



**OUTPATIENT PULMONARY
REHABILITATION
HS-076**



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**Outpatient Pulmonary
Rehabilitation**

Policy Number: HS-076

Original Effective Date: 1/12/2009

**Revised Date(s): 1/29/2010; 1/21/2011;
8/11/2011**

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

BACKGROUND

COPD is an obstructive lung condition characterized by chronic dyspnea, or shortness of breath, and by expiratory airflow limitation that does not significantly fluctuate. COPD encompasses chronic bronchitis and emphysema; additionally, patients with chronic asthma, cystic fibrosis, bronchiectasis, and bronchiolitis may suffer from chronic airflow obstruction. In the United States, the overall prevalence of COPD in adult, white populations is 4% to 6% in men and 1% to 3% in women, with a rate of 10% to 15% in persons older than 55. In the age group 55 to 74, COPD ranked third in men and fourth in women as a cause of death. Cigarette smoking is considered to be the single most important risk factor in the development of COPD, and, although overall rates of smoking are decreasing, morbidity and mortality from COPD continues to increase due to the long latency period before clinical disease occurs. Shortness of breath, or dyspnea, is the most disabling symptom for patients afflicted with COPD. Dyspnea can create a viscous cycle, where the patient avoids physical activity due to the discomfort, frustration, and panic brought on by dyspnea, which leads to further deconditioning, which increase dyspnea upon future exertion. The net result can be substantial disability and restriction of activity. Spirometry is used to quantify disease severity, and the forced expiratory volume in 1 second (FEV₁) is the most widely used parameter in the diagnosis and treatment of COPD. Although disagreement exists over the exact cutoff scores, FEV₁ results are used to determine the stage of severity of COPD and to assign the patient to the appropriate intensity of rehabilitation.

Pulmonary rehabilitation (PR) has been designed to engage the COPD patient in a multidisciplinary program that strives to increase endurance and tolerance of physical exertion, provide nutritional and lifestyle counseling, assist the patient in quitting smoking, and improve the psychological well-being and quality of life of the patient. Exercise training is considered critical since exercise tolerance is believed to generalize into a greater ability to perform activities of daily living. To accomplish these aims, PR programs are divided into two components, an exercise training component and an educational, counseling, and behavioral component. PR can take place in an inpatient setting or home environment, but outpatient-based programs have been the most widely used and evaluated. Although PR is used in patients with chronic pulmonary diseases other than COPD, the majority of studies involve COPD patients; therefore, this technology will focus on the use of PR for these patients.

Smoking cessation is the single most important intervention to affect outcome of COPD at all stages of the disease. Patients with mild to moderate COPD should have the implications of their continued smoking explained to them. Those continuing to smoke are certain to lose FEV₁ at an accelerated rate that cannot be prevented by drug therapy, and worsening disability is likely. Smoking cessation is just as important in severe stages of COPD as at earlier stages. Although lost function cannot be restored, those who stop smoking will deteriorate more slowly and have a better chance of benefiting from treatment. Cessation of smoking should be a general rule for PR programs.

There is substantial evidence from randomized controlled trials that PR programs are safe and effective in increasing the capacity and tolerance for physical exertion and in enhancing the quality of life in medically stable patients with COPD who do not have severe psychiatric or comorbid medical disease. Long-term follow-up indicates that many of the gains remain intact up to one year later (from Hayes, 2002).

POSITION STATEMENT

Outpatient pulmonary rehabilitation **is considered medically necessary** if ALL of the following criteria are met:

- Member has a diagnosis stable Chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disease that is under optimal medical management; **AND,**
- Pulmonary Function Tests (PFTs) reveal Forced Vital Capacity (FVC), Forced Expiratory Volume in one second (FEV₁), or diffusing capacity of the lungs for carbon monoxide (DLCO) (uncorrected by volume) less than 65% of the predicted normal within one year prior to initiating rehabilitation; **AND,**

- Member exhibits disabling symptoms that significantly impair level of functioning and ability to perform activities of daily living; **AND**,
- Expectation of measurable improvement in a reasonable and predictable time frame; **AND**,
- Member is physically able, motivated and willing to participate; including non-smoking or participation in a smoking cessation program with no smoking for at least three months.

