Pulmonary Rehabilitation (PR):
Program and Payment Policy
Guidelines from the Medicare
Final Ruling Implemented January 2010

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Pulmonary Rehabilitation:
Prior to January 2010
PR was covered in states/regions that had LCDs:
Components of PR were individually billed:
   RT billed for RT services (usually G codes used)
   PT billed for PT services (97000 series used

Physician involvement, but no direct physician supervision

Many diagnoses covered including COPD, RLD, etc.

Problem existed in states/regions that did NOT have an LCD for PR.
Pulmonary Rehabilitation: 
Prior to January 2010

If no LCD for PR
  Most places billed PR program services as Physical Therapy (97000) and when other components available (RN, RT), used G codes for billing their component
  Most diagnoses were covered

Things Have Changed......
as of January 2010
Pulmonary Rehabilitation: Effective January 2010

Final Ruling for PR and CR published in late October 2009

These rules will lead to a NCD but this is NOT the NCD

These rules are in effect January 1, 2010

“Pulmonary Rehabilitation will be a Physician supervised program for patients with COPD” (other diagnoses may be added later).

PR: Who are the Patients Covered by the New Ruling?

• Gold Classification for moderate to severe COPD must have a \( \downarrow \) FEV1/FVC ratio less than 70% predicted AND
  – Moderate COPD: FEV1 50-80% predicted
  – Severe COPD: FEV1 30-50% predicted
  – Very Severe COPD: FEV1 less than 30% and or presence of respiratory failure or cor pulmonale

• DOES NOT affect any other pulmonary patient population.
  – All other patient populations are covered under LCDs for their MAC.
What is covered

ALL PR programs MUST HAVE THESE components:

Physician-prescribed exercise.

Education or training (definition: education and training is closely and clearly related to the individual’s care and treatment and is tailored to such individual’s needs).

Psychosocial assessment.

Outcomes assessment.

An individualized treatment plan (the plan must be established, reviewed, and signed by a physician every 30 days.)
Physician Prescribed Exercise

Defined as physical activity, including aerobic exercise
   Exercise conditioning
   Breathing retraining
   Step and strengthening exercises

Some aerobic exercise MUST be included in EACH PR session

Documentation MUST include physician signature on initial exercise prescription

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Physician Prescribed Exercise

The Pulmonary Medical Director must:
   REVIEW and SIGN the plan for PR PRIOR to the Initiation of PR
Education or Training

Should include:
  Information on the patient’s respiratory problem and management of problem
  Must assist in achievement of individual’s goals towards independence of ADLs
  Education can be provided in a group setting, but it must be individualized for each patient’s needs

Psychosocial

A written evaluation of the individuals’ mental and emotional functioning as it relates to the respiratory condition
  Should include an assessment of the individual’s family and home environment that affects rehabilitation
  Include a psychosocial evaluation of individual’s response to and rate of progress
  Tools are available on www.aacvpr.org website
Outcomes Assessment

A written evaluation of the patient’s progress as it relates to the individual’s rehabilitation including:

- Beginning and end evaluations
- Objective clinical measures of PR program including:
  - Exercise performance
  - Self reported measures of SOB and behavior
  - Quality of life measures are important

Individualized Treatment Plan

Must be established, reviewed and signed by a physician who is involved in the patient’s care and has knowledge related to his/her medical condition every 30 days.

- Should include patient’s diagnosis
- Should include the type, amount, frequency and duration of items and services
- Should include goals set for the individual
“My doctor told me to start my exercise program very gradually. Today I drove past a store that sells sweat pants.”

Where can PR be performed?

- Outpatient hospital
- Provider based department
  - Program can be out of hospital in hospital based satellite but MUST FOLLOW PHYSICIAN SUPERVISION guidelines: present in suite or building
- Physician office
- No other facilities at this time

CORF: should not call their program Pulmonary Rehabilitation, but rather advertise it as something else.
Physician Supervision in the Physician’s Office

• Physician supervision of the program is defined according to setting.

• For PR services furnished in physicians’ offices and other Part B settings this means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the physician must be in the same room when the service or procedure is performed.

Physician Supervision: Hospital Outpatient Setting

• Direct physician supervision means the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure.

• This does not mean that the physician must be present in the room when the procedure is performed.

• In addition, Nurse practitioners and/or PA’s may NOT cover sessions. It has to be a physician.
Who are Providers

RN
RT
EP
PT

Reimbursement and Billing

Starting in January, 1, 2010, there will be a bundled code: G0424 that is used for Pulmonary Rehabilitation for only COPD patients covered by this ruling. This is the only code that can be billed per hour of treatment (treatment time MUST include aerobic exercise in each hour that is billed). No separate charges can be made for 6 minute walk tests, or any other components. 2 hours of PR can be billed, but aerobic exercise must be included in each hour billed.

