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Medicare Rules &Regulations:
Focus on Cardiac Rehab

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Disclosures

- I have no relevant disclosures

OUTLINE

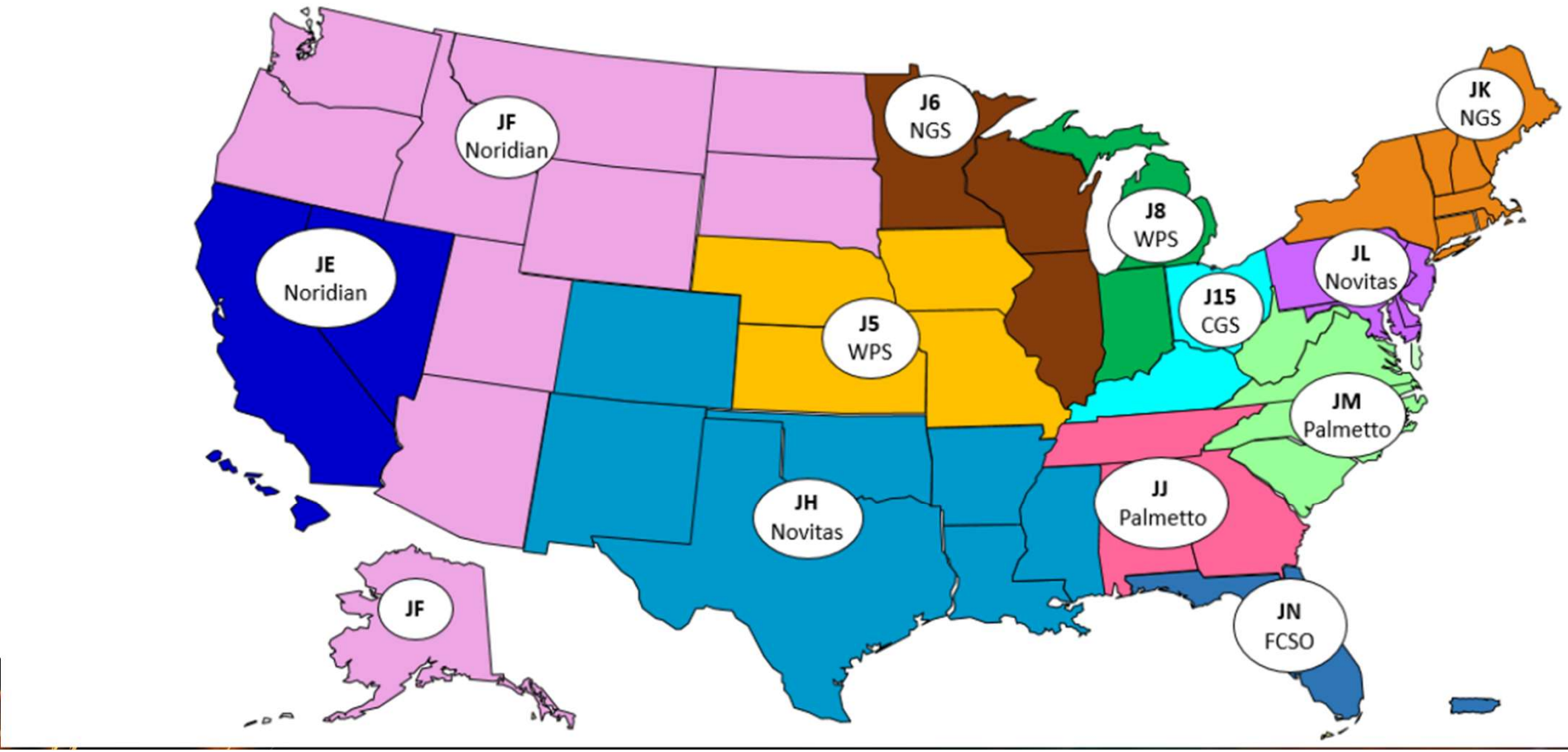
- Regulations Structure
- Basics & Core Components review of:
  - CR, ICR, SET PAD
- Virtual Delivery and Virtual Supervision
- Non-Physician Providers Roles in CR/ICR/PR
- Take-aways

REGULATORY RESOURCES

- Federal Register Law
  - Cardiac Rehab & Intensive Cardiac Rehab - Federal Register/Vol. 74, No. 226 p.62004; 42 CFR § 410.49
  - Pulmonary Rehab - Federal Register/Vol. 74, No. 226, p 62002
- CMS – National Coverage Determination
  - Congestive Heart Failure Coverage

