Essential Requirements for Pulmonary Rehabilitation Programs

Janie Knipper, RN, MA, AE-C, FAACVPR
AACVPR MAC Liaison, J5 & J8
MSCVPR
March 25, 2017
jane-knipper@uiowa.edu
I have no disclosures.

Any opinions expressed are my own.
Objectives

- Attendees will understand the role of the AACVPR MAC Liaison Task Force and the MAC Resource Groups or MRGs.
- Attendees will be familiar with operational, billing, and coding rules in current Medicare regulations that contribute to a more efficient PR program paradigm.
- Attendees will be familiar with Medicare expectations for pulmonary rehabilitation documentation, including specific expectations of the J8 Medicare Contractor, Wisconsin Physician Services (WPS).
AACVPR MAC Liaison Task Force

**Purpose:** to develop, foster, & maintain a relationship with each MAC (Medicare Administrative Contractor) Medical Director(s)

**Goals:**

1. Provide a channel for two-way communication on all issues pertinent to cardiac/pulmonary rehabilitation (CR/PR) between providers of these services and the MAC
2. Serve as resource to MAC MD(s) to provide current evidence, best practice, clinical expertise and expert opinion on these services with both national and local input
3. Assist MAC in ensuring quality CR/PR services through on-going education of providers regarding MAC expectations/ regulations
4. Serve as resource to programs with regulatory questions/issues
Role of MAC Liaison for J8

- Work closely with the Task Force (TF) team on determining best strategies specific to each MAC
- Share progress & challenges with other TF members
- Form a MAC Resource Group or MRG
- Work closely with each state affiliate’s leadership for optimal functionality and productivity of this TF
MAC Resource Group - MRG

MRG members in MAC Jurisdiction 8:

Donna Donakowski (MI)
Phone: (248) 609-0122
Donna.donakowski@comcast.net

Susan Bauman (IN)
dbauman@netnitco.net

ROLE:

– Responsible for maintaining an effective communication process from AACVPR to CR/PR programs in the MAC
– Maintain strong collaboration between affiliates within a MAC for successful outcomes
2016 Goal – MAC Liaison:

- Meet face-to-face with MAC Medical Director(s)
- Goal met?
  - **No** – J5 MAC MD refused a face-to-face meeting; J8 MD, Ella Noel, has never returned attempts to communicate
  - Dr. Cheryl Ray – “All communication b/w providers and WPS must go through the Provider Outreach and Education Office or POE”
  - POE finally agreed to web-based call, but it would only include an RN from POE & representatives from claims department
  - June 2, 2016: Claims Department reps – no red flags seen in claims from J5, J8 CR & PR providers
Medicare Conditions for Coverage: Code of Federal Regulations

Pulmonary Rehab: 42 CFR 410.47

- The “provision” is 1.5 pages in length - broadly written intentionally

- MACs are allowed some degree of interpretation in compliance with these regulations
## GOLD Classification of COPD

<table>
<thead>
<tr>
<th>Stage</th>
<th>FEV$_1$/FVC</th>
<th>FEV$_1$</th>
</tr>
</thead>
<tbody>
<tr>
<td>I - Mild COPD</td>
<td>&lt; 0.70</td>
<td>FEV$_1$ $&gt;$80% predicted</td>
</tr>
<tr>
<td>II - Moderate COPD</td>
<td>&lt; 0.70</td>
<td>FEV$_1$ 50% - 79% predicted</td>
</tr>
<tr>
<td>III - Severe COPD</td>
<td>&lt; 0.70</td>
<td>FEV$_1$ 30% - 49%</td>
</tr>
<tr>
<td>IV - Very Severe COPD</td>
<td>&lt; 0.70</td>
<td>FEV$_1$ &lt;30% OR &lt;50% with signs of chronic respiratory failure</td>
</tr>
</tbody>
</table>

GOLD = Global Strategy for the Diagnosis, Management, and Prevention of COPD – GOLD Update 2017
Timeframe for PFTs prior to PR

42 CFR 410.47 – No timeline for PFTs

➤ WPS: “No timeline requirements to complete PFTs prior to starting a PR program, only that the GOLD classification requirements must be met.”

