Coverage Summary

Respiratory Therapy, Pulmonary Rehabilitation and Pulmonary Services

<table>
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<tr>
<th>Policy Number: R-001</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 02/14/2008</th>
</tr>
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<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 03/21/2017</td>
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Related Medicare Advantage Policy Guidelines:

- Heat Treatment, including the Use of Diathermy and Ultrasound for Pulmonary Conditions (NCD 240.3)
- Postural Drainage Procedures and Pulmonary Exercises (NCD 240.7)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

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I. COVERAGE

Coverage Statement: Pulmonary rehabilitation services are covered when Medicare coverage criteria are met.

DME Face to Face Requirement: Effective July 1, 2013, Section 6407 of the Affordable Care Act (ACA) established a face-to-face encounter requirement for certain items of DME (including stationary compressed gas oxygen system; cough stimulating device; high frequency chest wall oscillation system; oscillatory positive expiratory device and nebulizer). For DME Face to Face Requirement information, refer to the Durable Medical Equipment (DME), Prosthetics, Corrective
1. **Pulmonary Rehabilitation**

**For services furnished on or before December 31, 2009:**

On December 27, 2006, CMS initiated the national coverage determination (NCD) process for Pulmonary Rehabilitation. After examining the available medical evidence, CMS has determined that no national coverage determination is appropriate at this time, and that decisions pursuant to § 1862(a)(1)(A) should be made by local contractors through the local coverage determination process or by case-by-case adjudication. Accordingly, the local contractors may continue to make decisions under § 1862(a)(1)(A), with regard to services related to pulmonary rehabilitation, through the local coverage determination process or on a case-by-case basis. See the **NCD for Pulmonary Rehabilitation Services (240.8)**. (Accessed March 14, 2017)

**For services furnished on or after January 1, 2010:**

a. Medicare covers pulmonary rehabilitation items and services for patients with moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease.

b. Pulmonary rehabilitation programs must include the following components:
   - Physician-prescribed exercise. Some aerobic exercise must be included in each pulmonary rehabilitation session;
   - 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;
   - Psychosocial assessment;
   - Outcomes assessment; and
   - An individualized treatment plan detailing how components are utilized for each patient.

c. Pulmonary rehabilitation items and services must be furnished in a physician’s office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services.


**Notes:**


- Local Coverage Determinations (LCDs) exist and compliance with these policies is required where applicable. See the following LCDs at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx):
  - Respiratory Care (Respiratory Therapy)
  - Respiratory Therapeutic Services
  - Respiratory Therapy (Respiratory Care)
  - Respiratory Therapy
2. **Postural Drainage and Pulmonary Exercises**

Postural drainage and pulmonary exercises are covered inpatient, outpatient and in the patient’s home. For specific coverage criteria, see the NCD for Postural Drainage and Pulmonary Exercises (240.7). (Accessed March 14, 2017)

3. **High Frequency Chest Wall Oscillation (HFCWO) Devices**

   - Medicare does not have a National Coverage Determination (NCD) for High Frequency Chest Wall Oscillation Devices.
   - DME MAC Local Coverage Determinations (LCDs) exist for all 50 states and compliance with these LCDs is required where applicable.
   - Refer to the DME MAC LCDs for High Frequency Chest Wall Oscillation Devices (L33785) for coverage guidelines.
   - Committee approval date: March 21, 2017
   - Accessed July 3, 2017

4. **Nebulized Beta Adrenergic Agonist Therapy**

   *On September 10, 2007, CMS posted a National Coverage Determination (NCD) for nebulized beta adrenergic agonist therapy for lung diseases. After examining the available medical evidence, CMS determined that no NCD is appropriate at this time and that section 1862(a)(1)(A) reasonable and necessary decisions should continue to be made by local Medicare contractors through the local coverage determination process or case-by-case adjudication. See the NCD for Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases (200.2). (Accessed March 14, 2017)*

5. **Exhaled Breath Condensate (EBC) pH (CPT code 83987)**

   - Medicare does not have a National Coverage Determination (NCD) for exhaled breath condensate (EBC) pH.
   - Local Coverage Determinations (LCDs) which address this procedure exist and compliance with these LCDs is required where applicable. For state-specific LCDs, see the LCD Availability Grid (Attachment A).
   - For states with no LCDs, refer to the Noridian LCDs for Non-Covered Services (L35008) for coverage guidelines.
     (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy).
   - Committee approval date: March 21, 2017
   - Accessed July 3, 2017

6. **Heat Treatment, including the Use of Diathermy and Ultrasound for Pulmonary Conditions**

   Heat treatment, including the use of diathermy and ultrasound for pulmonary conditions are not covered. There is no physiological rationale or valid scientific documentation of effectiveness of diathermy or ultrasound heat treatments for asthma, bronchitis, or any other pulmonary condition and for such purpose this treatment cannot be considered reasonable and necessary.

