Pulmonary Rehabilitation in the Physician Office Setting

On July 15, 2008 President Bush signed the Medicare Improvements for Patients and Providers Act (MIPPA) into law. Section 144 of this legislation included, for the first time, Pulmonary Rehabilitation as a specific benefit category under Part B of Medicare. In November of 2009 CMS issued final rules with an effective date of January 1, 2010.

The new program included two delivery venues, Hospital Outpatient Department and Physician Offices. A new CPT code, G0424 was created to describe each one hour session of the new service. A total of 36 sessions are allowed (72 at Contractor discretion). The new rules are somewhat limiting, in that coverage only applies to COPD patients and some previously covered venues where not included in the new coverage rules. (Some medically necessary benefits, albeit not “Pulmonary Rehab”, may still be covered in these cases.)

Pulmonary rehab is now recognized as a standard treatment protocol for most patients with COPD. A well designed program in a physician’s office can be profitable, as well as offer a valuable service for patients with Moderate to very severe COPD. While most programs are located in hospital outpatient departments, there can be many advantages (both clinical and financial) to programs within physician offices. Clinically, the advantages include improved patient compliance and attendance rates, physician oversight and availability, and access to care. Financially, the physician office has lower overhead costs, supervising physician accessibility.

According to the Medicare claims manual, Medicare covers pulmonary rehabilitation items and services for patients with moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease. Pulmonary rehabilitation programs must include the following components:

- Physician-prescribed exercise. Some aerobic exercise must be included in each pulmonary rehabilitation session;
- Education or training closely and clearly related to the individual’s care and treatment which is tailored to the individual’s needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling;
- Psychosocial assessment;
- Outcomes assessment; and,
- An individualized treatment plan detailing how components are utilized for each patient.

Pulmonary rehabilitation items and services must be furnished in a physician’s office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time 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.

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.

The following is the applicable HCPCS code for pulmonary rehabilitation services:
G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 2 1-hour sessions per day. In order to report one session of pulmonary rehabilitation services in a day, the duration of treatment must be at least 31 minutes. Two sessions of pulmonary rehabilitation services may only be reported in the same day if the duration of treatment is at least 91 minutes. In other words, the first session would account for 60 minutes and the second session would account for at least 31 minutes, if two sessions are reported. If several shorter periods of pulmonary rehabilitation services are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.
The new PR Program is (for now) limited to Moderate to Very Severe COPD. CMS intends to use the NCD process to expand coverage as scientific evidence demonstrates appropriateness. “The NCD process will enable us to evaluate the medical and scientific evidence to properly ascertain the specific conditions, and appropriate patients for whom a PR program is most beneficial. However, in the interim, until the NCD process is complete, the respiratory services previously allowed by local contractors for other medical conditions under other part B benefit categories remain in effect.

So, is the program right for your office? Here are some things to consider.

Is it a good fit for your practice? Do you have expertise in the management of individuals with respiratory pathophysiology? This is a requirement of the new rules. “the physician has expertise in the management of individuals with respiratory pathophysiology and is licensed by the State in which the PR program is offered” Do you have a sufficient eligible population of COPD patients? Feasibility requires volume.

Do you have adequate space? The amount of space necessary depends on the size and scope of the program. While the rules do not specify space requirements, it is essential the space is functional. One should plan on at least 300 square feet as the minimum for a small program, and more space for larger groups.

What hours is there a physician present in your office? Rules require direct supervision of rehab staff, meaning the “physician must be present in the suite of offices and immediately available to furnish assistance and direction throughout the performance of the service or procedure”.

Do you have the necessary staff? According to CMS “The disciplinary team/PR staff play an important role under the direction of the physician. These team members may include, but are not limited to, nurses, social workers, respiratory therapists, and dietitians.

Keep in mind that MIPPA created a new benefit category, a comprehensive Pulmonary Rehabilitation Program. This is different from the way services have been covered in the past.

By Greg Shockey, President of Lung Centers of America

Lung Centers of America has created one and two day seminars titled Lung Center University to provide in-depth information on clinical, administrative and financial aspects on running a pulmonary rehabilitation program under the new guidelines. The course includes a reference manual with a reprint of the rules published in the federal register and other official guidance. You can find the upcoming schedule of seminars at www.lungrehab.com.