

Policy: MP230

Section: Medical Benefit Policy

Subject: Outpatient Pulmonary Rehabilitation

Applicable Lines of Business

Commercial	X	CHIP	X
Medicare	X	ACA	X
Medicaid	X		

I. Policy: Outpatient Pulmonary Rehabilitation

II. Purpose/Objective:

To provide a policy of coverage regarding Outpatient Pulmonary Rehabilitation

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

Maintenance Therapy - *Maintenance therapy* consists of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur.

Pulmonary Rehabilitation – Pulmonary Rehabilitation (PR) is an evidence-based, multidisciplinary and comprehensive intervention for members with chronic respiratory diseases who are symptomatic and have decreased daily activities. The goal of PR is to:

- Restore the patient to the highest possible level of independent function
- Educate the patient and significant others about the disease, treatment options and coping strategies
- Encourage patients to be actively involved in providing for their own healthcare and to be more independent in activities of daily living (ADL).

INDICATIONS:

Coverage for outpatient pulmonary rehabilitation will be approved up to 36 visits per benefit period. If coverage for pulmonary rehabilitation is available, the following conditions of coverage apply.

The Plan covers a comprehensive, individualized program of outpatient pulmonary rehabilitation as medically necessary for members with a documented diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD), either emphysema or chronic bronchitis, or other chronic pulmonary diseases that meet the following criteria. Pulmonary rehabilitation is considered *medically necessary* when **ALL** of the following exist:

- Activities of daily living (ADL) are currently limited by breathing difficulty
- Moderate to severe lung function impairment by pulmonary function tests: FEV1 at values 25-60% of prediction
- No other medical/psychological limitations (e.g. congestive heart failure, substance abuse, significant liver dysfunction, metastatic cancer, disabling stroke, dementia, organic brain syndrome)
- The members has stopped smoking for a minimum of 3 months (if applicable) prior to the requested therapy
- Stable on medical therapy (e.g. routine care under physician, compliance with medications and prescribed treatments)

Outpatient pulmonary rehabilitation as preoperative conditioning component for individuals that are candidates for lung volume reduction surgery or lung transplantation is considered *medically necessary*.

Pulmonary rehabilitation programs are considered medically necessary following lung transplantation.

Spirometric Classification of Severity of Chronic Obstructive Pulmonary Disease (Global Initiative for Chronic Obstructive Lung Disease [GOLD], 2006)

Stage	Characteristics	Effect on Health Related Quality of Life
At Risk	<i>Normal</i> Chronic symptoms (cough, sputum) Exposure to risk factor(s) Normal spirometry	Minimal
I: Mild	FEV ₁ /FVC < 70% predicted FEV ₁ > 80% predicted With or without symptoms	Patient may not be aware that lung function is abnormal
IIA: Moderate	FEV ₁ /FVC < 70% predicted FEV ₁ 79%-50% predicted With or without symptoms	Patients typically seek medical attention

IIB: Moderate	FEV ₁ /FVC <70% predicted FEV ₁ 49% - 30% predicted With or without symptoms	Patients typically seek medical attention
III: Severe	FEV ₁ /FVC <70% predicted FEV ₁ <30% predicted and/or FEV ₁ <50% plus chronic respiratory failure or right heart failure	Quality of life is appreciably impaired

Evaluation and Treatment

Pulmonary Rehabilitation program typically consists of 1-2 hour visits that are provided 2-5 times per week for approximately 6- 12 weeks, with most programs lasting 6-8 weeks. If measurable improvement in functional ability is not demonstrated within the first 4-6 visits or 1-2 weeks, the clinical appropriateness and utility of the program should be re-evaluated.

The written plan of care should be available upon request of the Plan, and sufficient to determine the medical necessity of the treatment and include the following;

1. The diagnosis including the date of onset or exacerbation of the disorder/diagnosis;
 - a. Initial evaluation;
 - b. Detailed and specific long-term and short-term goals;
 - c. Reasonable estimate of goal completion;
 - d. Specific treatment techniques or exercises to be utilized in treatment;
 - e. Measurement of exercise conditioning based on oxygen saturation and exercise prescription
 - f. Use of symptom scale to rate dyspnea and fatigue
 - g. Functional capacity assessment to evaluate patient's exercise tolerance, hypoxemia, and use of supplemental oxygen
 - h. Outcome measures in each of clinical, behavioral and health domains such as but not limited to lower extremity exercise training, dyspnea, health-related quality of life (HRQOL), and psychosocial outcomes
 - i. Expected frequency and duration of treatment.
2. Signature of the members attending physician and therapist

The algorithms, clinical and consensus based guidelines will be reviewed by the Medical Management Team on an annual basis. Any changes to the guidelines will be based on peer-reviewed, published medical evidence or the consensus of the Medical Management Team.

EXCLUSIONS:

Outpatient pulmonary rehabilitation for the treatment of other conditions, including but not limited to, asthma, cystic fibrosis, bronchopneumonia, dysplasia or simple shortness of breath is considered **experimental, investigational and unproven** and **NOT COVERED**.

Coverage for outpatient pulmonary rehabilitation in the presence of any of the following co morbidities or complications is not considered medically necessary or contraindicated (list may not be all-inclusive):

- Active infection
- Acute cor pulmonale
- Exacerbation of intercurrent illness
- Hospice
- Recent myocardial infarction
- Severe pulmonary hypertension
- Significant hepatic dysfunction
- Uncontrolled hypertension
- Unstable angina
- Unstable cardiovascular condition

Therapy services will be denied if the practitioner does not meet state practice guidelines as licensed nurses, respiratory therapist, physical therapist, occupational therapist, or speech/language pathologist.under written order of a pulmonary physician. Services provided by other non-licensed, non-physician staff are **NOT COVERED**.

Multiple courses of pulmonary rehabilitation are considered **not medically necessary** either as maintenance therapy in patients who initially respond, or in patients who fail to respond or whose response to an initial rehabilitation program has diminished over time.

Once therapeutic benefit has been reached, or a home program can be utilized for further gains, continued supervised therapy is not considered medically necessary.

- (**exception:** within the Medicaid business segment coverage to maintain a current level of function will be considered for coverage if found to be medically necessary)

Therapy in members who are asymptomatic or without any documented clinical condition is considered not medically necessary.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Outpatient Pulmonary Rehabilitation

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

- 94625 Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)
- 94626 Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)
- G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)
- G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, face to face, one on one, each 15 minutes (includes monitoring)
- G0239 Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)
- G0302 Pre-operative pulmonary surgery services for preparation for LVRS, complete course of services, to include a minimum of 16 days service.
- G0303 Pre-operative pulmonary surgery services for preparation for LVRS, 10 to 15 days of service
- G0304 Pre-operative pulmonary surgery services for preparation for LVRS, 1 to 9 days of service
- G0305 Post-discharge pulmonary surgery services after for LVRS, minimum of 6 days of services
- G0424 Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to 2 session per day
- S9473 Pulmonary rehabilitation program, non-physician provider, per diem

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 12/2009

Revised: 11/22 (add post-transplant indication)

Reviewed: 12/10, 12/11, 12/12, 12/13, 12/14, 12/15, 12/16 (member language), 11/17, 11/18, 11/19, 11/20, 11/21, 11/23, 11/24

CMS UM Oversight Committee Approval: 12/23, 12/24

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

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