If an individual has any other diagnosis (pulmonary hypertension, interstitial lung disease, pulmonary fibrosis, sarcoïdosis, or any other lung disease other than COPD) billing will be as you currently have been doing under your LCD which is using the 97000 series and using separate billing for initial evaluations, six minute walk tests, etc and covered under the Medicare physical therapy benefit. Please keep in mind that we are still awaiting the final NCD policy that may add other conditions to the program, therefore, this provision is subject to change.
Physical Therapy and PR

PTs should be very careful when performing services outside of the delineated Medicare pulmonary rehabilitation program benefit as CMS has indicated that it is highly adverse to duplication of physical therapy services to patients participating in a pulmonary rehabilitation program.

The actual written statement from CMS says that when PT and Pulmonary Rehab are billed on the same day: CMS will be monitoring claims that have both the G0424 code and CPT 97000 series on the same day.

Therefore, should PTs evaluate and treat individuals with a diagnosis of COPD who are also participating in Pulmonary Rehabilitation, the documentation must explicitly explain the indication for physical therapy above and beyond the therapy received in the pulmonary rehabilitation program. Physical therapy services will be highly scrutinized and the documentation should be highly reflective of the medical necessity for physical therapy.
Other wording specific to Physical Therapy

“We expect that physical therapists could conduct assessments and individualized treatments as part of the PR, CR, or ICR program because physical therapists have the knowledge and skills to assist in addressing common problems that lead to physicians ordering PR, CR, or ICR services for their patients, including poor aerobic capacity, poor endurance, and shortness of breath, in the context of chronic pulmonary or cardiovascular disease. In the context of PR, while we also stated that individuals requiring PR services have a chronic respiratory disease and are in need of supervised aerobic exercise, not PT, we acknowledged that patients require assessments to address individualized needs and the provision of a mix of services necessary to address those needs (74 FR 33613).”

Other wording specific to Physical Therapy

“Therefore, we would expect that when physical therapists provide evaluations and individualized treatment services under a PR, CR, or ICR treatment plan, these services would be billed as PR, CR, or ICR services under the PR, CR, or ICR CPT or Level II HCPCS G-codes that apply. When these programs are provided in a physician office setting and the physical therapist serves as a member of a multidisciplinary team, the services may not be separately billed as therapy services or as services incident to physician services and they need not follow the requirements of those policies.”
**Additional CMS wording affecting Physical Therapy**

“There may be patients with therapy needs that are outside the treatment plan appropriate for PR, CR, or ICR and such patients should receive medically necessary PT services specific to those other needs under a PT plan of care and according to the policies for PT services. However, we would not expect it to be the norm that PT services and PR, CR, or ICR services are furnished to the same beneficiaries in the same day. Clearly, a single period of care can only be billed as one type of treatment service, so providers and suppliers could never bill both PT and PR, CR, or ICR services for the same time period for the same patient (for example, during an hour session from 10 to 11 a.m. on a single date of service).”

**Additional CMS wording affecting Physical Therapy**

“We plan to monitor claims data for PR, CR, and ICR services as well as any additional claims for therapy services. If we detect patterns of care that are inconsistent with our stated expectations for PR, CR, or ICR services and therapy services, we may encourage Medicare contractors to review cases in which a provider or supplier reports both types of services for the same patient during the same span of time (for example, over a several month period) or we may propose changes to our payment methodologies for these services.”
Pulmonary Rehabilitation for Patients with Diagnoses Other Than COPD

PR for patients with diagnoses other than COPD should be similar to PR for COPD EXCEPT FOR the billing:
- Billing should be as it was before January 2010.
- Billing should be per LCD for your MAC.
- If no LCD for PR, billing should be for Physical Therapy Services and other component should be billed as you were billing before.

CORFs

In the final rule, CMS reiterates that services provided in a CORF do not meet the definition of a PR program and are not covered as such. Therefore, the CORF may continue to cover physical therapy for patients with respiratory conditions under the Medicare PT benefit, including moderate to very severe COPD.
Other Physical Therapy Settings

For patients who are referred to physical therapy with a diagnosis of COPD and there are no available PR programs in a reasonable distance from the patient’s home, or there is an access issue regarding attending a PR program, the physical therapist should include this in their documentation to make a strong case for physical therapy services in lieu of attending pulmonary rehabilitation.

Documentation on initial evaluation should emphasize the medical necessity for patients seeing physical therapy who have a diagnosis of COPD.