   See the NCD for Heat Treatment, Including the Use of Diathermy and Ultra-Sound for
7. **Bronchial Thermoplasty**

- *Medicare does not have a National Coverage Determination (NCD) for Bronchial Thermoplasty.*
- *Local Coverage Determinations (LCDs) do not exist at this time.*
- *For coverage guidelines, refer to the UnitedHealthcare Medical Policy for Bronchial Thermoplasty with individual consideration for FDA approved indications.*

*(IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy.)*

- **Committee approval date: March 21, 2017**
- **Accessed May 12, 2017**

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### II. DEFINITIONS

**Pulmonary Rehabilitation (PR):** The American Thoracic Society (ATS) defines pulmonary rehabilitation (PR) as a multidisciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy. It is designed to reduce and control symptoms experienced by patients with debilitating pulmonary disease and to teach the patients to maximize their ability to carry out activities of daily living (ADLs). PR is designed to reduce symptoms, optimize functional status, increase participation, and reduce health care costs through stabilizing or reversing systematic manifestations of the disease. *NCD for Pulmonary Rehabilitation Services (240.8).* *(Accessed March 14, 2017)*

**Outpatient Pulmonary Rehabilitation,** which can be hospital-based or community-based, is currently the most widely available and, as such, has the potential to benefit the most patients. The outpatient setting may include an outpatient hospital based clinic, comprehensive outpatient rehabilitation facility, physician’s office; alternate or extended care facility, or the patient’s home. *LCDs for Respiratory Care (Respiratory Therapy) (L34149).* *(Accessed March 14, 2017)*

**Respiratory Therapy (Respiratory Care):** The services prescribed by a physician or a non-physician practitioner for the assessment, diagnostic evaluation, treatment, management, and monitoring of members with deficiencies and abnormalities of cardiopulmonary function. *LCDs for Respiratory Care (Respiratory Therapy) (L34149).* *(Accessed March 14, 2017)*

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### III. REFERENCES

See above

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### IV. REVISION HISTORY

03/21/2017  Annual review with no updates.

08/16/2016  Re-review with the following update:

Guideline 5 [Exhaled Breath Condensate (EBC) pH ] - changed default polcy for states with no LCDs from LCD for Non-Covered Services (L34886) to LCD for Non-Covered Services (L35008); current default for states with no LCDs, L35008, was retired effective 5/31/2016; combined with L35008.

03/15/2016  Annual review with the following updates:

Guideline 3 (High Frequenecy Chest Wall Oscillation Devices) – removed the
duplicate information pertaining to the DME MAC geographic coverage (already provided in the referenced LCDs).

Guideline 5 (Exhaled Breath Condensate pH) – changed default guideline for states with no LCDs from Noridian LCD for Non-Covered Services (L24473) (retired) to Noridian LCD for Non-Covered Services (L34886).

03/23/2015  Annual review with the following updates:

Guideline 3 (High Frequency Chest Wall Oscillation Devices): Replaced coverage guidelines with reference link to the DME MAC LCDs for High Frequency Chest Wall Oscillation Devices.

Guideline 5 [Exhaled breath condensate (EBC) pH]: Removed the language that states all available LCDs align.

Guideline 7 (Bronchial Thermoplasty):
• Removed the following language:
  Requests for Bronchial Thermoplasty should be reviewed on a case by case basis in accordance with Medicare’s “reasonable and necessary” requirement. Refer to the FDA information below.
• Added the following to indicate:
  For coverage guidelines, refer to the UnitedHealthcare Medical Policy for Bronchial Thermoplasty with individual consideration for FDA approved indications.

10/21/2014  Removed detailed DME Face-to-Face Requirement information and replaced with a reference link to the DME, Prosthetics, Corrective Appliances/Orthotic and Medical Supplies Grid.

03/18/2014  Annual review with the following updates:
• Guideline #7 Bronchial Thermoplasty – deleted reference to CPT codes 31660 and 31661.
• Updated the definition of Pulmonary Rehab and Respiratory Therapy (Respiratory Care) to align with Medicare definition.

12/17/2013  Guideline #7 (Bronchial Thermoplasty) - Replaced default guideline for states without LCDs from UnitedHealthcare Medical Policy for Bronchial Thermoplasty with the following language:

Requests for Bronchial Thermoplasty should be reviewed on a case by case basis in accordance with Medicare’s “reasonable and necessary” requirement. Also added the applicable FDA indications/contraindication information.

08/20/2013  Added a note pertaining to the DME Face-to-Face Requirement in accordance with Section 6407 of the Affordable Care Act as defined in the 42 CFR 410.38(g).

06/24/2013  Guidelines #7 (Bronchial Thermoplasty) – added to applicable coverage (new to policy) with UnitedHealthcare Medical Policy for Bronchial Thermoplasty as default guidelines for states with no LCDs/Articles.

04/29/2013  Annual review; with the following updates:
• Guidelines #4 (Nebulized Beta Adrenergic Agonist Therapy) - Section updated based on the NCD for Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases (200.2).
- Guidelines #5 (Exhaled Breath Condensate pH) - Changed the default guidelines for states with no LCDS from Trailblazer LCD for non-Covered Services (L26811) (retired) to Noridian LCD for Non-Covered Services (L24473).

04/23/2012 Annual review; with the following updates:
- Guidelines #5 (Exhaled Breath Condensate pH) – default policy changed from UHC Medical Policy (retired 4/1/2012) to Trailblazer L26811.
- Guidelines for Nitric Oxide deleted from this Coverage Summary.

08/29/2011 Updated to include Guidelines # 6 Heat Treatment, including the Use of Diathermy and Ultrasound for Pulmonary Conditions.

06/30/2011 Annual review. Updated Guidelines # High Frequency Chest Wall Oscillation (HFCWO) Devices using the standard CS format.

V. ATTACHMENT(S)

<table>
<thead>
<tr>
<th>Attachment A - LCD Availability Grid</th>
<th>Exhaled Breath Condensate (EBC) pH</th>
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<tr>
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End of Attachment A