Outpatient pulmonary rehabilitation **is considered NOT medically necessary** and NOT a covered benefit for:

- Services to a member who would be expected to spontaneously return to prior level of function without skilled therapeutic intervention; **OR**,
- Services for maintenance of a chronic baseline condition of functional level; **OR**,
- Members with acute and/or unstable disease; **OR**,
- Members incapable of participating in rehabilitation due to mental or physical limitations; **OR**,
- Members where documentation does not support measurable benefit; **OR**,
- Members who are unable or unwilling to use training; **OR**,
- Members who continue to smoke and refuse a smoking cessation program.

Outpatient pulmonary rehabilitation services are defined as those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of members with deficiencies and abnormalities of pulmonary function.

Outpatient pulmonary rehabilitation generally occurs for a period of four to six hours per week for eight to twelve weeks. Services over twelve weeks must receive authorization as a skilled service. Discontinuation of services is expected to be based on reaching maximum benefit and is not based on length of rehabilitation.

CODING

Non-Covered CPT® Code

94799 Unlisted Pulmonary service or procedure when billed for Pulmonary Rehabilitation

ICD-9-CM Procedure Code

93.99 Rehabilitation, not elsewhere classified

HCPCS Level II Codes

G0424 Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to 2 sessions per day

S9473* Pulmonary rehabilitation program, non-physician provider, per diem

*NON COVERED FOR MEDICARE – Refer to HCPCS Level II Temporary National Codes

HCPCS Level II Modifiers

GA Signed ABN is on file.

GZ Signed ABN is on file

KX Requirements specified in the medical policy have been met

Covered ICD-9-CM Diagnosis Codes This list may not be all inclusive

277.02 Cystic fibrosis with pulmonary manifestations

491.0 Simple Chronic Bronchitis

491.1 Chronic Recurrent Bronchitis, mucopurulent

491.20 Obstructive chronic bronchitis without exacerbation

491.8 Other Obstructive chronic bronchitis; chronic bronchiolitis; tracheitis; tracheobronchitis

492.0 Emphysematous Bleb

492.8 Other Emphysema, Lung or Pulmonary; Obstructive, NOS

493.20	Chronic Obstructive Asthma, unspecified; Asthma with COPD
494.0	Bronchiectasis without acute exacerbation
496	Chronic airway obstruction, not elsewhere classified
748.61	Congenital bronchiectasis

*Current Procedural Terminology (CPT®) ©2011 American Medical Association: Chicago, IL.

REFERENCES

Peer Reviewed

1. Hayes Directory, Pulmonary Rehabilitation. Archived 2008. April 29, 2002.

Government Agencies, Professional and Medical Organizations

1. American College of Physicians, Clinical guideline, Diagnosis and management of stable chronic obstructive pulmonary disease. November, 2007.
2. American Thoracic Society and European Respiratory Society. Standards for the Diagnosis and Management of Patients with COPD, 2004.
3. American Thoracic Society/European Respiratory Society Statement on Pulmonary Rehabilitation, November, 2005.
4. Centers for Medicare and Medicaid Services (CMS), National Coverage Determination (NCD). Pulmonary Rehabilitative Services (240.8).
5. Centers for Medicare and Medicaid Services (CMS) Pub 100-04 Medicare Claims Processing, Transmittal 1966, Pulmonary Rehabilitation (PR) Services; Dated: May 7, 2010; Implementation Date October 4, 2010.
6. Institute for Clinical Systems Improvement (ICSI). Chronic Obstructive Pulmonary Disease. January, 2007.
7. Joint ACCP/AACVPR Evidence-Based Clinical Practice Guidelines, 2007.
8. Local Coverage Determination (L5738), Centers for Medicare and Medicaid Services. Pulmonary Rehabilitation Services.
9. National Collaborating Centre for Chronic Conditions. COPD, National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care. February, 2004.

HISTORY AND REVISIONS

Date	Action
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
8/11/2011	<ul style="list-style-type: none">• Approved by MPC.• Deleted sentence on p. 2 – “The member must have a clinical condition or diagnosis of acute illness, injury or impairment requiring therapy services;”• Added statement on p. 2 (bottom) – “Therapy is covered for Georgia Medicaid members age 21 and older only when requested immediately following and in treatment of an acute illness, injury or impairment.”• OH specific item (p. 3) re: Physical Performance Test or measurement and Functional Capacity Evaluations to establish disability. Added two new reference items.