Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

Special Issue

First Update to the 2002 Medicare Physician Fee Schedule Database

Also:

- Effective date for HCPCS Code Q3017
- ICD-9-CM Diagnosis Coding for Noncovered Investigational/Experimental Procedures
- Local Medical Review Policy for Pulmonary Rehab
- New Modifiers for Use in Billing for Hospice Patients

Changes included in this first update to the 2002 Medicare Physician Fee Schedule Database (MPFSDB) are outlined below. All changes in this special issue are **effective for services furnished on or after January 1, 2002, processed on or after April 1, 2002, *except where otherwise noted***. For an explanation of procedure code status and other MPFSDB indicators, please refer to the November 2001 *Medicare B Update!* special issue, entitled *"2002 Healthcare Common Procedure Coding System and Medicare Physician Fee Schedule Database Update"* (pages 8-12).

Code	Indicator Revised
A0380**	Procedure Status = I
A0390**	Procedure Status = I
J7193	Procedure Status = X
J7195	Procedure Status = X
J7198	Procedure Status = X
10021	PC/TC = 0
10021 TC	Procedure Status = H
10021 26	Procedure Status = H
10022	PC/TC = 0
10022 TC	Procedure Status = H
10022 26	Procedure Status = H
17004	Multiple Procedure = 0
34800	Assistant Surgery = 2
34802	Assistant Surgery = 2
34804	Assistant Surgery = 2
34808	Assistant Surgery = 2
34812	Assistant Surgery = 2
34813	Assistant Surgery = 2
34820	Assistant Surgery = 2
34825	Assistant Surgery = 2
34826	Assistant Surgery = 2
76085 TC	Global Surgery = ZZZ
76390	Procedure Status = N
76390 26	Procedure Status = N
76390 TC	Procedure Status = N
90887	Procedure Status = N
92597	Procedure Status = I
92598	Procedure Status = I
93613	Global Surgery = ZZZ
93613	PC/TC = 0
93613 TC	Procedure Status = H
93613 26	Procedure Status = H
93662 TC	Global Surgery = ZZZ
95824 26	Global Surgery = XXX
96000	Bilateral Surgery = 2
96001	Bilateral Surgery = 2
96002	Bilateral Surgery = 2
96003	Bilateral Surgery = 2
96004	Bilateral Surgery = 2
96567	PC/TC = 5
99375	Procedure Status = I
99378	Procedure Status = I

Continued inside...

The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Issues published beginning in 1997 are available at no cost from our provider Web site, **www.floridamedicare.com.**

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other _____

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS, INC. A CMS Contracted Carrier & Intermediary

Professional and technical components are established for *CPT* code 93025 (previously, this was a global-only service). MPFSDB indicators are as follows; allowances for the new components are included in the table at the end of this article.

93025
Proc Stat: A
Global: XXX
Pre-Op: 0.00
Intra-Op: 0.00
Post-Op: 0.00
PC/TC: 1
Mult Surg: 0
Bilt Surg: 0
Asst Surg: 0
Co Surg: 0
Team Surg: 0
Diag Supv: 02

93025-TC,
Proc Stat: A
Global: XXX
Pre-Op: 0.00
Intra-Op: 0.00
Post-Op: 0.00
PC/TC: 1
Mult Surg: 0
Bilt Surg: 0
Asst Surg: 0
Co Surg: 0
Team Surg: 0
Diag Supv: 02

93025-26
Proc Stat: A
Global: XXX
Pre-Op: 0.00
Intra-Op: 0.00
Post-Op: 0.00
PC/TC: 1
Mult Surg: 9
Bilt Surg: 9
Asst Surg: 9
Co Surg: 9
Team Surg: 9
Diag Supv: 02

Effective April 1, 2002, three *CPT* codes are now covered for ambulatory blood pressure monitoring. MPFSDB indicators for these codes are as follows; allowances are included in the table at the end of this article. For information concerning coverage of ambulatory blood pressure monitoring, please refer to the Second Quarter 2002 *Medicare B Update!* (pages 17-18). These services remain noncovered for services provided prior to April 1, 2002.