Other Physical Therapy Settings

Documentation is critical

Utilize other diagnoses as primary and COPD diagnosis as secondary

Emphasize the other components of initial evaluation that demonstrates impairment and medical necessity for PT

Include other components that are found in PR (education, outcomes assessment, muscle strengthening, breathing exercises and retraining) and not just aerobic conditioning
Functional Impairments and Interventions in the Pulmonary Rehabilitation Population

Lung Function Impairment

Figure 4.8: Dyspnea spiral
Functional Impairments

Chronic illness and increased age are associated with functional impairments.

Older adults with COPD have both age-related and disease-related decline in pulmonary function and physical function.

Dyspnea is a major symptom of COPD, and progressive dyspnea is associated with a decline in physical function.

Decline in pulmonary and physical function often compromises one's ability to perform physical activities.

Decline in physical function can also affect individual's confidence or self-efficacy for performing physical activities.

Functional impairments have a strong effect on domestic activity (ADLs) and outdoor activities (leisure, community involvement, etc. (Morimoto))
Functional Impairments

- Posture Changes due to Breathing Patterns
- Flexibility impairments
- Skeletal Muscle Weakness
- Endurance changes in muscle
- Endurance changes in activity
- ADL impairments
- Assistive Device Requirements
- Anxiety/Depression

Skeletal Muscle Impairment

Skeletal muscles of patients with COPD are dysfunctional
- Poor capillarization
- Greater number of type II fibers
- Low muscle mass, especially in muscles of ambulation (Bernard 1998, Engelen 2000)

Skeletal Muscle Impairment

Strong association was elicited between TLM (total lower extremity muscle mass) and muscle strength (Reid KF J Nutr Health 2008) Lower extremity muscle mass is an important determinant of physical performance among functionally-limited elders.

Muscle weakness in old age, is associated with physical disability and an increased risk of falls.

Low body weight in COPD patients is associated with worsening dyspnea, reduced leg strength, and poor prognosis.

Classical rehabilitation strategies are then limited by reduced exercise tolerance. (Vivodtzev I Chest 2006)

Skeletal muscle impairment

Perception of leg effort/discomfort limits the exercise in 40-45% of patients with COPD (Casaburi 2001)

Skeletal muscle dysfunction characterized by:
- Reduction in muscle mass and strength
- Atrophy of slow twitch oxidative endurance muscle fibers
- Decrease in fiber capillarization
- Decrease in oxidative enzyme capacity
- In effect: decrease in muscle endurance
- Lactic acidosis at lower exercise workloads
Without PR...Life for a Pulmonary Patient is like a Roller Coaster Ride

Equipment for Pulmonary Physical Therapy

Track  
Treadmill  
Various stationary bicycles  
Oximeters  
Oxygen equipment  
Various strength training options
Pulmonary patient outcomes

Exercise capacity
Symptoms
Health Related Quality of Life
Specific to Physical Therapy

Pulmonary patient outcomes--
-Exercise capacity

Exercise capacity
  6 minute walk test
  Shuttle walk test
  Graded exercise test
Pulmonary patient outcomes -- Symptoms

Dyspnea and Fatigue
Visual analog scale
Borg scale
CRQ: Chronic Respiratory Disease Questionnaire
UCSD Shortness of Breath Questionnaire

Pulmonary patient outcomes -- Health Related Quality of Life

SF-36
CRQ: Chronic Respiratory Disease Questionnaire
SGRQ: St. George's Respiratory Questionnaire
Pulmonary patient outcomes—Physical Therapy specific

Muscle strength
Balance
TUG: Timed up and Go

Outcome Measurement

Assess Pre Program
Assess mid way through program
Assess at end of program
Document results and keep data on program results
Other Functional Testing

- Short Physical Performance Battery:
  - 3 performance measures scored from 0 to 4 points: Standing balance, Walk speed, Chair stand test
  - Mobility measurement using Timed Up and Go Tests
  - Upper limb activity: Grocery Shelving Tests
  - Rate own activity performance: Patient Specific Functional Scale
  - Lawton Instrumental ADL Scale

UCSD Shortness of Breath Questionnaire

- How short of breath do you get:
  - At rest
  - Walking on a level at your own pace
  - Walking on a level with others your age
  - Walking up a hill
  - Walking up stairs
  - While eating
  - Standing up from a chair
  - Brushing teeth
  - Shaving and/or brushing hair
  - Showering/bathing
  - Dressing
UCSD Shortness of Breath Questionnaire

- How short of breath do you get:
  - Dressing
  - Picking up and straightening up
  - Doing dishes
  - Sweeping/vacuuming
  - Making bed
  - Shopping
  - Doing laundry
  - Washing car
  - Mowing lawn
  - Watering lawn
  - Sexual activities

Functional Dyspnea Scale

- Functional Dyspnea Scale
  - 0 Not troubled with breathlessness except with strenuous exercise.
  - 1 Troubled by shortness of breath when hurrying on the level or walking up a slight hill.
  - 2 Walks slower than people of the same age on the level because of breathlessness or has to stop for breath when walking at own pace on the level.
  - 3 Stops for breath after walking about 100 meters or after a few minutes on the level.
  - 4 Too breathless to leave the house or breathless when dressing or undressing.

