

Pulmonary Rehabilitation: Billing & Coding Medicare Guidelines

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- I have no financial disclosures.

Resources

AACVPR Website: Under “Advocacy”

- Medicare Administrative Contractors
- Regulatory & Legislative Information
- Health Policy & Reimbursement Discussions
- Reimbursement Updates
- Pulmonary Rehab Toolkit—guide to calculating appropriate charges for G0424
- Pulmonary Rehab FAQs

AACVPR Webinar: Regulatory Update: 2016 Coverage & Payment Rules Effective 1/1/16, November 19, 2015

Medicare Improvements for Patients and Providers Act of 2008: established coverage for pulmonary rehab.

Medicare Provision for Pulmonary Rehab:

“Medicare Part B covers pulmonary rehabilitation services for beneficiary who have a diagnosis of Moderate to Very Severe COPD as defined by the GOLD Classification” (for dates of service on or after January 1, 2010.)

Components of PR Program

Physician –prescribed exercise

- Type (mode)
- Amount (intensity)
- Frequency
- Duration
- Progression
- Appropriate for the individual patient

Education and Training

- Tailored to the individual's needs, including information on respiratory management and if appropriate, smoking cessation
- Should be documented on the ITP

Psychosocial Assessment

- Requires a written evaluation as it relates to an individual patient
- Periodic reevaluations are necessary to ensure the individual's needs are being met
- Can use recognized tool for depression screening, but must include physician's plan of action based on the results

Outcomes Assessment

- Show the interventions / services did or did not result in some benefit to the patient
- Goal-based
- If goal not met, what modifications were made to address the failure

Individualized Treatment Plan

- Most important!
- Must be developed by a physician (in conjunction / consultation with the rehab staff)
- Whether the initial PR ITP is developed by the referring physician or the PR medical director, the medical director must review and sign the plan prior to subsequent treatment in the PR program
- Must include:
 - description of the individual's diagnosis
 - type, amount, frequency, and duration of the services furnished
 - goals set for the individual under the plan
- Must be signed and dated every 30 days by the physician

APC Payment Methodology

APC: Ambulatory Payment Classification

- Each APC includes similar services
- Based on information provided by hospitals to CMS
 - Administrative costs from hospital cost report, filed annually
 - Charges identified on every claim submitted to CMS

Billing Codes

COPD vs. Non-COPD

- Medicare beneficiaries with COPD are billed through G0424
- Medicare beneficiaries with other primary diagnoses are billed through G0237, G0238, G0239
- So, patients receiving virtually the same services are billed differently, based on the diagnosis

What is COPD?

Medicare requires that a patient meet the COPD GOLD stages II-IV criteria to be eligible for Medicare coverage of pulmonary rehabilitation (use of G0424).

FEV₁/FVC ratio is the criteria for COPD diagnosis. This ratio must be < 0.70.

FEV₁ identifies the severity of COPD.

GOLD 1: Mild $FEV_1 \geq 80\%$ predicted

GOLD 2: Moderate FEV_1 50-79% predicted

GOLD 3: Severe FEV_1 30-49% predicted

GOLD 4: Very Severe $FEV_1 < 30\%$ predicted

This is based on post-bronchodilator FEV_1 . If a post bronchodilator value is absent (simple spirometry or only pre-bronchodilator values), the patient can still meet CMS requirements for pulmonary rehab.

Note that mild COPD is not covered.

Respiratory Services Codes

G0237: “Therapeutic procedures to increase strength and endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes.”

Example: Breathing retraining or inspiratory muscle training on select patients who would benefit. The training is performed between one staff person and one patient in a face-to-face situation.

G0238: “Therapeutic procedures to improve respiratory function, other than ones described by G0237, one-on-one, face-to-face, per 15 minutes.”

Example: Teaching patients strategies for performing tasks with less respiratory effort including ADLs, airway clearance strategies, stair climbing, or other activities to improve functional capacity.

G0239: “Therapeutic procedures to improve respiratory function, two or more patients treated during the same period, face-to-face.”

Example: Group exercise

Not a timed code; it is billed once per day only.

Payment Rates 2016

Procedure Code	APC	Payment Rate	Co-pay
G0424	5733	\$55.94	\$11.19
G0237	5734	\$91.18	\$18.24
G0238	5733	\$55.94	\$11.19
G0239	5732	\$30.51	\$ 6.11

All of the above codes are recognized as packaged codes. Other related services are not separately billable.

Why is reimbursement so low?

- There are flaws comparing bundled and unbundled codes
- Hospitals have under-reported the cost of providing pulmonary rehab services (low charges on Medicare claims data)
- Fix: Use the Pulmonary Rehab Toolkit to guide you and your hospital through an accurate review of the “charges” associated with pulmonary rehab (G0424)

Medicare's Goal

- Transition from Fee-for-Service (FFS) to Value-Based Purchasing
- FFS model rewards volume
- Look for models that:
 - reduce spending without reducing quality
 - or
 - improve patient care without boosting spending

Legislative Update

S. 488 and HR 3355

- Allows non physician practitioners to supervise pulmonary rehab programs
(not synonymous with medical direction)
- Supervision is presumed to be met when services are provided in a hospital
- Physician supervision is a non reimbursable service
- DOTH March 23-24, 2016 Washington DC

FAQs

- What is the lifetime limit for PR?

