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Northwest Utilization Review

UR 12.2: Pulmonary Rehabilitation Medical Necessity Criteria

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DEFINITIONS

Pulmonary Rehabilitation is a multidisciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and independence.

POLICY AND CRITERIA

MEDICAL NECESSITY CRITERIA

A. Diagnosis of moderate to very severe chronic obstructive pulmonary disease (COPD), defined as GOLD classification II, III and IV, when referred by the physician treating the chronic respiratory disease; or,

B. Preoperative or postoperative for lung transplant or resection; or,

C. Interstitial lung diseases (e.g. idiopathic pulmonary fibrosis); or,

D. Bronchiectasis; or,

E. Pulmonary arterial hypertension; or,

F. CT scan determined severe emphysema; or,

G. Confirmed or suspected COVID-19 with persistent symptoms that include respiratory dysfunction for at least 4 weeks; or,

H. For other diagnoses for which pulmonary rehab may be indicated, the pulmonologist will provide evidence-based references supporting its approval; or,

I. Referral from pulmonology.

OTHER REQUIREMENTS:

Pulmonary Rehabilitation Programs must include the following components:

a. Physician-prescribed exercise. Some aerobic exercise must be included in each pulmonary rehabilitation session (Respiratory Therapists who see patients under case management may order Pulmonary Rehab under the Pulmonology doctor-of-the-day);

b. 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;

c. Psychosocial assessment;

d. Outcomes assessment; and

e. An individualized treatment plan detailing how components are utilized for each patient.

Pulmonary rehabilitation items and services are typically furnished in a physician's office or a hospital outpatient setting with a physician immediately available and accessible for medical consultations and emergencies at all times during which items and services are being furnished under the program.

CONTRAINDICATIONS (THESE ARE NOT MEDICARE APPROVED, APPLY TO COMMERCIAL MEMBERS ONLY)

NOTE: Coverage for pulmonary rehabilitation cannot be denied for a **Medicare** member based on the existence of a contraindicated situation/condition. When medical necessity criteria and the facility/program requirements are met, coverage for Medicare members must be authorized. It is up to the prescribing practitioner to determine if a co-existing condition contraindicates the provision of pulmonary rehabilitation.

a. The patient has not quit smoking or will not participate in smoking cessation activities prior to or during the course of pulmonary rehabilitation services (including tobacco, marijuana and vaping);
b. The patient is not physically able, motivated or willing to participate;
c. There is no expectation of measurable improvement in a reasonable and predictable time frame;
d. Presence of unstable cardiac disease;
e. Presence of active pulmonary infection (excludes COPD exacerbation) unless ordered/approved by a pulmonologist;
f. Presence of unstable pulmonary hypertension.

SPECIAL GROUP CONSIDERATIONS

Medicare: **There is currently no National or Local Coverage Determination addressing pulmonary rehabilitation.**

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/condition for that beneficiary.

Note: Beneficiaries with moderate to very severe COPD (defined as GOLD classification II, III, and IV) who have completed pulmonary rehab (PR), may participate in PR again if they had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks. Similarly, beneficiaries who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks and complete PR, may participate in PR again if they have moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease.

RATIONALE

EVIDENCE BASIS

COPD

A 2015 Cochrane systematic review evaluated pulmonary rehabilitation for COPD and reports moderately large or clinically significant improvements in dyspnea, fatigue, emotional function, and enhanced sense of control individuals have over their condition following pulmonary rehabilitation.[1] The review also indicates that

pulmonary rehabilitation is beneficial in improving health-related quality of life and exercise capacity.[1] A 2016 Cochrane review of pulmonary rehabilitation after exacerbations of COPD reports moderate to large effects of pulmonary rehabilitation on health-related quality of life and exercise capacity in patients with COPD after an exacerbation.[2] This review evaluated the effect of pulmonary rehabilitation on hospital readmissions and reports that moderate-quality evidence indicates that pulmonary rehabilitation reduced hospital readmissions, but results across studies were heterogenous.[2] The heterogeneity in these findings may be explained by variation in the extensiveness of pulmonary rehabilitation programs evaluated in the included studies.

Interstitial Lung Disease

A 2021 Cochrane systematic review of pulmonary rehabilitation for interstitial lung disease indicates that functional exercise capacity, dyspnea, and quality of life are likely improved by pulmonary rehabilitation in the short-term and that these benefits were sustained longer term.[3] Due to issues of study quality, such as inadequate reporting of methods, lack of outcome assessment blinding, and heterogeneity in results, the certainty of this evidence was rated as low to moderate.[3]

COVID-19

A 2021 ECRI Clinical Evidence Assessment of rehabilitation for patients with post-acute sequela of COVID-19 notes that available clinical evidence demonstrates significant improvements in pulmonary function following rehabilitation.[4]

REFERENCES

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4. ECRI. Rehabilitation for Patients with Postacute Sequela of COVID-19. ECRI Clinical Evidence Assessment June 2021.
5. Pub 100-02 Medicare Benefit Policy; Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010 (Chapter 15, section 231).
6. Medicare Billing and Coding: Pulmonary Rehabilitation Services Article A52770
7. MCG; Ambulatory Care- Pulmonary Rehabilitation (contraindications) 26th edition.
8. Noridian Pulmonary Rehab Program Criteria