➤ WPS: “No regulation that state PFTs need to continue on a yearly basis.”

➤ WPS: “Will only cover services that are reasonable & necessary for the treatment of a patient at the time of service.

*If you have a policy that states otherwise, change it! It is not based on any regulations.
Billing for PR: Procedure Code G0424

- Patient must have some exercise every session.
  - Differs from CR regulation
- One session must be at least 31 minutes in duration.
- Two sessions must be at least 91 minutes in duration.
  - Not required to bill for two sessions if ≥ 91 min.
- KX modifier **MUST** be used for any PR sessions beyond 36 in patient’s Medicare lifetime.
  - This indicates to Medicare that additional documentation should be requested to determine medical necessity
  - **PR services exceeding 72 session will be denied!**
- No time limit to complete PR sessions.
- PR is not associated with an “event”
HIPAA Eligibility Transaction System (HETS)

HETS indicates the # of sessions of PR **remaining** for that patient’s lifetime, but indicates the # of CR sessions **used**:

<table>
<thead>
<tr>
<th>Pulmonary Rehab Sessions</th>
<th>Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>72</td>
</tr>
<tr>
<td>Technical</td>
<td>39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiac Rehab Sessions</th>
<th>Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>0</td>
</tr>
<tr>
<td>Technical</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensive Cardiac Rehab Sessions</th>
<th>Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>0</td>
</tr>
<tr>
<td>Technical</td>
<td>0</td>
</tr>
</tbody>
</table>
HIPAA Eligibility Transaction System

- PR sessions were **not tracked prior to 2010**
  - Any sessions completed prior to January 1, 2010 **do not count** as part of the PR 72 session limit
- HETS is **ONLY** for Medicare patients
- Private insurance companies may or may not have session limits; even so, they **DO NOT COUNT** toward the Medicare lifetime limit

**Access to HETS:**

- [www.wpsgha.com](http://www.wpsgha.com)
- Requires authorization for use
Physician Supervision

- 42.CFR 410.47: PR is a physician supervised program
  - A physician must be **physically immediately** available and accessible for medical emergencies at all times the program is being furnished
  - Supervising physician must at all times be **interruptible** to physically respond immediately
  - **Supervising physician does not have to be the medical director**

42.CFR 410.47
CMS Change Request 6823, May 7, 2010
CMS - Medical Direction

Medicare standards for this position:

1. Is responsible and accountable for the PRP and staff
2. Is involved substantially, in consultation with staff, in directing the progress of the individual in the program including direct patient contact related to the periodic review of his or her treatment plan
3. Has expertise in management of individuals with respiratory disease
4. Basic life support training
5. Is licensed to practice medicine in state where pulmonary rehabilitation program is offered.

42.CFR 410.47
Clarification from WPS – Documentation of Physician Supervision

- **WPS:** Daily physician supervision log/record “is acceptable”
- Log MUST accompany medical record documentation if audited

- **WPS 2016:** “Documentation of physician supervision should be somewhere in the patient’s medical record for each day of service”
Individualized Treatment Plan

The ITP is the only form of documentation discussed in the Medicare provision.