The number of sessions is based on medical necessity, up to 36 per “course” with a lifetime limit of 72 sessions.
(The count started 1/1/10.)

- When is the KX modifier used?

The KX modifier is used with the G0424 code whenever the patient exceeds 36 sessions. It applies to Medicare and Medicare managed claims, but not commercial insurance.

KX is used for a patient who has documented medical necessity for PR beyond the initial 36 sessions.

- What is the minimum number of minutes for a session to be billed to Medicare?

A session must be at least 31 minutes in duration to be billed. If 2 sessions are provided in one day, the first session would be the first 60 minutes and the second session would need to be at least 31 minutes.

Exercise must be provided in every session.

- Can COPD patients and non-COPD patients be combined in the PR program?

Yes, but adhere to the differences in coding and billing. The non COPD patients are technically receiving respiratory therapy services with G0237-G0239 codes.

- Can we bill separately for smoking cessation?

No; this is considered part of a comprehensive pulmonary rehab program. There are 2 CPT codes available for physicians that are outside the services of a PR program.

- Can we bill separately for a 6-minute walk?

No; it is not separately billable if provided in PR.

- Can we charge for the initial assessment if we do a 6-minute walk?

Yes, the 6-minute walk is the exercise component. Other requirements must be met: physician supervision, at least 31 minutes.

- What are PFT requirements for non-COPD?

This would come from the MAC (Cigna for OH and KY), in the form of an LCD. Some programs use FVC, FEV1, DLCO < 65%, from an old LCD prior to 2010.

- What about those new ICD-10 codes?

J44.9 for COPD (chronic bronchitis, emphysema, and some forms of chronic obstructive asthma that meet PFT requirements)

- How do we know how many sessions a patient has already done?

CMS has transitioned from a Common Working File system to a system titled, HIPAA Eligibility Transaction System (HETS).

Consult business or billing office for details on the new process.

- The medical director is required to have “direct patient contact” in each 30 day period. What does this mean?
A brief conversation between the physician and patient (“eyeballing the patient”) would meet the requirement, as well as the medical director attending the education session and interacting with the patients.

- What is the difference between medical direction and physician supervision?

Medical Director: required, can be a shared responsibility; responsible for supervising the program and staff and is involved substantially in directing the progress of individuals in the program, in consultation with the staff.

Supervising Physician: required, must be physically immediately available and accessible for medical emergencies at all times the program is being furnished. Must be “interruptible” to physically respond immediately. In a hospital, can be a physician-run code team or emergency department physician.

These do not have to be the same physician!

- Who can sign the ITP?

The initial one must be signed by the medical director.

Subsequently, the ITP can be signed by the medical director or physician (referring doctor) who is knowledgeable of the patient and involved in his/her care.

- Is a modifier -59 required when billing 2 sessions on the same day?

No, not necessary for G0424, or a combination of respiratory care services, G0237-G0239. Remember that G0239 can only be charged once daily.

- Good grief; this is a lot of information and I still have questions!

Rich Sukeena: serves on the AACVPR MAC Task Force representing J-15. You can email him with specific issues related to the CGS regulations related to PR.

Richard.Sukeena@UHhospitals.org

Also use the AACVPR website!

OIG Audit of Hospital Cardiac and Pulmonary Rehab Program in New Jersey:

Deficiencies were found and refunds from the hospital to the Federal Government were sought by the OIG.

- All-inclusive ITP: only documentation that auditors recognized during the audit
- Physician prescribed exercise: type, amount, frequency, and duration appropriate for the individual patient
- ITP must be signed and dated every 30 days by the physician
- Psychosocial assessment requires written evaluation as it relates to an individual patient
- Education and counseling should be documented on the ITP
- ITP must include a description of the individual's diagnosis, type, amount, frequency, and duration of the services furnished, and goals set for the individual

AACVPR's Response:

It is time to create an inclusive ITP that succinctly and adequately documents essential information and eliminate what is not critical to patient progress or communication.

AACVPR is committed to doing this over the next months. AACVPR is working with CMS for guidance and expectations on the Federal and local MAC level.

It will be a process to determine what is critical to include in the one inclusive form we are required to have. AACVPR will continue discussions with CMS for further helpful clarification.

Come to the OACVPR Meeting!
April 4 & 5, 2016
Hilton Polaris
Columbus, Ohio

Break Out sessions Monday evening include both a cardiac and pulmonary track.

Roundtable discussions include cardiac, pulmonary and management.

Great speakers, nationally known, from both cardiac and pulmonary areas.

OACVPR.net for program and registration