Most terminally ill patients have dyspnea at rest or on minimal exertion (functional scale level 4).

Modified Dyspnea Scale  (Breathing)

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<tr>
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</tr>
<tr>
<td>9</td>
<td>Very Severe</td>
</tr>
<tr>
<td>10</td>
<td>Maximum</td>
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**Depression Tools**

- Beck Depression Inventory
- Mood/depression questionnaire
- Center for Epidemiologic Studies Depression (CESD) Scale
BODE Index

Body mass index, airflow Obstruction, Dyspnea and Exercise Capacity Index

Includes the following:
FEV1.0 (% of predicted)
6 MWDistance
Dyspnea (0-4 scale describing level of activity that provokes dyspnea)
BMI

Used more for defining severity of disease and mortality

Point Values on the BODE Index

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</table>

*Modified Medical Research Council Scale describing level of activity that provokes dyspnea. Lower numbers = less dyspnea

Bode scores range 0-10 with higher numbers indicating >risk of death

Celli NEJM 2004;350(10):1005
Long Term Assessment

Benefits of Rehab may decrease over time following end of formal rehab program

Evidence indicates benefit to having maintenance program following PR
  - Follow up phone calls
  - Self care skills
  - Continuing education programs
  - Support: ongoing clinic

May identify individuals who would be candidates in re-enrollment

Final Words on Reimbursement
Reimbursement

G0424 should be used for PR for ALL COPD patients diagnosed as moderate, severe or very severe according to GOLD guidelines AND who are insured by MEDICARE.

All COPD patients NOT insured by Medicare should be billed as they were before.

All other pulmonary patients (RD, IPF, etc.) who are insured by MEDICARE should be billed as they were before (according to LCD for pulmonary rehabilitation in your MAC, or for physical therapy).

All other non COPD, non MEDICARE patients: verify coverage with each insurance company.

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Reimbursement

CMS states that up to 36 sessions (code G0424) would be allowed for services provided in connection with a PR program and decides that additional sessions may be appropriate in some circumstances. CMS authorizes the Medicare contractors to approve up to an additional 36 sessions when medically necessary. This means that beneficiaries may access as many as 72 sessions of PR when appropriate. CMS will allow up to two one hour sessions per day.
Reimbursement

G0424 payment in Outpatient Hospital Setting or Provider Based Setting (satellite): $50/hour

Time parameters for the “one hour” code is actually 31 minutes. Anything from 31-90 minutes is considered 1 hour.

>91 minutes is considered 2 hours, but documentation must demonstrate “Monitored exercise” was performed IN EACH HOUR of PR.

Reimbursement and Billing

All services are BUNDLED into this payment.

This means there are no additional codes permitted to be billed on same day for evaluation, 6 MWT, specific interventions, etc.
Reimbursement and Billing

G0424 payment in Physician Office:
$23.44/hour (assuming the 2009 Medicare conversion factor of $36.0660)
This is a BUNDLED code in the Physician Office as well and therefore no other services can be billed for rehabilitation or evaluation.

Recommendations

Set up PR program for all patients irrespective of diagnosis and treat all the same
Flag charts of COPD patients (moderate – very severe)
Bill G0424
Follow all rules for physician supervision, documentation, outcomes, etc.
All other patients bill the 97000 codes per LCD for PR or if no LCD for PR per LCD for PT
97001, 97110, 97150, and 6MWT code (94620
Make sure documentation reflects medical necessity
Recommendations

For outpatient physical therapy NOT hospital based
  If patient has COPD diagnosis, make sure referral is for PT and NOT PR
  Document medical necessity for seeing PT, and/or document lack of availability of PR.
  Confirm primary diagnosis, make sure documentation reflects diagnosis, and use COPD as secondary.

Food for Thought

Need for Evidence to show clinical indicators for PT need
Need clinical research to document need and benefit of PT for Pulmonary Rehab
AND ALWAYS REMEMBER:
Life is not measured by the number of breaths we take, but by the moments that take our breath away.