



MASSACHUSETTS

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Medical Policy

Outpatient Pulmonary Rehabilitation

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Policy Number: 136

BCBSA Reference Number: 8.03.05

NCD/LCD: National Coverage Determination (NCD) for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35)

Related Policies

- Lung and Lobar Lung Transplant, [#015](#)
- Heart/ Lung Transplant, [#269](#)
- Lung Volume Reduction Surgery for Severe Emphysema, [#364](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

A single course of pulmonary rehabilitation in the outpatient ambulatory care setting may be **MEDICALLY NECESSARY** for treatment of chronic pulmonary disease for patients with moderate to severe disease who are experiencing disabling symptoms and significantly diminished quality of life despite optimal medical management.

A single course of pulmonary rehabilitation may be **MEDICALLY NECESSARY** in an outpatient ambulatory care setting as a preoperative conditioning component for those considered appropriate candidates for lung volume reduction surgery or for lung transplantation.

Pulmonary rehabilitation programs are considered **MEDICALLY NECESSARY** following lung transplantation.

Pulmonary rehabilitation programs are considered **INVESTIGATIONAL** following other types of lung surgery, included but not limited to lung volume reduction surgery and surgical resection of lung cancer.

Multiple courses of pulmonary rehabilitation are considered is **INVESTIGATIONAL**, either as maintenance therapy in patients who initially respond, or in patients who fail to respond, or whose response to an initial rehabilitation program has diminished over time.

Home-based pulmonary rehabilitation programs are **INVESTIGATIONAL**.

Pulmonary rehabilitation programs are [INVESTIGATIONAL](#) in all other situations.

Pulmonary rehabilitation in the outpatient ambulatory setting is [NOT MEDICALLY NECESSARY](#) for patients with severe psychiatric disturbance (e.g., dementia, organic brain syndrome), and significant or unstable medical conditions (e.g., congestive heart failure, acute cor pulmonale, substance abuse, significant liver dysfunction, metastatic cancer, disabling stroke).

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical necessity criteria and coding guidance can be found through the link below.

[National Coverage Determinations \(NCDs\)](#)

National Coverage Determination (NCD) for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35)

Note: To review the specific NCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is not required .
Commercial PPO and Indemnity	Prior authorization is not required .
Medicare HMO Blue SM	Prior authorization is not required .
Medicare PPO Blue SM	Prior authorization is not required .

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above **medical necessity criteria MUST** be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

There is no specific CPT code for this service.

HCPCS Codes

HCPCS codes:	Code Description
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G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)
G0302	Preoperative pulmonary surgery services for preparation for LVRS, complete course of services, to include a minimum of 16 days of services
G0303	Preoperative pulmonary surgery services for preparation for LVRS, 10 to 15 days of services
G0304	Preoperative pulmonary surgery services for preparation for LVRS, 1 to 9 days of services
G0305	Post discharge pulmonary surgery services after LVRS, minimum of 6 days of services
G0424	Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day
S9473	Pulmonary rehabilitation program, nonphysician provider, per diem

The following ICD Diagnosis Codes are considered medically necessary when submitted with the HCPCS codes above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
D38.1	Neoplasm of uncertain behavior of trachea, bronchus and lung
D84.1	Defects in the complement system
D86.0	Sarcoidosis of lung
D86.2	Sarcoidosis of lung with sarcoidosis of lymph nodes
D86.87	Sarcoid myositis
D86.9	Sarcoidosis, unspecified
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
I26.01	Septic pulmonary embolism with acute cor pulmonale
I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale
I26.09	Other pulmonary embolism with acute cor pulmonale
I26.90	Septic pulmonary embolism without acute cor pulmonale
I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale
I26.99	Other pulmonary embolism without acute cor pulmonale
I27.0	Primary pulmonary hypertension
J22	Unspecified acute lower respiratory infection
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J43.9	Emphysema, unspecified
J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation

J44.9	Chronic obstructive pulmonary disease, unspecified
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J70.1	Chronic and other pulmonary manifestations due to radiation
J70.2	Acute drug-induced interstitial lung disorders
J70.3	Chronic drug-induced interstitial lung disorders
J70.4	Drug-induced interstitial lung disorders, unspecified
J70.5	Respiratory conditions due to smoke inhalation
J70.8	Respiratory conditions due to other specified external agents
J70.9	Respiratory conditions due to unspecified external agent
J84.10	Pulmonary fibrosis, unspecified
J84.111	Idiopathic interstitial pneumonia, not otherwise specified
J84.112	Idiopathic pulmonary fibrosis
J84.113	Idiopathic non-specific interstitial pneumonitis
J84.114	Acute interstitial pneumonitis
J84.115	Respiratory bronchiolitis interstitial lung disease
J84.116	Cryptogenic organizing pneumonia
J84.117	Desquamative interstitial pneumonia
J84.17	Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere
J84.2	Lymphoid interstitial pneumonia
J84.89	Other specified interstitial pulmonary diseases
J95.3	Chronic pulmonary insufficiency following surgery
J95.822	Acute and chronic postprocedural respiratory failure
J96.10	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.11	Chronic respiratory failure with hypoxia
J96.12	Chronic respiratory failure with hypercapnia
J96.20	Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.21	Acute and chronic respiratory failure with hypoxia
J96.22	Acute and chronic respiratory failure with hypercapnia
J98.2	Interstitial emphysema
J98.3	Compensatory emphysema
J98.4	Other disorders of lung
J98.8	Other specified respiratory disorders
J99	Respiratory disorders in diseases classified elsewhere
M32.13	Lung involvement in systemic lupus erythematosus
M33.01	Juvenile dermatomyositis with respiratory involvement
M33.11	Other dermatomyositis with respiratory involvement
M33.21	Polymyositis with respiratory involvement
M33.91	Dermatomyositis, unspecified with respiratory involvement
M34.0	Progressive systemic sclerosis
M34.1	CR(E)ST syndrome
M34.2	Systemic sclerosis induced by drug and chemical
M34.81	Systemic sclerosis with lung involvement
M34.82	Systemic sclerosis with myopathy
M34.83	Systemic sclerosis with polyneuropathy
M34.89	Other systemic sclerosis
M34.9	Systemic sclerosis, unspecified
M35.02	Sicca syndrome with lung involvement
P27.0	Wilson-Mikity syndrome

P27.1	Bronchopulmonary dysplasia originating in the perinatal period
P27.8	Other chronic respiratory diseases originating in the perinatal period
P27.9	Unspecified chronic respiratory disease originating in the perinatal period
Q21.0	Ventricular septal defect
Q33.4	Congenital bronchiectasis
T82.817A	Embolism due to cardiac prosthetic devices, implants and grafts, initial encounter
T82.818A	Embolism of vascular prosthetic devices, implants and grafts, initial encounter
Z48.24	Encounter For Aftercare Following Lung Transplant
Z94.2	Lung Transplant Status

Description

In 2013, the American Thoracic Society and the European Respiratory Society defined pulmonary rehabilitation (PR) as a “comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to exercise training, education, and behavior change.”¹ PR programs are intended to improve patient functioning and quality of life. Most research has focused on patients with chronic obstructive pulmonary disease, although there has been some interest in patients with asthma, cystic fibrosis, or bronchiectasis.

PR is also routinely offered to patients awaiting lung transplantation and lung volume reduction surgery. PR before lung surgery may stabilize or improve patients’ exercise tolerance, teach patients techniques that will help them recover after the procedure, and allow health care providers to identify individuals who might be suboptimal surgical candidates due to noncompliance, poor health, or other reasons.

Summary

Pulmonary rehabilitation (PR) is a multidisciplinary approach to reducing symptoms and improving quality of life in patients with compromised lung function. PR programs generally include a patient assessment followed by therapeutic interventions including exercise training, education, and behavior change.

Chronic Pulmonary Disease Rehabilitation

For individuals with moderate-to-severe chronic obstructive pulmonary disease (COPD) who receive a single course of outpatient PR, the evidence includes numerous randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. The published studies found improved outcomes (ie, functional ability, quality of life) in patients with moderate-to-severe COPD who underwent a comprehensive PR program in the outpatient setting. Among the many randomized trials, the structure of the PR programs varied, so it is not possible to provide guidance on the optimal components or duration of a PR program. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with idiopathic pulmonary fibrosis who receive a single course of outpatient PR, the evidence includes an RCT. Relevant outcome are symptoms, functional outcomes, and quality of life. The number of controlled studies is limited. One small RCT evaluated a comprehensive PR program in patients with idiopathic pulmonary fibrosis; at 3 months postintervention, outcomes did not differ between groups that did and did not receive PR. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with bronchiectasis who receive a single course of outpatient PR, the evidence includes RCTs, systematic reviews, and observational data. Relevant outcomes are symptoms, functional outcomes, and quality of life. A systematic review of 4 RCTs on PR for patients with bronchiectasis found that some, but not all, outcomes, improved more with PR than with non-exercise control conditions immediately after the intervention. The evidence is insufficient to determine the effects of the technology on health outcomes.

Although most published evidence on outpatient PR for chronic pulmonary diseases assesses COPD, observational studies have reported on outcomes from PR for other chronic pulmonary diseases. Clinical

guidelines from pulmonary organizations have supported the use of outpatient PR for individuals who are experiencing disabling symptoms and have significantly diminished quality of life despite optimal medical management. Therefore, outpatient PR may be considered medically necessary for this population.

