Designing a Comprehensive Pulmonary Rehabilitation Program

Janie Knipper

The 2017 AACVPR Program Planning Committee, PR Section, led by Janie Knipper, identified the need for a preconference workshop to meet the needs of people new to pulmonary rehab (PR), as well as those people developing new PR programs. The following people developed the workshop titled, Designing a Comprehensive Pulmonary Rehabilitation Program: Janie Knipper, RN, MA, AE-C, MAACVPR; Brian Carlin, MD, MAACVPR; Gerilynn Connor, BS, RRT, MAACVPR, FAARC; Kim Eppen, PT, PhD; Trina Limberg, BS, RRT, FAARC, MAACVPR. This report will review Janie Knipper's contribution to the workshop.

It is important for all staff working in a PR program to understand the difference between "pulmonary rehabilitation" and respiratory services, as defined by The Centers for Medicare and Medicaid Services (CMS). It is also important to know which patients can participate in each of these services; as well as how to bill appropriately for each service.

There are four resources that all PR programs should have readily available to staff as they attempt to understand the rules that guide the practice of PR. The first is the AACVPR *Guidelines for Pulmonary Rehabilitation Programs*. 4th ed. Champaign, IL: Human Kinetics; 2011. A new edition of this book should be available by fall of 2018. The second resource is the most recent Official ATS/ERS statement on pulmonary rehab: Spruit MA, Singh SJ, Garvey C, et.al. An official American Thoracic Society/European Respiratory Society statement: Key concepts and advances in pulmonary rehabilitation. *Am J Respir Crit Care Med* 2013; 188(8):e13-e64. This document contains a summary of the evidence-base for PR. There are two federal documents that you should have readily available as these provide the Medicare rules and regulations. The first of these is the *Federal Register*, Vol. 74, No. 226, Wednesday, November 25, 2009, Rules and Regulations. Section 144: Payment and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions-pulmonary rehabilitation services. The Federal Register (FR), is the daily newspaper of the Federal government, published every business day, and is tens of thousands pages long. It contains Federal Agency Regulations, proposed rules and public notices. The second federal document is the *Code of Federal Regulations* 410.47 Pulmonary rehabilitation program: Conditions for coverage. The **CFR** is the codification of the general and permanent rules and **regulations** published in the **Federal** Register by the executive departments and agencies of the **federal** government. *CFR* 410.47 provides definitions for the PR-related terms listed in in the FR. Both federal documents can be found on the AACVPR website or can be found by entering the titles into an internet search engine.

Comprehensive Outpatient Pulmonary Rehabilitation:

Federal Register Vol 74, No. 226 specifically states, "This rule implements the new Medicare standards for PR programs and establishes the requirements for furnishing such services to Medicare beneficiaries with COPD". The document goes on to say that COPD is "one of the more common and severely debilitating chronic respiratory diseases, exemplified by ***chronic bronchitis and emphysema***." There are a number of ICD-10 codes that relate to chronic bronchitis and emphysema. The following list includes the more general of those diagnoses. Within each of these diagnoses, there are more specific diagnoses:

- Bronchitis, not specified as acute or chronic: J40
- Simple chronic bronchitis: J41.0

- Mucopurulent chronic bronchitis: J41.1
- Mixed simple and mucopurulent chronic bronchitis: J41.8
- Unspecified chronic bronchitis: J42
- Chronic obstructive pulmonary disease, unspecified: J44.9
- Unilateral pulmonary emphysema: J43.0
- Panlobular emphysema: J43.1
- Centrilobular emphysema: J43.2
- Other emphysema: J43.8
- Emphysema, unspecified: J43.9

The Medicare definition of PR as written in the *FR*, Vol 74, No 226, page 61879, refers to comprehensive outpatient PR (OP PR):

"A PR program is typically a *multidisciplinary* program, *individually tailored* and *designed to optimize physical and social performance and autonomy* of care for patients with chronic respiratory impairment. The *main goal* is to empower and facilitate the individuals' ability *to exercise independently*. Exercise is combined with other training and support mechanisms to *encourage long-term adherence to the treatment plan*. The appropriate PR program will train and motivate the patient to attain his or her maximum potential in self-care and overall quality of life."

The *FR* goes on to say that PR requires a referral from a physician. A non-physician provider, i.e. Physician's Assistant or Nurse Practitioner, CANNOT independently order PR (or CR). This was recently verified by CMS. The patient must have a diagnosis of moderate to very severe COPD according to the GOLD (Global Initiative for Obstructive Lung Disease) criteria. The length of stay in OP PR is *individualized*, and depends on functional capacity, disease severity, and patient risk; and offers a comprehensive approach, including individualized, progressive exercise training, disease self-management training, counseling and behavior change options, and psychosocial support.

The CFR 410.47 provides definitions of the required components of PR:

- *Physician-prescribed exercise* – physical activity including aerobic exercise, prescribed & supervised by a physician
- *Education or training* – to the extent it is closely related to the patient's care and treatment, and tailored to patient's needs
- *Psychosocial assessment* - a ***written*** evaluation of an individual's mental & emotional functioning as it relates to the individual's rehabilitation or respiratory condition.
- *Outcomes assessment* – a ***written*** evaluation of the patient's progress as it relates to the individual's rehabilitation which includes, beginning & end evaluations, based on patient-centered outcomes; objective clinical measures of effectiveness of the PR program for the individual patient, including exercise performance & self-reported measures of shortness of breath and behavior.
- Treatment is furnished under a written (or electronic) treatment plan (the ITP), that is e***stablished, reviewed & signed by a physician*** involved in the patient's care and who has knowledge related to his/her condition. This can be the referring physician, primary care physician or the medical director; however the ITP **MUST** include the signature of the medical

director/supervising physician. The physician must review and sign the plan ***prior to*** the patient beginning the program, and ***every 30 calendar days*** thereafter. For the MD to be able to do this, he/she must have direct contact with the patient every 30 days.