93784
Proc Stat: A
Global: XXX
Pre-Op: 0.00
Intra-Op: 0.00
Post-Op: 0.00
PC/TC: 4
Mult Surg: 0
Bilt Surg: 0
Asst Surg: 0
Co Surg: 0
Team Surg: 0
Diag Supv: 01

93786
Proc Stat: A
Global: XXX
Pre-Op: 0.00
Intra-Op: 0.00
Post-Op: 0.00
PC/TC: 3
Mult Surg: 0
Bilt Surg: 0
Asst Surg: 0
Co Surg: 0
Team Surg: 0
Diag Supv: 01

93790
Proc Stat: A
Global: XXX
Pre-Op: 0.00
Intra-Op: 0.00
Post-Op: 0.00
PC/TC: 2
Mult Surg: 0
Bilt Surg: 0
Asst Surg: 0
Co Surg: 0
Team Surg: 0
Diag Supv: 09

Finally, new allowances have been established for the following *CPT* codes:

	PAR			NONPAR			LIMITING CHARGE		
CODE	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
36533	735.51	790.39	824.48	698.73	750.87	783.26	803.54	863.50	900.74
36533*	330.61	354.08	373.59	314.08	336.38	354.91	361.19	386.83	408.15
92136	89.04	96.08	100.51	84.59	91.28	95.48	97.28	104.97	109.81
92136 TC	28.42	29.73	30.66	27.00	28.24	29.13	31.05	32.48	33.50
92136 26	60.62	66.35	69.85	57.59	63.03	66.36	66.23	72.49	76.31
93025 TC	254.44	274.41	285.53	241.72	260.69	271.25	277.98	299.79	311.94
93025 26	38.34	40.19	41.57	36.42	38.18	39.49	41.89	43.91	45.42
95250	216.09	234.22	243.96	205.29	222.51	231.76	236.08	255.89	266.53
95824 26	41.16	44.34	46.16	39.10	42.12	43.85	44.97	48.44	50.43
95903	32.31	34.95	36.33	30.69	33.20	34.51	35.30	38.18	39.69
95903 TC	8.86	9.39	9.83	8.42	8.92	9.34	9.68	10.26	10.74
93784**	103.88	111.97	115.92	98.69	106.37	110.12	113.49	122.33	126.64
93786**	50.75	54.20	56.55	48.21	51.49	53.72	55.44	59.21	61.78
93790**	19.41	21.26	22.39	18.44	20.20	21.27	21.21	23.23	24.46
97601	40.37	43.22	45.26	38.35	41.06	43.00	44.10	47.22	49.45

* These amounts apply when service is performed in a facility setting.
** Effective for services performed on or after April 1, 2002.

Source: CMS Transmittal AB-02-018, CR 2036

Effective Date for HCPCS Code Q3017

Implementation of the ambulance fee schedule was projected for January 1, 2002. In anticipation of that date, the 2002 HCPCS listed code Q3017 (Ambulance service, advanced life support [ALS] assessment, no other ALS service provided) with an effective date of January 1, 2002. However, because the ambulance fee schedule final regulation has not been published, implementation of the fee schedule is delayed until at least April 1, 2002. Therefore, **the effective date for Q3017 is April 1, 2002**, to coincide with the start of the transition to the ambulance fee schedule.

Because it will not be an active Medicare code until April 1, 2002, contractors will deny claims for Q3017 with a date of service after January 1, 2002.

Source: CMS Transmittal AB-02-016, CR 2014

Billing for Noncovered Investigational/Experimental Services

Information concerning billing of noncovered services was provided in the Second Quarter 2002 *Medicare B Update!* (pages 7-8). Because the beneficiary is liable for investigational or experimental services, Florida Medicare has since established a method by which these services may be differentiated from other noncovered services.

Effective for services performed on or after January 1, 2002, processed on or after April 22, 2002: A service for which a specific *CPT*/HCPCS code exists but is performed for an investigational or experimental indication must be billed with the appropriate *CPT*/HCPCS code, modifier GA or GZ, and **ICD-9-CM diagnosis code 796.4** (other abnormal clinical findings). ICD-9-CM diagnosis code 796.4 should be entered in the *detail diagnosis* section of the claim.

Note: Billing ICD-9-CM code 796.4 will result in denial of the associated service. Do not use ICD-9-CM code 796.4 diagnosis code for any *potentially* covered service.