Preparation for Lung Surgery

For individuals with scheduled lung surgery for volume reduction, transplantation, or resection who receive a single course of outpatient PR, the evidence includes RCTs and observational studies. Relevant outcomes are symptoms, functional outcomes, and quality of life. There is a lack of large RCTs comparing PR with no PR for preoperative candidates undergoing lung volume reduction surgery (LVRS), lung transplantation, or lung cancer resection. Moreover, the available studies have evaluated exercise programs, but not necessarily comprehensive PR programs. Also, the few small RCTs, and observational studies have only reported short-term outcomes and inconsistent evidence of benefit even on these outcomes. The evidence is insufficient to determine the effects of the technology on health outcomes. Findings from the National Emphysema Treatment Trial have suggested that PR is an appropriate component of care for patients with COPD before undergoing LVRS. Also, PR is considered standard of care in patients undergoing lung transplantation to maximize preoperative pulmonary status. Thus, PR may be considered medically necessary for patients considered appropriate candidates for LVRS or lung transplantation.

Pulmonary Rehabilitation After Lung Surgery

For individuals who have had LVRS who receive a single course of outpatient PR, the evidence includes a case series. Relevant outcomes are symptoms, functional outcomes, and quality of life. No published RCTs were identified. The case series evaluated a comprehensive PR program after LVRS in 49 patients who had not received preoperative PR. Health-related quality of life was higher at 3 to 6 months and 12 to 18 months post surgery. The series did not provide data on patients who underwent LVRS and did not have postoperative PR, or patients who had preoperative PR. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have had lung transplantation who receive a single course of outpatient PR, the evidence includes RCTs, systematic reviews, and observational studies. Relevant outcomes are symptoms, functional outcomes, and quality of life. Neither of the 2 RCTs identified in a 2010 systematic review reported on functional outcomes, but uncontrolled studies have reported improvements in functional outcomes. An RCT, published after the systematic review, found that patients who had a postsurgical exercise intervention walked more 1 year post discharge than before and had a significantly greater 6-minute walk distance. Findings on other outcomes were mixed. The most recent RCT (2017) did not identify a difference in outcomes with longer duration of PR. Case series data also support improvements in 6-minute walk distance after postoperative PR. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have had lung cancer resection who receive a single course of outpatient PR, the evidence includes an RCT. Relevant outcomes are symptoms, functional outcomes, and quality of life. One small RCT has evaluated a comprehensive PR program in patients who underwent thoracotomy for lung cancer. The trial was terminated early, had a high dropout rate, and reported mixed findings. An exercise-only intervention in patients who had lung cancer surgery had mixed findings and did not evaluate functional outcomes. The evidence is insufficient to determine the effects of the technology on health outcome

Repeat or Maintenance Pulmonary Rehabilitation

For individuals who have had an initial course of PR who receive repeat or maintenance outpatient PR, the evidence includes RCTs. Relevant outcomes are symptoms, functional outcomes, and quality of life. There are only a few RCTs, and many of them have methodologic limitations and/or did not report clinically significant outcomes. The evidence is insufficient to determine the effects of the technology on health outcome.

Home-Based Pulmonary Rehabilitation

For individuals who have an indication for outpatient PR who receive a single course of home-based PR, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. Most studies of home-based PR have compared outcomes with standard care. Very few have compared home-based PR with the hospital- or clinic-based PR, and the available studies are mostly of low quality. The evidence is insufficient to determine the effects of the technology on health outcome.

Policy History

Date	Action
4/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
6/2018	National Coverage Determination (NCD) for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35) clarified for Medicare Advantage members. 6/26/2018
5/2018	BCBSA National medical policy review. Policy statements reordered to align with the summary. Prior Authorization Information reformatted. Policy statements unchanged.
2/2018	Clarified coding information.
10/2017	Clarified coding information.
4/2016	New references added from BCBSA National medical policy.
7/2015	BCBSA National medical policy review. In summary, "lung resection surgery" corrected to "lung volume reduction surgery."
6/2015	BCBSA National medical policy review. New medically necessary and investigational indications described. Effective 6/1/2015.
11/2014	Clarified coding information.
6/2014	BCBSA National medical policy review. New investigational indications described. Effective 6/1/2014.
5/2014	Updated Coding section with ICD10 procedure and diagnosis codes/. Effective 10/2015.
4/2014	Coding information clarified.
2/2013	New references from BCBSA National medical policy.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
4/2011	Reviewed - Medical Policy Group – Cardiology and Pulmonology. No changes to policy statements.
3/2010	Reviewed - Medical Policy Group - Pulmonology, Allergy/Asthma/Immunology, ENT and Otolaryngology. No changes to policy statements.
11/1/2009	Medical Policy 136 effective 11/1/09 describing covered and non-covered indications.
6/2007	BCBSA national policy review. No changes to policy statement.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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