- Comprehensive OP PR is limited to a **maximum** of two 1-hour sessions per day for **up to 36 sessions (lifetime limit).** Contractors ***may*** approve up to an additional 36 sessions **when medically necessary**. Additional sessions are ***NOT PRE-AUTHORIZED*** sessions! Medicare will audit the medical record after the service is provided to determine if they agree with medical necessity.

- PR exceeding 36 sessions ***must*** be billed with the KX Modifier, which indicates that requirements specified in the medical policy have been met. It is important to discuss the KX modifier with your billing office to ensure they understand the importance of using the KX Modifier with all sessions beginning with 37; and to determine who will add the Modifier – you or the billing office. PR services (for patients with traditional Medicare) that exceed 72 session will be denied! It is also important for either someone in the billing department, or someone working in PR to take responsibility for determining the number of Medicare lifetime sessions a patient has remaining. This is done by checking the HETS file (HIPAA Eligibility Transaction System). In MAC J5 this file is accessed through www.WPSGHA.com . The site is password protected. Your billing office should be able to obtain access for PR staff.

- Comprehensive OP PR is billed with **CPT Code - G0424:** Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session. The revenue code is 0948. Session duration must be as follows: One session = ≥ 31 minutes; and two sessions = ≥ 91 minutes, with the first session = 60 minutes and second session = 31 minutes. Each session **MUST** include exercise, but there is **no specified time of exercise.**

The CMS Manual System, Change Request 6823 clearly identifies all of the following as **cause for denial**:

- PR was provided in an appropriate or invalid place of service, i.e., in a CORF, rather than in a hospital outpatient department or a physician's office
- More than 2 units (sessions) were billed on the same date of service
- PR claims exceeded 36 sessions without a KX Modifier
- Claims exceed 72 sessions in the patient's Medicare lifetime
- Absence of physician direct patient contact prior to starting PR and every 30 days
- ITP lacks physician signature *prior to* initiating PR, and every 30 days thereafter

Respiratory Services:

The ***Federal Register*****, Vol. 74, No. 226, page 61882,** while providing the rules for "pulmonary rehabilitation", also states:

"Respiratory services previously allowed by local contractors for other medical conditions under other Part B benefit categories remain in effect." "Respiratory services . . . **Do not constitute a comprehensive PR program** but individualized services. To the extent these existing individual respiratory services are ***reasonable and necessary***, a local contractor may still cover them." This does *NOT* mean you have to have a Respiratory Therapist on your staff.

Most MACs, including J5, ***do not*** *have a list of "approved" medical diagnoses* for participation in Respiratory Services. Only those MACs with a local coverage decision (LCD) have a list of ICD-10 codes "that support medical necessity" for Respiratory Services. The AACVPR *Guidelines for Pulmonary Rehabilitation Programs* lists diagnoses "appropriate" for participation. When enrolling patients in a Respiratory Services program, PR staff should be certain the patient has a diagnosis of chronic respiratory disease other than COPD, and the patient must demonstrate medical necessity, such as, persistent symptoms despite medical therapy, functional limitations, quality of life impairment, and/or increased health care utilization, e.g. ED visits, hospitalizations.

It is important to note that *42 CFR 410.47 has* ***NO timeline for PFTs*** to be completed prior to enrollment in PR. Since there are NO rules in MAC J5 for Respiratory Services, there is also **NO timeline *for* PFTs** to be completed prior to enrollment in Respiratory Services. The PFTs must have been completed at some point in time to diagnose the chronic lung disease, but with no timeline as to how recent they must be.

The *Federal Register*, Vol. 66, No. 212, November 1, 2001 provided the definitions of the CPT codes to use for billing Respiratory Services:

- G0237: Respiratory therapeutic procedure to increase strength & endurance, each 15 minutes, includes monitoring. This is used when working with the patient one-on-one. Note: a 15 minute time unit is defined as 15 + or – 7 minutes, i.e., 8 minutes to 22 minutes (2 units = 23 minutes – 37 minutes, etc).
- G0238: Respiratory therapeutic procedure to improve respiratory function other than described by G0237, each 15 minutes, includes monitoring. This is used when working with the patient one-on-one. Note: a 15 minute time unit is defined as 15 + or – 7 minutes, i.e., 8 minutes to 22 minutes (2 units = 23 minutes – 37 minutes, etc).
- G0239: Respiratory therapeutic procedure, group (2 or more individuals) – billed once per session, includes monitoring. Do NOT bill this code more than once per day.

The Respiratory Services codes listed above must be medically necessary. Billing a patient with a one-on-one code without medical necessity is grounds for denial. Using a one-on-one code because you scheduled only one patient for a session, or because only one patient attended the session does not constitute medical necessity.

It is important that PR staff know prior to enrolling a patient, the rules of each patient's insurance provider. Insurance plans differ. Some require prior authorization, some do not. Some have session limits, some do not. To be safe, PR staff must obtain prior authorization for services (except traditional Medicare which does not provide prior authorization). The AACVPR MAC Liaison Task Force developed a prior authorization template for your use. The template can be found on the AACVPR Members Resources webpage.

In summary, it is crucial that PR staff know and understand Medicare rules for both Comprehensive Pulmonary Rehabilitation and Respiratory Services. We must use good clinical judgment when determining if a patient should participate in Pulmonary Rehab/Respiratory Services. We must establish a working relationship with our business/billing office to ensure we are kept informed of denials or audits, and so we all know who accepts responsibility for KX Modifier. We must provide excellent service, and bill ethically for each service.