LOCAL MEDICAL REVIEW POLICY

Pulmonary Rehabilitation Services in Chronic Respiratory Disease

Revision Overview: Multiple revisions were made to the policy; therefore, notice and comment was required. Complete deletion of existing 94799 Pulmonary Rehabilitation Services Policy

Policy Number
PulmRehab

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Pulmonary Rehabilitation Services in Chronic Respiratory Disease

AMA *CPT* Copyright Statement

CMS National Coverage Policy
- Section 1862(a)(1)(A) of Title XVIII of the Social Security Act. This section excludes expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Section 1833(e) of Title XVIII of the Social Security Act. This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.
- CMS Publication 6, Medicare Coverage Issues Manual, Section 80-1 addresses patient education programs.
- CMS Transmittal No. AB-00-39, May 1, 2000, consolidates CMS Program Memoranda for outpatient rehabilitation therapy services.
- CMS Transmittal No. AB-98-14 (April 1998) addresses The National Institute of Health's National Emphysema Treatment Trial (NETT).

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
04/20/1998

Original Policy Ending Date
N/A

Revision Effective Date
04/22/2002

Revision Ending Date
04/21/2002

LMRP Description
Introduction

Patients with diagnosed Chronic Respiratory Diseases have a progressive increase in the mechanical work of breathing and limited respiratory reserve capacities. These factors may lead to symptoms of chronic dyspnea on exertion, wheezing, chronic cough, and debilitating functional disabilities, which limit exercise and Activities of Daily Living (ADLs) due to chronic respiratory inflammation, edema, mucous plugging, hypoxemia, carbon dioxide retention, pulmonary hypertension, or cor pulmonale. Services to ameliorate these symptoms, improve functional capacity and enhance the effective management of pulmonary diseases may be provided through a physician directed, individualized plan of care using multidisciplinary qualified heath professionals.

The goal of these services is not to achieve a maximum exercise tolerance, but to ultimately transfer the responsibility of treatment from the clinic, hospital, or doctor to self care in the home by the patient, the patient's family, or the patient's caregiver. Unless the patient will be able to conduct ongoing self care at home, there will be only a temporary benefit. The endpoint of treatment, therefore, is not when the patient achieves maximal exercise tolerance or stabilizes, but when the patient or his or her caregiver is able to continue the treatment modalities at home. Treatment is individualized and supervised by the patient's attending physician (referring physician or facility Medical Director). Medicare does not cover services of a maintenance exercise program where a skilled therapist's services are not medically necessary.

Pulmonary Rehabilitation (PR) services incorporate the following:
1. Assessment by the physician and multidisciplinary qualified health professionals.
2. Development of an individualized treatment program (Plan of Care).
3. Therapeutic exercise and activities including breathing retraining.
4. Bronchial hygiene and aerosol medications.
5. Activities of Daily Living (ADLs) training.
6. Clinical monitoring of the patient's pulmonary functioning during rehabilitation services.

Purpose
The three primary objectives of PR services are:
1. To control, reduce, and alleviate the symptoms and pathophysiologic complications of chronic pulmonary diseases,
2. To train the patient how to reach the highest possible level of independent functioning for his/her Activities of Daily Living (ADLs) within the limitations of the pulmonary disease, and
3. To train the patient to self-manage his/her daily activities consistent with the functional impairments of his/her pulmonary disease process.

Indications and Limitations of Coverage and/or Medical Necessity

Indications for Pulmonary Rehabilitation Services:
Services must be reasonable and medically necessary. Patients who require PR treatment must meet all of the following criteria:
1. Diagnosis of a chronic, yet not acutely decompensated, respiratory system impairment that is under optimal medical management. (See "ICD-9-CM Codes That Support Medical Necessity")
2. Pulmonary Function Tests (PFTs) revealing DLCO, FVC or FEV1 <60% within one year of initiating PR services. If symptoms due to pulmonary disease are very disabling and significantly impair the patient's level of functioning, other objective evidence of impaired pulmonary physiology may be allowed on an individual consideration basis;
3. Exhibit symptoms such as breathlessness or fatigue that produce significant disability or handicap, as defined by the ATS Position Statement, 1999. Disability may include significant limitation of social activities, leisure, employment, home chores, or basic or instrumental activities of daily living or loss of personal independence;
4. Expectation of measurable improvement in a reasonable and predictable timeframe; and
5. Be physically able, motivated and willing to participate in PR.

