier on the claim lines as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond the 36 sessions is medically necessary up to a total of 72 sessions for that beneficiary.