42 CFR 410.47(a)(i)
The ITP

Suggestion:

- If narratives (including education documentation) are included in *monthly summary (reassessment) in ITP*, auditor is guaranteed to find necessary narrative.
- If narratives are on another “form”, will an auditor find all required information?
- ITP is *the* documentation (other than MD order) an auditor may use to assess compliance.
Individualized Treatment Plan

ITP must include -

- “a description of the individual’s diagnosis”
- Pulmonary Rehab = GOLD moderate to very severe COPD
- Defined as chronic bronchitis and/or emphysema in Federal Register, November 25, 2009
- GOLD 2017: “COPD is caused by a mixture of small airways disease (e.g., obstructive bronchiolitis) and parenchymal destruction (emphysema)”

COPD Diagnoses with ICD-10 Codes

- 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
Requirements for ITP

42 CFR 410.47 – Medicare Provision for PR:

➢ Goals set for the individual under the plan
➢ Patient’s progress as it relates to the individual’s rehab
➢ Effectiveness of the PR program for the individual patient
➢ Written evaluation of an individual’s mental & emotional functioning as it relates to the individual’s rehab or respiratory condition
Requirements for ITP

- PR (and therefore the ITP) must consist of the following **mandatory** components:
  - Physician-prescribed exercise
  - Education or training related to each individual’s needs
  - Psychosocial assessment
  - Outcomes assessment
  - Individualized treatment plan (ITP)

42.CFR 410.47
CMS Change Request 6823, May 7, 2010
Physician Prescribed Exercise

- Exercise policy and procedure should specify the procedure for developing and modifying an individualized exercise prescription.

- The prescription as a dynamic blueprint to continuously monitor and record the patient's objective and subjective responses to the exercise therapy.

- While the supervising physician may not personally orchestrate each change in the exercise program, he or she will certainly rely on recorded data and observations based on the exercise sessions in his or her periodic reviews of the patient's progress.
Education/Training

42 CFR 410.47:

- Education or training **closely and clearly related to the individual’s care and treatment which is tailored to the individual’s needs**
- Any education or training prescribed **must assist in achievement of individual goals**
  - Does the ITP reflect evidenced-based care?
  - Does each intervention in the ITP play a role in helping the patient achieve their goals?
Education/Training Documentation

➢ Suggestion:

➢ *Brief* narratives
  – Check box is not sufficient
  – Copious narrative and repetitive data/documentation not required or necessary
  – CMS cares about the ITP; not so much about daily notes
    – Example of daily note: Pursed-lips breathing training provided – See ITP for detailed documentation
Psychosocial Assessment

42 CFR 410.47:

- Psychosocial evaluation of the individual’s response to and rate of progress under the ITP
- Written evaluation of psychosocial assessment
  - What does the score mean?
  - What is the plan for the patient based on score?
- Periodic re-evaluation, every 30 days vs beginning & end evaluations
Psychosocial Assessment

Additional assessment

- Anxiety, Panic
- Depression
- Perceived social isolation
- Perception of existing social support
- Transportation: self; significant other; public transportation; Medicaid-provided transportation; etc.
- Lives alone or with another adult
- Living situation: independent; assisted living; nursing home; stairs in home; bedroom located on ____ floor; bathroom located on ____ floor
Progress/Outcomes

42 CFR 410.47:

- ITP must include documentation of progression over 30-day period
- Objective clinical measures ... and self-reported measures of exertion and behavior
Progress

Psychosocial Reassessment - Progress Toward Goals:

- Psychosocial Reassessment Date: ***
  - Verbalizes/demonstrates management of anxiety:
  - Verbalizes/demonstrates management of depression:
  - PHQ-9 Depression score = ***
  - Attended appointment with social services:
  - Attended appointment with mental health counselor:
  - Attended appointment with MD for medication assistance:
  - Adherent with anti-anxiety medication:
  - Adherent with anti-depressant medication:
  - Patient is satisfied with current support system: ***
# Outcomes – in the ITP

<table>
<thead>
<tr>
<th>Outcome:</th>
<th>Pre</th>
<th>Mid</th>
<th>Post</th>
<th>F-U</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional Status/Exercise Capacity:</strong></td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Six Minute Walk Distance (meters)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6MW Distance - % change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quality of Life:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saint George’s Respiratory Questionnaire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychosocial:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Health Questionnaire - 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Symptoms:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mMRC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD Assessment Test (CAT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medicare Compliance: Clarification from WPS (J8MAC)