Coverage of Services
PR services are defined as those services that are medically necessary for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of pulmonary function. **After the initial assessment is performed, treatments are usually administered three or more days a week. Such services are generally medically necessary for a period of six to ten weeks.**

A treatment program addressing pulmonary rehabilitative services generally occurs once in a lifetime. It is recognized that some patients, because of an exacerbation or new complications (e.g., disease worsening, beginning use of supplemental oxygen, chronic hypercapnia, respiratory failure, use of oxygen at night or non-invasive ventilation, etc.), may benefit from additional therapeutic encounters. Medical record documentation must support the need for the additional PR sessions.

All PR services must meet the following criteria:
1. Be ordered by a physician.
2. Qualify as a covered service.
3. Be reasonable and necessary for the diagnosis and/or treatment of a pulmonary illness listed below.
4. Be consistent with the nature and severity of the individual's symptoms and diagnosis.
5. Be reasonable in terms of procedure/modality, amount, frequency and duration and part of an individualized physician directed Plan of Care.
6. Be generally accepted by the professional community as being a safe and effective treatment for the purpose used.
7. Be of a level of complexity, or the patient's condition must be such, that the services can be rendered only by a skilled clinician.
8. Be delivered by qualified health professionals in accordance with state and federal regulations.
9. Patient training may occur in groups of four conducted by a qualified health professional or groups of six if an assistant is also present.
10. Not exceed the patient's particular PR needs.
11. Promote recovery, restore function, and ensure safety affected by illness or injury.
12. Have an expectation that there will be measurable improvement of the patient's condition in a reasonable and generally predictable period of time, and
13. Demonstrate practical improvement as evidenced by increased exercise tolerance, improved Activities of Daily Living (ADLs), and decreased symptoms (e.g., cough, dyspnea, wheezing).

Physician Orders
A licensed physician, who has training and experience in the treatment of patients with pulmonary disease will order, supervise, guide, and direct each patient's PR plan of care. All treatment orders for PR therapies must include the following:
1. Be specific as to the type, frequency, and duration of the procedure, modality, or activity and individualized for the patient.
2. Verbal and telephone orders must be co-signed and dated by the physician prior to billing the claim.
3. A blanket pulmonary rehabilitation (PR) order is not acceptable.

The patient's attending physician (referring physician or facility Medical Director) will attest to the following prior to the initiation of PR services:

1. That a physical examination performed within the last 90 days indicates that the patient is **capable** of participating in the plan of care.
2. That the patient is **willing** to cooperate and participate in the plan of care.
3. That the patient has quit smoking or will participate in smoking cessation activities prior to or during the course of PR services.

Typical Components of Pulmonary Rehabilitation Services

PR services use a physician-directed multidisciplinary approach with Respiratory Therapists (RTs), Registered Nurses (RNs), Physical Therapists (PTs), Occupational Therapists (OTs), and other qualified personnel, and may include any combination of these services. A duplication of services occurs when there is a direct overlap of services, or where a single discipline can provide the care. When there is an order for the same treatment modality or procedure for multiple clinicians (e.g., therapeutic exercise, breathing retraining), each clinician is expected to provide skilled treatment that reflects his or her unique skills and knowledge without exceeding the patient's skilled care needs. The treatment is directed toward each clinician's patient-specific goals. This is critical to establish that the services provided by various disciplines are reasonable, necessary, and distinct from each other. Frequency, duration, goals, and measurable objectives of each service provided are to be clearly documented.

The primary components of PR services typically include the following:

1. **Assessment/Reassessment (*CPT* codes 97001, 97002, 97003, or 97004). An initial evaluation by rehabilitation personnel is required.** Components of this assessment include the patient history, relevant review of systems, pertinent physical assessment and tests/measurements and the reason for the initial referral.

   It will also include determination of functional limitations, assessment of strength, flexibility, posture, and gait, and determination of the initial intensity for exercise training. This should include a history and physical examination by a physical/occupational therapist. An assessment, determination of goals, and therapeutic prescription for strength, flexibility, posture, and gait should be completed. Only one initial evaluation for PR will be reimbursed per patient. Re-evaluations are covered only if the documentation shows significant change in the patient's condition that supports the need to perform a formal re-evaluation of the patient's status.