    NCD 20.10.1; 42 CFR §410.49(b)(1)(vii))
  - SET PAD - MLN Matters Number: MM11022

A/B MAC Jurisdictions



MAC Clarification

- A MAC may expand on, clarify, expound on or add to, but not be more restrictive than what the CMS National Coverage Determination entitles the beneficiary to receive.
- The LCD, if the MAC has one, can include coding, billing and policy.
- Caution when asking or reading questions on “The Pulse” related to regulatory issues. Rules vary greatly state to state.
- Use reliable sources, with reference documents when able.
  - AACVPR MAC Task Force Members, AACVPR Reimbursement Updates, State Affiliate Reimbursement Leaders, AACVPR Webinars, Experts at your facility, etc.

CARDIAC REHAB CORE COMPONENTS

- From the Federal Register
- Physician supervised program that furnishes:
  - Physician prescribed exercise
  - Cardiac risk factor modification
  - Psychosocial assessment
  - Outcomes assessment
- Must be provided in a hospital outpatient setting (on or off-campus) or in a physician's office.

CARDIAC REHAB DIAGNOSES

- Acute MI within preceding 12 months
- Coronary Artery Bypass Surgery
- Current Stable Angina Pectoris
- Heart Valve repair or replacement
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart or Heart-Lung transplant
- Stable, chronic Heart Failure defined as:
  - EF of 35% or less; after 6 weeks of optimal heart failure therapy
  - Stable = Patients who have not had recent (< 6 weeks) or planned (< 6 months) major cardiovascular hospitalizations or procedures.

*Private insurers may cover other diagnoses

CR INDIVIDUALIZED TREATMENT PLAN

- Is tailored to each patient
- Describes the individual's diagnosis
  - Best practice = include EF% for CHF and date of MI, PCI, CABG, etc.
- Includes the type, amount, frequency, and duration of the items and services furnished under the plan
- Includes goals set for the individual
- Must be established (signed by a physician on or before the patient's first billable session), reviewed and signed by a physician every 30 days.

CARDIAC REHAB – OTHER

- Outcomes evaluation
  - Performed at beginning and end of program
  - Used to develop and review ITP
- Visit limit is 2 1-hour sessions per day up to 36 sessions over 36 weeks
  - One session = >31 min with some amount of exercise performed
  - Two sessions = >91 min with some exercise performed
  - Exercise must be performed each DAY, not each session
  - Use KX Modifier for visits over 36 (applies through patient lifetime)
- Provided under direct physician supervision

Intensive Cardiac Rehab CORE COMPONENTS

- Meets all criteria and diagnoses for Cardiac Rehabilitation programs

- Must be an approved Medicare program models:
  - Dr. Ornish's Program for Reversing Heart Disease
  - Pritikin Program
  - Benson-Henry Institute Cardiac Wellness Program

- Visit limit is 6 1-hour sessions per day up to 72 sessions over 18 weeks

Supervised Exercise Therapy for Peripheral Artery Disease (SET PAD)

- Covered for patients with intermittent claudication for the treatment of symptomatic peripheral arterial disease (unless patient has absolute contraindication to exercise)
- SET PAD program must:
  - Consist of session must last 30-60 minutes, comprised of therapeutic exercise training for PAD (walking to mod-to-max claudication and rest intervals)
  - Be conducted in hospital outpatient setting or physician's office
  - Be delivered by qualified personal who are trained in exercise therapy for PAD
    - See AACVPR for training materials and webinars
  - Be under DIRECT supervision of a physician, OR Non-Physician Provider who are trained in BOTH BLS and ACLS

SET PAD CORE COMPONENTS (CONT)

- Referral to SET PAD must be made by:
  - Physician responsible for PAD treatment
  - During a face-to-face visit at which time patient receives CVD and PAD risk reduction education, behavior intervention, and outcomes assessments.
- Visit limit is up to 36 sessions over a 12-week period; extension for another 36 visits may be covered with use of a KX modifier
- Bill with code 93668
- ICD-10 Coding requirements – specified in policy

Virtual Delivery

Defined as services provided via real-time audio-visual, rather than face to face treatments onsite; reimbursed at same rate using the same codes, all service criteria must be maintained.