- Supervising physician must have initial, direct contact w/patient *prior to* subsequent treatment, and
- ITP must be signed *prior to* patient’s first exercise rehab treatment session

**WPS:** “The initial assessment is for evaluation, and should not be a treatment session as well”
Initial evaluation of the patient is completed

The individualized treatment plan is developed based on the assessment findings

Medical Director signs the ITP

Patient begins the PR Program - Session 1
“If the plan is developed by the referring physician or the PR physician... **PR physician must also review and sign the plan prior to initiation of the PR program.**”

-CMS Medicare Benefit Policy Pub 100-02, Transmittal 124
-Federal Register, Nov 25, 2009, pg 61883
Medicare Compliance
Clarification from WPS (J8MAC)

- Supervising physician must have at least one direct contact in each 30-day period.

- **WPS:** “If a patient is not present on the day the physician is present, it is necessary to reschedule the day for the direct contact within that 30 days”

**NOTE:** MD cannot bill for direct patient contact
Respiratory Services

For Chronic Lung disease other than COPD
Respiratory Services (non-COPD)

- J5, J8 MAC does **NOT** have a Local Coverage Decision (LCD) for Respiratory Services
- **WPS:** There is no plan to develop an LCD for Respiratory Services
  - No list of approved diagnoses
  - No PFT guidelines
Suggestion:

- Review PFTs for presence of chronic lung disease
- Does the patient have persistent symptoms despite medical therapy?
- Does the patient have functional limitations related to chronic lung disease symptoms?
- Does the patient perceive impaired quality of life?
- Has the patient had increased health care utilization?
Respiratory Services

- **G0237**: Respiratory therapeutic procedure to increase strength & endurance of the respiratory muscles, each 15 minutes, 1:1, includes monitoring
- **G0238**: Respiratory therapeutic procedure to improve respiratory function other than described by G0237, each 15 minutes, 1:1, includes monitoring
- **G0239**: Respiratory therapeutic procedure, group (2 or more individuals), includes monitoring – billed once per session
- Plus other pertinent services provided with Respiratory Services
  - **94664**: Initial Aerosol/Inhaler training – billed once per session

*Federal Register, Vol. 66, No. 212, November 1, 2001*
Medicare Compliance
Clarification from WPS (J8MAC)

Use of 1:1 codes, G0237 and G0238

- **WPS:** 1:1 supervision *must be medically necessary*, or indicated or it should not be billed to Medicare.
- **WPS:** The same is true with a group session or class – *if only one patient attends, this may not be billed as individual or 1:1 care unless medically necessary.*
Medicare Compliance
Clarification from WPS (J8MAC)

Can Nonphysician Providers (NPPs) independently order CR & PR?

- **WPS:** Nonphysician practitioners (NP, PA, CNS) are **NOT** allowed to **independently order** CR & PR services. There must be an MD co-signature on order/referral.
Medicare Advantage Plans, Private Insurance and State Medicaid Programs
Medicare Advantage

➢ Don’t necessarily follow Medicare rules
   ➢ A plan may or may not have a 72 session lifetime limit for PR
   ➢ Don’t track sessions in the HETS file – contact each plan directly

➢ Contact individual MA Plan to determine their rules
Private Insurance

- May or may not have session limits for PR
- May only pay for 1:1 services, not group
- *Must contact each insurance company for each patient*
State Medicaid Plans

- Often have session limits, e.g. 25 visits/year
- *May* only pay for 1:1 services
- *May* require prior authorization after an initial visit
- *Must contact the Plan regarding each patient*
Pre-Authorization for Services

- See Pre-Auth template in handout
- Also found on AACVPR MAC webpage
AACVPR PR Reimbursement Toolkit

https://www.aacvpr.org/Advocacy/Pulmonary-Rehabilitation-Toolkit
Why do we need the PR Reimbursement Toolkit?