   Routine screening and evaluations during admission to care, and routine re-evaluations are not covered.

2. **Education/Instruction (*CPT* code 97535)**. Education and instruction are key components of training the patient for independent, or modified, self-care and to maximize his or her rehabilitation potential. The patient, and his or her family or caretakers, should have a basic understanding of the specific therapeutic interventions they will be asked to follow. Patient education and instruction must:
   - be individualized to the patient's specific medical needs as identified in the initial assessment(s);
   - be part of the therapy treatment session;
   - be reasonable and necessary for the treatment and effective management of the patient's illness; and
   - not exceed the patient's need.

   For example, while it is recognized that general pathology of respiratory illnesses may be of interest to patients, such generalized knowledge is not essential to the effective management of a patient's particular condition, and would be considered excessive. However, when education is directed to the patient specific respiratory illness, education about the illness may be necessary to help the patient understand the medical need for compliance with his or her medications and treatment program including compensatory breathing techniques. Individualized instruction and training in the proper and effective use of bronchial hygiene therapy, effective coughing techniques, oxygen therapy, aerosol medications, and respiratory care equipment are frequently components of the rehabilitation process. Clinicians must document the patient's carry over of education, instruction, and training into his or her daily activities.

   In order to be covered by Medicare, patient education services must be rendered via direct, one-on-one contact with the clinician. For example, viewing of films or videotapes, listening to audiotapes, and completing interactive computer programs do not qualify as covered PR services. Likewise, group sessions that only offer generalized (i.e., non-individualized) education and training are not covered.

3. **Therapeutic Procedures to Improve Respiratory Function (HCPCS codes G0238 and G0239)**. An individualized physical conditioning and exercise program using proper breathing techniques, and a home functional maintenance program (FMP), should be considered for any patient with exercise limitations

   The objectives of exercise training are to: 1) advance the intensity and duration of exercise as tolerated by the patient and 2) assure the patient's understanding of the nature and role of continued life-long exercise. Clinicians must clearly document the rationale for continued skilled intervention for any exercise program. Routine exercise, or any exercise, without a documented need for skilled care, is not covered.

4. **Bronchial Hygiene/Aerosol Medications (*CPT* codes 94640, 94664, 94665, 94667, and 94668)**. These diagnostic and therapeutic procedures are not routinely rendered to all patients receiving PR services. Documentation in the medical record must support the medical necessity for the individual services for the particular patient receiving these services.

5. **Therapeutic Procedures to Increase Strength or Endurance of Respiratory Muscles (HCPCS code G0237)**. When problems with strength or endurance of respiratory muscles are identified in the initial assessment, an individualized program of exercise and ADLs (using compensatory techniques, breathing retraining, and energy conservation) may be reasonable and necessary. Breathing retraining, energy conservation, and relaxation techniques are often used. Inspiratory muscle resistance training (IMT) may be considered reasonable and necessary in a very select population of pulmonary patients who demonstrate significantly decreased respiratory strength and who remain symptomatic despite optimal therapy.

6. **Psychological Services**. Psychological services are not routinely reasonable or necessary; the research to date does not support the benefits of short-term psychological interventions for PR therapy patients. Medically necessary psychological services of physicians, clinical psychologists, clinical nurse specialists, advanced registered nurse practitioners, and licensed clinical social workers are billed to the carrier.

Plan of Care

An individualized plan of treatment is developed for each patient based on the identified problems. All treatment orders for PR services must be specific as to the type, frequency, and duration of activity. The treatment orders must specify which clinicians will render the services that are unique to their area of expertise. The treatment plan must be reasonable and directed at achieving specific goals established for each patient. Specific goals must be individualized to each patient's specific needs and capabilities, stated in objective, measurable, functional terms, and developed mutually by the patient and clinical team. Clinicians should specify the time frame, or target date for achievement, for both short-term and long-term goals. The discharge plan is an integral part of the plan of care. The discharge plan is addressed from the start of care. An important part of the discharge plan is a post-discharge functional maintenance program (FMP) that the clinicians develop for the patient during the course of PR services.