FOR HOSPITAL OUTPATIENT PROGRAMS

- Virtual delivery will no longer be paid by Medicare as of May 11th when PHE ended
- Current legislation on this issue

FOR PHYSICIAN OFFICE PROGRAMS

- Very few programs effected by this; physician owned programs
- Telehealth visits allowed through end of 2023 – per Consolidated Appropriations Act (CCA) of 2022

DIRECT SUPERVISION & VIRTUAL SUPERVISION

Defined as immediately available and accessible for medical consultation and medical emergencies AT ALL TIMES items and services are being furnished.

Required for CR/ICR/PR services - Must be MD or DO

Required for SET PAD – Can be MD/DO or NPP

Virtual Supervision (real-time, audio-visual) options are available through 12/31/23; unless CMS approves an extension

NON-PHYSICIAN PROVIDERS (PA, NP, CNS)

Direct supervision for CR/ICR/PR programs under Public Law 115-123; Effective 1/1/2024

Direct supervision for SET PAD currently in effect

May not ORDER any of these services.

May not sign ITPs for CR/ICR/PR.

2023 Pay Rates – All services

Service	Procedure Code	APC	Payment Rate	Patient/Secondary Insurance Amount
Cardiac Rehabilitation w/o Monitor	93797	5771	$120.07	$24.02
Cardiac Rehabilitation w/ Monitor	93798	5771	$120.07	$24.02
Intens Cardiac Rehab w/ Exerc	G0422	5771	$120.07	$24.02
Intens Cardiac Rehab w/o Exerc	G0423	5771	$120.07	$24.02
Therapeutic Procedures-strength/endurance	G0237	5731	$24.96	$5.00
Other Resp Procedures – Individual	G0238	5731	$24.96	$5.00
Other Resp Procedures – Group	G0239	5732	$33.96	$6.80
Pulmonary Rehabilitation w/o Continuous Oximetry Monitoring	94625	5733	$57.48	$11.50
Pulmonary Rehabilitation w/ Continuous Oximetry Monitoring	94626	5733	$57.48	$11.50
Peripheral Vascular Rehab	93668	5733	$57.48	$11.50

Presentation Take Away's

1. The regulations for CR/ICR/PR/PAD are very short, easy to read and something EVERYONE providing the care should be familiar with.
2. Build relationships with other programs in your MAC jurisdiction and use AACVPRs resources throughout the year.
3. Keep up to date on regulatory and legislative issues through AACVPR's many communication initiatives (Health Policy & Reimbursement Updates, Webinars, Discussion Forums).

Now on to Susan for Pulmonary Rehab!

Medicare Rules & Regulations

Focus on Pulmonary Rehab

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Sept 14, 2023

Disclosures

No relevant disclosures

Outline

- Pulmonary Rehab (PR) vs Outpatient Respiratory Services (ORS)
- Medicare vs Other Insurers
- Diagnoses
- Billing Codes
- Patient Criteria
- Similarities (and Differences) Between CR and PR
- Practice
- Take-aways

Two Programs / One Umbrella

1. Pulmonary Rehab (PR)
   - Billed when patient meets criteria for PR with their specific insurance
   - Patient eligibility varies among insurers

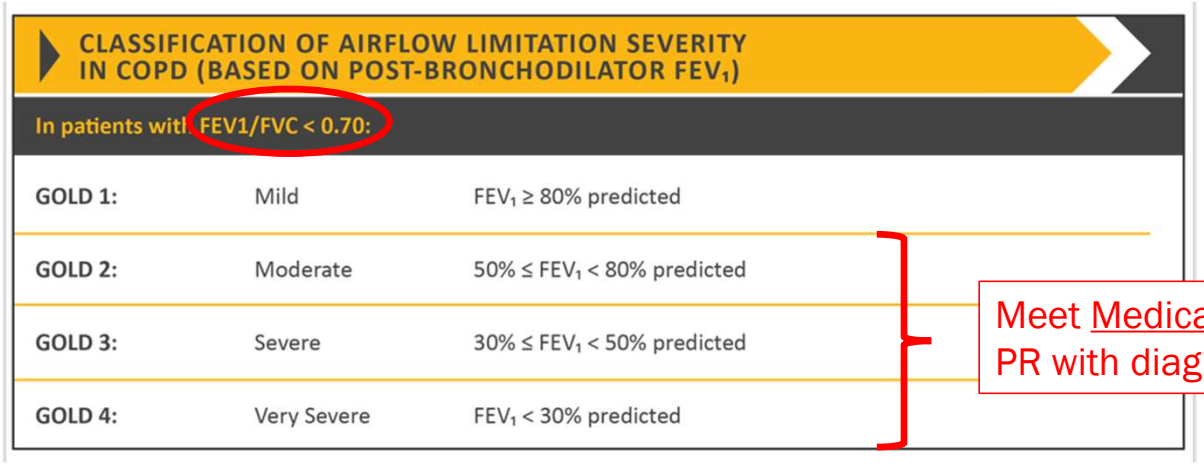
2. Outpatient Respiratory Services (ORS)
   - Billed when patient has a diagnosed chronic, symptomatic respiratory disease/disorder, but does not meet policy-specific criteria for PR
   - Insurance may or may not provide specific guidance for ORS