➢ To guide us in working with our Chargemaster* people to create a charge that truly reflects all of the services we provide to patients with COPD.

*Chargemaster: a list of services a hospital offers & the charges associated with those services.
How to Get Started:

- Determine **what** your hospital is “charging” for PR services (G0424) AND how the hospital determined that charge.
  - Does the “charge” reflect what it should?
    - Does it reflect **EVERY** service you provide to patients with COPD?
      - You, the PR staff, know best what services you provide as part of the PR code!
  - If the charge does not reflect all services you provide, challenge the hospital’s calculations
    - Ask to see the UB-04 if needed, to see what is billed
Next step:

- Determine **who** is responsible for computing the charges for pulmonary rehab
  - Chief Financial Officer
  - Compliance Officer
  - Other
- Schedule an appointment & include your Department Director or Medical Director
Bring with you:

- List of components that should be considered in developing the charge
  1. Services you provide to patients with COPD
  2. Equipment required to provide the service
  3. Supplies required to provide the service
- Ask: **when** can the “charge master” be changed?
- Once agreed upon, confirm charges have been adjusted – UB-04 (standard Medicare form to process claims for outpatient services)
What services would you charge for if G0424 wasn’t bundled?
- **G0237**: Therapeutic procedures to increase strength and endurance of respiratory muscles
  - Breathing retraining, 1:1, each 15 minutes
  - Inspiratory muscle training, 1:1, each 15 minutes
  - Strength training that requires 1:1 supervision

- **G0238**: Therapeutic procedures to improve respiratory function, other than described by G0237
  - Pre- and post-activity vital signs
  - Energy conservation
  - Stair climbing
  - Dyspnea measurement and management

- **G0239**: Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, 2 or more individuals
  - Group energy conservation classes
  - Stair climbing
  - Exercise
Charge Code Examples

- **99406**: Tobacco cessation counseling: Intermediate, >3 minutes to 10 minutes
- **99407**: Tobacco cessation counseling: Intensive, > 10 min
- **82962**: Glucose, blood
- **94620**: Pulmonary Stress Test/Simple (6MWT)
- **94664**: Demonstration &/or evaluation of patient utilization of aerosol generator, nebulizer, MDI, DPI or IPPB device
- **94640**: MDI or nebulizer treatments
- **94667**: Manipulation of chest wall, i.e. chest PT, PEP device, Vest, etc.
- **94760, 94761**: Pulse oximetry
Charge Code Examples

- **98960**: Education/training for patient self-management, 1:1, ea 30 min
  - Prevention and management of exacerbations
  - Action plan
  - Disease self-management strategies
  - Management of panic, anxiety and depression
  - End of life planning
  - Control of airway irritants and allergens

- **98961**: Education and training for patient self-management, 2-4 patients, each 30 minutes

- **98962**: Education and training for patient self-management, 5-8 patients
- **99211-99215**: Evaluation & management for initial evaluation and development of ITP
- **97001**: PT evaluation
- **97003**: OT evaluation
- **97802**: Medical nutrition therapy, initial assessment & intervention, individual, each 15 min
- **97803**: Medical nutrition therapy, reassessment & intervention, individual, each 15 min
- **97804**: Medical nutrition therapy, reassessment and intervention, group, each 30 minutes
These codes were examples of the types of services offered in a typical Pulmonary Rehabilitation Program.

The intent was NOT to indicate the codes can be used in the current payment system.
Are you charging enough?

- Add up all the charges that you would realistically bill if you could
- Divide the totaled charges by the average number of sessions in your PR Program.

Example:
- All charges add up to $10,000/36 sessions = $277.78
- All charges add up to $10,000/24 sessions = $416.67
Consider the range of complexity of patients with COPD.

**Bottom Line:** Most PR programs provide service to groups of high risk patients with complex health problems. Is all you do worth only ~$54/session?
Questions?

Thank you!

jane-knipper@uiowa.edu