Discharge Criteria and Follow-Up

A patient should be discharged from PR services when the documentation shows any of the following:

1. The PR treatment goals are achieved or the patient has reached maximum medical benefit;
2. There is minimal or no potential for further significant progress;
3. The patient is non-compliant with the established plan of care; and/or
4. The patient no longer requires skilled PR services (See "Coverage of Services").

If the patient's condition changes, new components of PR treatment may be ordered for the patient. If new components are repetitive of prior services rendered, documentation must support the need for such additional service. Under the Medicare Program, it is not considered reasonable or necessary for clinicians to routinely screen patients for a potential need for skilled services.

CPT/HCPCS Section & Benefit Category

Medicine/Pulmonary/Physical Medicine and Rehabilitation

CPT/HCPCS Codes

94010	94668	97004
94060	94760	97535
94640	94761	G0237
94664	97001	G0238
94665	97002	G0239*
94667	97003	

* G0239 is to be billed only once per day.

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

The following are acceptable medical diagnoses for patients receiving PR services:

135	501	516.0
277.00	502	516.2
491.0-491.8	503	516.3
492.8	504	516.8
493.00-493.92	505	518.89
494.0-494.1	506.4	519.00-519.9
496	508.1	V42.6
500	515	

This policy does **not** apply to those individuals in the National Institute of Health National Emphysema Treatment Trial (NETT). Those individuals are covered under NETT.

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed above does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in the policy.

Diagnoses that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denials

When pulmonary rehabilitation services are performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Pulmonary rehabilitation services will be denied for:

1. PR services to a patient who would be expected to spontaneously return to his or her prior level of function without skilled therapeutic intervention.
2. Services for maintenance of a chronic baseline condition or functional level.
3. Patients with acute and/or unstable disease.
4. Patients incapable of participating in PR due to mental or physical limitations.
5. Patients where documentation does not support measurable benefit.
6. Patients who are unable or unwilling to use training.
7. Patients who continue to smoke and refuse a smoking cessation program.

Non-Covered Services

1. Non-individualized (i.e., generalized) treatment, education and training.
2. Routine psychological screening and/or routine psychological therapy.
3. Duplication of services between occupational therapists, physical therapists, respiratory therapists, and/or registered nurses.
4. Treatment that exceeds the patient's needs for the identified condition.

5. Routine, non-skilled and/or maintenance care, such as:
   - repetitive services for chronic baseline conditions;
   - plateau in patient's progress toward goals;
   - inability to sustain gains;
   - no overall improvement; and/or
   - generalized exercise.
6. Services delivered to patients who have poor rehabilitation potential, as evidenced by poor motivation to quit smoking and/or failure to meet indicators listed above for participation in PR services.
7. Treatment that is not reasonable and necessary due to a lack of significant objective findings in preliminary pulmonary diagnostic testing.
8. Therapy groups with greater than six (6) patients and/or that are not individualized to each patient's goals.
9. Routine follow-up visits.
10. Viewing of films or videotapes; listening to audio tapes; completing interactive computer programs; any supervised or independent technology-based instruction.

Exclusions
The following are excluded from coverage under the Medicare Program and are not reimbursable directly or indirectly:
1. Exercise equipment or supplies.
2. Biofeedback services for relaxation.
3. General education and training not related to the patient's illness.

Noncovered ICD-9-CM Codes
Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Noncovered Diagnoses
N/A

Coding Guidelines
General Information
- Each treatment procedure or modality billed must match the documentation in the daily therapy notes.
- A global daily fee billing is **not** acceptable.
- Procedure codes 94010, 94060, 94640, 94664-94668, 94760, and 94761 are **not routinely rendered** to all patients receiving PR services. Documentation in the medical record must support the medical necessity for the individual services for the particular patient receiving these services. Please refer to applicable existing local medical review policies (LMRPs) for coverage requirement information and applicable ICD-9-CM codes regarding these procedure codes.
- Reimbursement for noninvasive ear or pulse oximetry for oxygen saturation: single determination (CPT code 94760) is included in the basic allowance of noninvasive ear or pulse oximetry for oxygen saturation, multiple determination (*CPT* code 94761) when performed on the same day by the same provider. Effective January 1, 2000, procedure codes 94760 and 94761 are considered bundled services and, therefore, are not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day.