Pulmonary Rehab and Medicare

Medicare allows (2) diagnoses in Pulmonary Rehabilitation

1.	COPD	Moderate to very severe COPD (GOLD class II, III, and IV) *next slide No time limit for PFTs
2.	Post COVID-19	Confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least 4 weeks The four week “wait” may begin with symptom onset PFTs are NOT required Positive COVID-19 test is NOT required Hospitalization is NOT required

GOLD Classifications for COPD



CLASSIFICATION OF AIRFLOW LIMITATION SEVERITY IN COPD (BASED ON POST-BRONCHODILATOR FEV_1)		
In patients with FEV1/FVC < 0.70:		
GOLD 1:	Mild	$FEV_1 \geq 80\%$ predicted
GOLD 2:	Moderate	$50\% \leq FEV_1 < 80\%$ predicted
GOLD 3:	Severe	$30\% \leq FEV_1 < 50\%$ predicted
GOLD 4:	Very Severe	$FEV_1 < 30\%$ predicted

Meet Medicare criteria for PR with diagnosis of COPD

Patients must meet *both* criteria (FEV1/FVC *and* FEV1).
Recommend keeping a copy of qualifying PFT in rehab records – especially for patients coming from outside your facility. This will help in case of an audit.

Table taken from Global Initiative for Chronic Obstructive Lung Disease. www.goldcopd.org

Pulmonary Rehab and Other Insurance

- MAOs (Medicare Advantage Organizations) *must* cover what traditional Medicare (MC) covers; they *may* include more in their policy
- Commercial insurers are often more inclusive with coverage than MC
  - May include more diagnoses in their policy than MC
  - May have different qualifying criteria
  - Helpful to obtain policies for the most common commercial insurers in your area
- "Closed" systems (VA, Kaiser) have their own set of rules
- Medicaid programs are "state-specific" and vary greatly
- **If you follow traditional MC criteria for all patients, you are missing patient referrals**
- It is impossible to know if a patient meets criteria for PR unless you check their specific policy.

Outpatient Respiratory Services (ORS)

- The Medicare “rules” for PR pertain only to patients registered in PR, NOT those attending Outpatient Respiratory Services
- Medicare does not provide a “list” of approved diagnoses or specific regulations for ORS, though other insurers may
- Unless specified by patient’s insurer, ORS has
  - No stated number of sessions (per medical necessity)
  - No PFT requirements
  - No ITP requirements, however…
    - Best practice calls for a comprehensive treatment plan to ensure all education, psychosocial, and individualized needs are met in program
    - Many programs use the same ITP for PR and ORS to standardize treatment

ORS Patient Criteria

- If patient's insurer provides specific criteria for ORS, must follow that
- Most patients referred with a *symptomatic respiratory condition* can participate in ORS
  - General criteria to consider:
    - Is the diagnosis a *chronic* respiratory disease/condition?
    - Do they have increased healthcare utilization? (ED visits, hospitalizations, etc.)
    - Continue to have symptoms despite medical treatment?
    - Functional limitations?
    - Quality of life impairment?
- ORS patients are still bound by "medical necessity" with an expectation of improvement

Potential diagnoses for ORS

- Examples of common diagnoses (not all-inclusive) that *may* be appropriate (consider criteria on previous page)
  - COPD (GOLD stage 1 – mild)
  - Asthma
  - Bronchiectasis
  - Interstitial pulmonary diseases (IPF, asbestosis, sarcoidosis)
  - Pulmonary hypertension
  - Obesity hypoventilation syndrome
- Keep in mind: Some MACs and commercial insurers provide specific guidelines for ORS

Billing for PR or ORS

- Five (5) codes are available in PR / ORS
  - (2) Pulmonary Rehab codes:
    - 94625
    - 94626
  - (3) Outpatient Respiratory Services codes
    - G0237
    - G0238
    - G0238

These are the ONLY codes we are to use in PR/ORS.

