

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 124	Date: May 7, 2010
	Change Request 6823

SUBJECT: Pulmonary Rehabilitation (PR) Services

I. SUMMARY OF CHANGES: Effective January 1, 2010, for claims processed on or after October 4, 2010, contractors shall pay claims containing HCPCS code G0424 when billing for PR services, including exercise and monitoring, as described in Pub. 100-02, Chapter 15, § 231, Pub. 100-04, Chapter 32, § 140, and CR 6751, TR 1871, dated December 11, 2009.

EFFECTIVE DATE: January 1, 2010

IMPLEMENTATION DATE: October 4, 2010

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/revise 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.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	15/231/Pulmonary Rehabilitation (PR) Program Services Furnished on or After January 1, 2010

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

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

Attachment – Business Requirements

Pub. 100-02	Transmittal: 124	Date: May 7, 2010	Change Request: 6823
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SUBJECT: Pulmonary Rehabilitation (PR) Services

Effective Date: January 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: Pulmonary Rehabilitation (PR) is a multi-disciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy and an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities.

In September 2007, the Centers for Medicare and Medicaid Services (CMS), in its final decision memorandum for PR Services, announced there was no basis for a national coverage determination at that time. Specifically, this decision was based on a determination by CMS that the Social Security Act did not expressly define a comprehensive PR program as a Part B benefit, and the evidence was not adequate to draw conclusions on the benefit of the individual components of PR. CMS does, however, cover the respiratory services in the Comprehensive Outpatient Rehabilitation Facility regulation (42 CFR 410.100), as well as those services determined covered by local contractors who retain discretion to allow coverage of components of PR.

The Medicare Improvements for Providers and Patients Act of 2008 (MIPPA) added payment and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law provides a single PR program, which was codified in the Physician Fee Schedule final rule at 42 CFR 410.47.

B. Policy: Effective January 1, 2010, MIPPA provisions added a physician-supervised, comprehensive PR program which includes mandatory components: (1) physician-prescribed exercise, (2) education or training, (3) psychosocial assessment, (4) outcomes assessment, and (5) an individualized treatment plan. See the Benefit Policy Manual (BPM), Pub. 100-02, chapter 15, section 231, the Claims Processing Manual (CPM), Pub. 100-04, chapter 32, section 140, for detailed policy and claims processing instructions. As specified at 42 CFR 410.47(f), pulmonary rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if medically necessary. 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.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
		M A C	M A C				F I S S	M C S	V M S	C W F	
6823.1	Effective January 1, 2010, for claims processed on or	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	after October 4, 2010, contractors shall pay claims containing HCPCS code G0424 when billing for PR services, including exercise and monitoring, as described in Pub. 100-02, BPM, chapter 15, section 231, Pub. 100-04, CPM, chapter 32, section 140, and CR 6751, TR 1871, dated December 11, 2009.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6823.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Roya Lotfi, coverage, 410-786-4072, roya.lofti@cms.hhs.gov, Pat Brocato-Simons, coverage, 410-786-0261, patricia.brocato-simons@cms.hhs.gov, Michelle Atkinson, coverage, 410-

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Post-Implementation Contact(s): CMS ROs

VI. FUNDING

A. For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. 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.

231 - Pulmonary Rehabilitation (PR) Program Services Furnished On or After January 1, 2010

(Rev.124, Issued: 05-07-10, Effective: 01-01-10, Implementation: 10-04-10)

A pulmonary rehabilitation (PR) program is typically a physician-supervised, 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 the individuals' ability to exercise independently. Exercise is combined with other training and support mechanisms to encourage long-term adherence to the treatment plan. Effective January 1, 2010, Medicare Part B pays for PR programs and related items and services if specific criteria is 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:

PR Program Beneficiary Requirements:

As specified in 42 CFR 410.47, Medicare covers PR items and services for patients with moderate to very severe chronic obstructive pulmonary disease (COPD) (defined as GOLD classification II, III, and IV), when referred by the physician treating the chronic respiratory disease. Additional medical indications for coverage for PR program services may be established through the national coverage determination process.

PR Program Component Requirements:

- Physician-prescribed exercise. This physical activity includes techniques such as exercise conditioning, breathing retraining, and step and strengthening exercises. Some aerobic exercise must be included in each PR session. Both low- and high- intensity exercise is recommended to produce clinical benefits and a combination of endurance and strength training should be conducted at least twice per week.*
- Education or training. This should be closely and clearly related to the individual's care and treatment and tailored to the individual's needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling. Any education or training must assist in achievement of individual goals towards independence in activities of daily living, adaptation to limitations, and improved quality of life (QoL).*
- Psychosocial assessment. This assessment means a written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition. It should include: (1) an assessment of those aspects of the individual's family and home situation that affects the individual's rehabilitation treatment, and, (2) a psychological evaluation of the individual's response to, and rate of progress under, the treatment plan. Periodic re-evaluations are necessary to ensure the individual's psychosocial needs are being met.*
- Outcomes assessment. These should include: (1) beginning and end evaluations based on patient-centered outcomes, which are conducted by the physician at the start and end of the program, and, (2) objective clinical measures of the effectiveness of the PR program for the*

individual patient, including exercise performance and self-reported measures of shortness of breath, and behavior. The assessments should include clinical measures such as the 6-minute walk, weight, exercise performance, self-reported dyspnea, behavioral measures (supplemental oxygen use, smoking status,) and a QoL assessment.

- An individualized treatment plan describing the individual's diagnosis and detailing how components are utilized for each patient. The plan must be established, reviewed, and signed by a physician every 30 days. The plan may initially be developed by the referring physician or the PR physician. If the plan is developed by the referring physician who is not the PR physician, the PR physician must also review and sign the plan prior to initiation of the PR program. It is expected that the supervising physician would have initial, direct contact with the individual prior to subsequent treatment by ancillary personnel, and also have at least one direct contact in each 30-day period. The plan must have written specificity with regards to the type, amount, frequency, and duration of PR items and services furnished to the individual, and specify the appropriate mix of services for the patient's needs. It must include measurable and expected outcomes and estimated timetables to achieve these outcomes.*

As specified at 42 CFR 410.47(f), PR program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if medically necessary.

PR Program Setting Requirements:

PR items and services must be furnished in a physician's office or a hospital outpatient setting. The setting must have 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 a defibrillator) to treat chronic respiratory disease. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times that the PR items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26, and for hospital outpatient therapeutic services as specified at 42 CFR 410.27.

PR Program Physician Requirements:

Medicare Part B pays for PR services supervised by a physician only if the physician meets all of the following requirements: (1) expertise in the management of individuals with respiratory pathophysiology, (2) licensed to practice medicine in the state in which the PR program is offered, (3) responsible and accountable for the PR program, and, (4) involved substantially, in consultation with staff, in directing the progress of the individual in the PR program.

(See Publication 100-04, Claims Processing Manual, chapter 32, section 140.4, for specific claims processing, coding, and billing requirements for PR program services.)