Documentation Requirements
Initial Assessment/Evaluation
The initial evaluation will identify the problems, develop a specific plan of treatment, and set specific goals. The assessment should include the following information:
1. Physician's evaluation of the history of the respiratory illness, patient's rehabilitation potential, treatment diagnosis, and any relevant secondary diagnoses.
2. Physician's review of recent pulmonary function tests, arterial blood gases, treadmill stress tests, or other relevant tests as indicated for a particular patient.
3. Review of any other diagnostic tests necessary to identify the patient's specific pulmonary need and potential for rehabilitation.
4. Past medical history, including any prior PR services.
5. Prior functional level (at baseline, or before the most recent exacerbation of the respiratory illness).
6. Psychosocial status. Patients with rehabilitation potential will have sufficient motivation, willingness, and cognitive skills to fully participate in his or her rehabilitation process. This includes a carry over of learned skills to make lifestyle changes.
7. Identification of specific problems and functional deficits in performing activities, tasks, or ADLs. These problems must be described in measurable, objective, and functional terms. These identified problems must be amenable to skilled therapy in order for these services to be medically necessary.
8. The patient's rehabilitation potential must be documented in measurable terms.

Daily Notes
Clinicians are required to document all activities, tasks, instruction, and treatment rendered. This documentation must be done each time the patient receives any PR service. The content of this documentation is more important than the format. The clinician must include the following with each daily note:
1. The treatment time, procedure or modality, date of service, signature, and clinician's credentials.
2. Notes that match the HCPCS codes, units, and charges billed on Form CMS-1500.
3. Content that addresses each individual patient's specific response to treatment, progress toward the stated goals, and the rationale for the continued need of the unique skilled PR services.

Specific documentation of progress toward the stated goals would include patient demonstration of proper breathing techniques, proper cleaning procedure of respiratory equipment, proper self-administration of aerosol medication, increasing exercise tolerance with effective use of compensatory breathing skills, and carry over of learned activities to specific goals in the home and community. The documentation should reflect when the patient reaches each goal.

All documentation must demonstrate clinical rationale for skilled intervention. Clinicians are required to document all activities, tasks, instruction, and treatment provided. This documentation must be done each time the patient receives any PR service.

The patient's medical record must contain documentation that fully supports the medical necessity for Pulmonary Rehabilitation services as covered by Medicare (see "Indications and Limitations of Coverage and/or Medical Necessity"). This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Utilization Guidelines
N/A

Other Comments

Administrative Costs

The following costs are not covered separately; they are considered indirect costs of providing PR services:

1. Teaching and education done by a pharmacist or dietitian;
2. General nutritional counseling;
3. Medical social services;
4. Team and/or family conferences;
5. Documentation time;
6. Discharge summaries; and
7. Educational books, pamphlets, audio/video tapes, CDs, DVDs, other computer software, or any other materials not considered medical supplies.

Limitation of liability and refund requirements apply when denials are based on medical necessity. They do not apply when the test, item or procedure is done for screening purposes. The provider must notify the beneficiary if the provider is aware that Medicare may not cover the test, item, or procedure.

Sources of Information and Basis for Decision

Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - **www.floridamedicare.com**.

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the Florida Pulmonary Society.

Carrier Advisory Committee Meeting held on August 25, 2001.

Start Date of Comment Period

08/17/2001

End Date of Comment Period

10/01/2001

Start Date of Notice Period

02/28/2002

Revision History

Revision Number	4	PCR B2002-082
Start Date of Comment Period:		08/17/2001
Start Date of Notice Period:		02/28/2002
		February 2002 Special Issue *Update!*
Revised Effective Date		04/22/2002

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity.

New Modifiers for Use in Billing for Hospice Patients

When a Medicare beneficiary elects hospice coverage, he/she may designate an attending physician not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered "hospice services." These attending physician services are billed to Medicare Part B, provided they were not furnished under a payment arrangement with the hospice. Prior to April 1, 2002, a statement attesting to this is required.

Effective for services rendered on or after January 1, 2002, processed on or after April 1, 2002, the attending physician codes services when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition with modifier GV: "Attending physician not employed or paid under agreement by the patient's hospice provider."

Claims for services *not* related to the hospice patient's terminal condition should be coded with the modifier GW: "service not related to the hospice patient's terminal condition."

Source: CMS Transmittal 1728, CR 1910

MEDICARE B UPDATE!

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