Billing Patients in PR

- Diagnoses used (ICD-10 codes) should match across the continuum: referral, registration, coding, billing

- When using COPD diagnosis, only (1) ICD-10 diagnosis code is used
  ICD-10 for COPD is J44.9

Billing Patients in PR

- When using the Post-COVID-19 diagnosis, (2) ICD-10 codes (diagnoses) are required

  First code: Specific symptom(s) or condition(s) related to the COVID-19 infection. Examples listed in ICD-10 coding manual include:

  - J96.1 – Chronic respiratory failure (not acute)
  - J12.82 – Pneumonia due to coronavirus disease
  - M35.81 – Multisystem inflammatory syndrome
  - R06.02 – Shortness of breath

  Second code: U09.9 – Post-COVID-19 condition, unspecified

*If getting denials, check with your billing/coding department. Could be due to hospital “scrubbing” software.

PR Billing Codes

- 2 codes effective 1/1/2022 (reimbursement is the same)
  - 94625 – Pulmonary Rehab *without* continuous pulse oximetry monitoring
  - 94626 – Pulmonary Rehab *with* continuous pulse oximetry monitoring
  - Like Cardiac Rehab codes *with* or *without* ECG
  - Previous PR code (G0424) was retired at end of 2021
- If you bill the *continuous* pulse ox code, documentation should include:
  - "Why" continuous pulse oximetry monitoring is necessary
  - Evidence that pulse oximetry was used for entire session (auditors interpret billing codes literally)
- Consider the following:
  - Are you using continuous monitoring for convenience only?
  - Patients (and staff) can rely too heavily on "numbers," which does not benefit the patient. Better for patient to learn to monitor their symptoms independently.

ORS Billing Codes

G0237 – Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, 1:1, each 15 minutes	Use for strengthening and endurance. Examples: breathing retraining (PLB, DB, paced breathing); Inspiratory Muscle Training (IMT); Incentive Spirometer (IS) use
G0238 – Therapeutic procedures to improve respiratory function, other than that in G0237, face-to-face, 1:1, each 15 minutes	Examples: Teaching MDI with spacer; Teaching strategies for energy conservation (as with ADLs); airway clearance strategies; stair climbing, ramp walking; self-management; smoking cessation
G0239 –Therapeutic procedures to improve respiratory function of increase strength or endurance of respiratory muscles, two or more individuals	**Typical group charge.** This code is used for group, routine exercise, even if only one patient is present.

15-minute billing increments:

1 = ≥ 8 min to 22 min	4 = 53 min to 67 min	7 = 98 min to 112 min
2 = 23 min to 37 min	5 = 68 min to 82 min	8 = 113 min to 127 min
3 = 38 min to 52 min	6 = 83 min to 97 min	9 = 128 min to 142 min

Medicare Requirements: Comparing CR and PR

Cardiac Rehab	Pulmonary Rehab
Up to (2) sessions may be billed per day 1 "session" = ≥ 31 minutes; 2 sessions = ≥ 91 minutes (If ≥ 91 min, must bill for 2 sessions) A "session" = time in rehab; not just exercise time Medicare beneficiary is responsible for one Medicare co-payment/day	
Some form of exercise must be performed each "day"	Some form of exercise must be performed each "session"
36 (72) sessions available per each qualifying event	36 (72) sessions *total* may be billed to MC (>72 will be denied) This includes billing codes G0424, 92625, and 94626 *and* both covered diagnoses: COPD and post-COVID
KX modifier required starting with session #37 (billed to MC) since 1/1/2010	
ITPs must be established, reviewed, and signed by a physician every 30 days	
Program supervision requirements are the same for CR and PR	

Let's Practice!

A Pulmonary (or Cardiac) Rehab patient comes to class but states they aren't feeling well. After an evaluation, it is agreed that they should return home. No exercise was completed.

Q: Can you submit a charge for this visit?

A:

Q: But you spent a lot of time with them! Can you submit a charge?

A:

Let's Practice!

A patient is referred to your program with the diagnosis of post-COVID. Which of the following are true?

a. Patient must exhibit symptoms for at least 4 weeks.
b. They do NOT need PFTs or a positive COVID test
c. When billing, (2) ICD-10 diagnosis codes are required: 1st is the condition/symptom patient is experiencing, followed by U09.9
d. All of the above

Last One!

You receive a patient referral with the diagnosis of Pulmonary Fibrosis. You know that this diagnosis is not covered by Medicare in Pulmonary Rehab, but this patient has a commercial insurance. How do you know if this patient is eligible for PR or should instead attend ORS?

a. Ask the patient
b. Email Susan (or Lorrie) and ask them
c. Just register in ORS – that's easier
d. Contact their insurance and ask! Provide the ICD-10 diagnosis and the billing codes you intend to submit and see if it is covered.

Presentation Take-aways

- Insurance coverage and requirements vary greatly. Do NOT treat every patient referral the same
- Pulmonary Rehab has (2) CPT code options
- Outpatient Respiratory Services has (3) CPT code options
- You can do this! Don’t feel intimidated! Work through the diagnoses, the insurance, and the “rules.” You will become more confident with practice.

*Ask the Experts session

Now to Stacey for Proposed Rules and Regulations!

Proposed HOPPS/PFS regulations and Legislative Updates

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Disclosures

None

Reminder

Objectives

- Review the proposed HOPPS/PFS regulations for 2024
- Participants will be able to state the resources available to help them achieve success within the regulatory world
- Discuss the current legislative issues impacting Cardiac and Pulmonary rehab professionals

Definitions

- HOPPS/OPPS – hospital outpatient prospective payment system
- PFS – physician fee schedule (as part of a physician practice)
- CMS – Center for Medicare and Medicaid services
- NPPs – physician assistants, nurse practitioners and clinical nurse specialists
- SSA – Social Security Act
- PBD – provider based department (as part of a hospital)

Virtual supervision for CR/ICR/PR

- In 2020, as part of the agency's response to the COVID-19 pandemic, CMS offered the flexibility to meet direct supervision requirements virtually
  - This meant having the virtual presence of a supervising physician through two-way, real time audio-visual connection (excluding audio-only)

- In CY 2023, CMS finalized a policy to extend this revised definition of direct supervision until Dec 31, 2023

Proposed Virtual supervision for CR/ICR/PR

- The **proposed** OPPS **and** PFS regulations extend this revised definition of two-way, real time audio-visual connection through 12/31/2024

- This policy will also be extended to the non physician practitioners (NPPs) who are eligible to supervise CR, PR, ICR in CY 2024

Nonphysician practitioners' role in CR, ICR, PR

Effective January 1, 2024

✓ NPPs can supervise ICR, CR and PR

✗ NPPs can't order ICR, PR, CR

✗ NPPs can't sign ITPs

✗ NPPs can't act as a Medical Director

Payment for ICR in Off-Campus, Non-Excepted Provider Based Department (PBD)

- Since 2010, as required by Section 1848 of the SSA, ICR services provided in the physician office has been paid at 100% of OPPS rate.

- Since 2017, reimbursement for off campus, non-excepted PBD of a hospital have been paid using PFS Relativity Adjuster, which is consistent due to section 603

- The outcome is inconsistent with Section 1848 and at odds with section 603

Proposed Payment for ICR in Off-Campus, Non-Excepted Provider Based Department (PBD)

- CMS proposes that effective 1/1/2024, ICR will be excluded from the PFS Relativity Adjuster at the code level and modify the claim process for G0422 and G0423

- This would result in 100% payment, no matter if the “PN” modifier has been used (this code signifies a service was provided in a non-excepted, off campus PBD of a hospital)

Request for Services to be added to Medicare Telehealth Services list for Proposed CY 2024 PFS

- In CY 2022 PFS final rule, some services were temporarily added to the Medicare Telehealth Services list.

- 93797 (Cardiac rehab, without continuous ECG monitoring) and 94625 (Pulmonary rehab without continuous oximetry monitoring) were part of that temporary addition

Proposed Medicare Telehealth Services list for CY2024

- 93797 and 94625 have been proposed to be included on the Medicare Telehealth Services list through CY 2024.

- Beginning 1/1/2025, in the absence of further action by Congress, CPT codes 93797 and 94625 will be not be furnished via telehealth to a beneficiary in the home.

Proposed Reimbursement for CY 2024

- No significant changes have been proposed for reimbursement in CY 2024

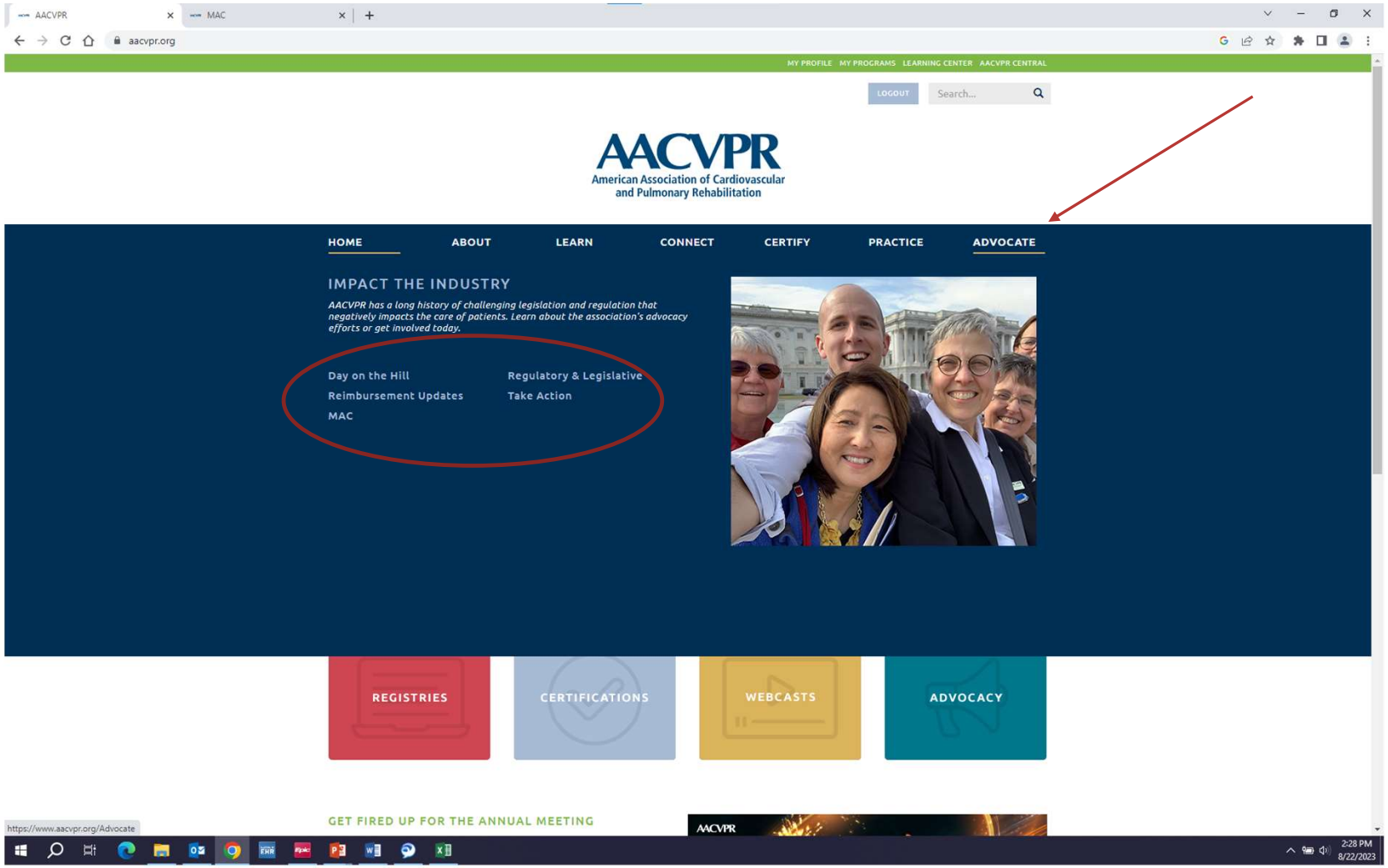
- AACVPR will communicate the finalized rates once they are available

Navigating the Regulatory world

- Know your trusted resources and their frame of reference
- Ensure that you are engaging your hospital compliance department as well as your professional resources
- Don’t hesitate to phone a friend

AACVPR resources

- AACVPR website
  - AACVPR Central – Health and Public Policy/Reimbursement updates
  - FAQs
  - Reimbursement update emails
- MAC Liaison Task Force members
- AACVPR Billing and Coding webinars
- AACVPR Affiliate Associations
- Email aacvpr@aacvpr.org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https://www.aacvpr.org/Advocate
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8/22/2023

Legislative Updates

- Sustaining Outpatient Services (SOS) Act – HR. 1409/S. 1849
- Sustainable Cardiopulmonary Rehabilitation Services in the Home Act – HR. 1406


Thank
you

Sustaining Outpatient Services (SOS) Act – HR. 1409/S. 1849

- Introduced by Representative Adrian Smith from Nebraska
- Currently we have 17 cosponsors
- If passed: Implements regulations that create specific financial thresholds. As long as no physician specialty, nationwide, bills for CR/PR CPT codes under the Medicare PFS in an amount greater than $2 million in the previous year, that code (or codes) would be exempt from Section 603 requirements

Sustainable Cardiopulmonary Rehabilitation Services in the Home Act – HR. 1406

- Introduced by Representative John Joyce from Pennsylvania
- Currently we have 28 cosponsors
- If passed: This bill permanently allows services relating to CR, ICR and PR to be furnished via telehealth at a beneficiary's home under Medicare.

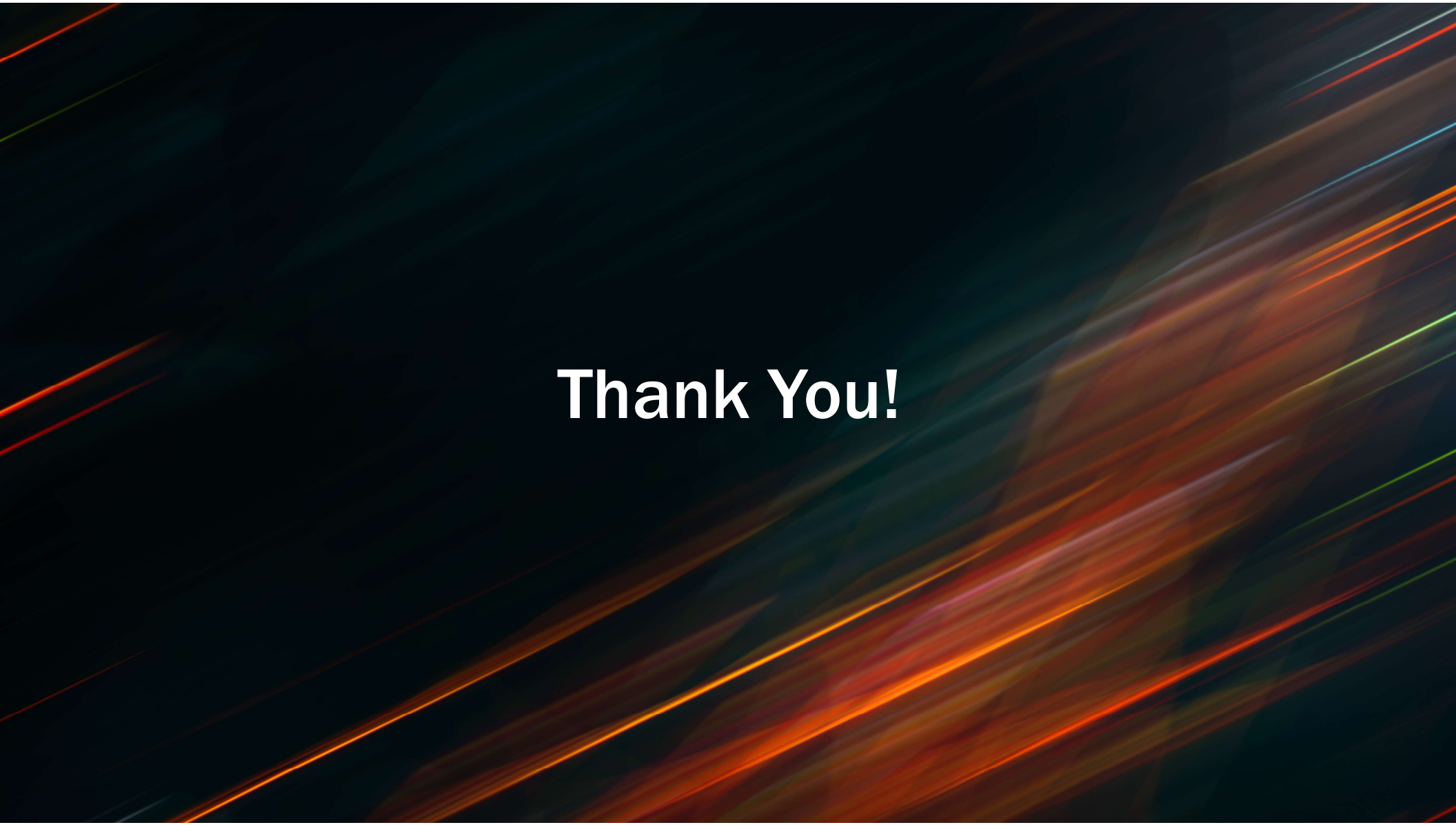
Your action can make the difference!!

Send a letter to the House

Send a letter to your Senators

Presentation Take Away's

- Stay tuned for finalized regulations from CMS
- Get connected with your resources
- Let your state representatives know how HR. 1409/S. 1849 and HR. 1406 can impact the patients in your state


Thank You!