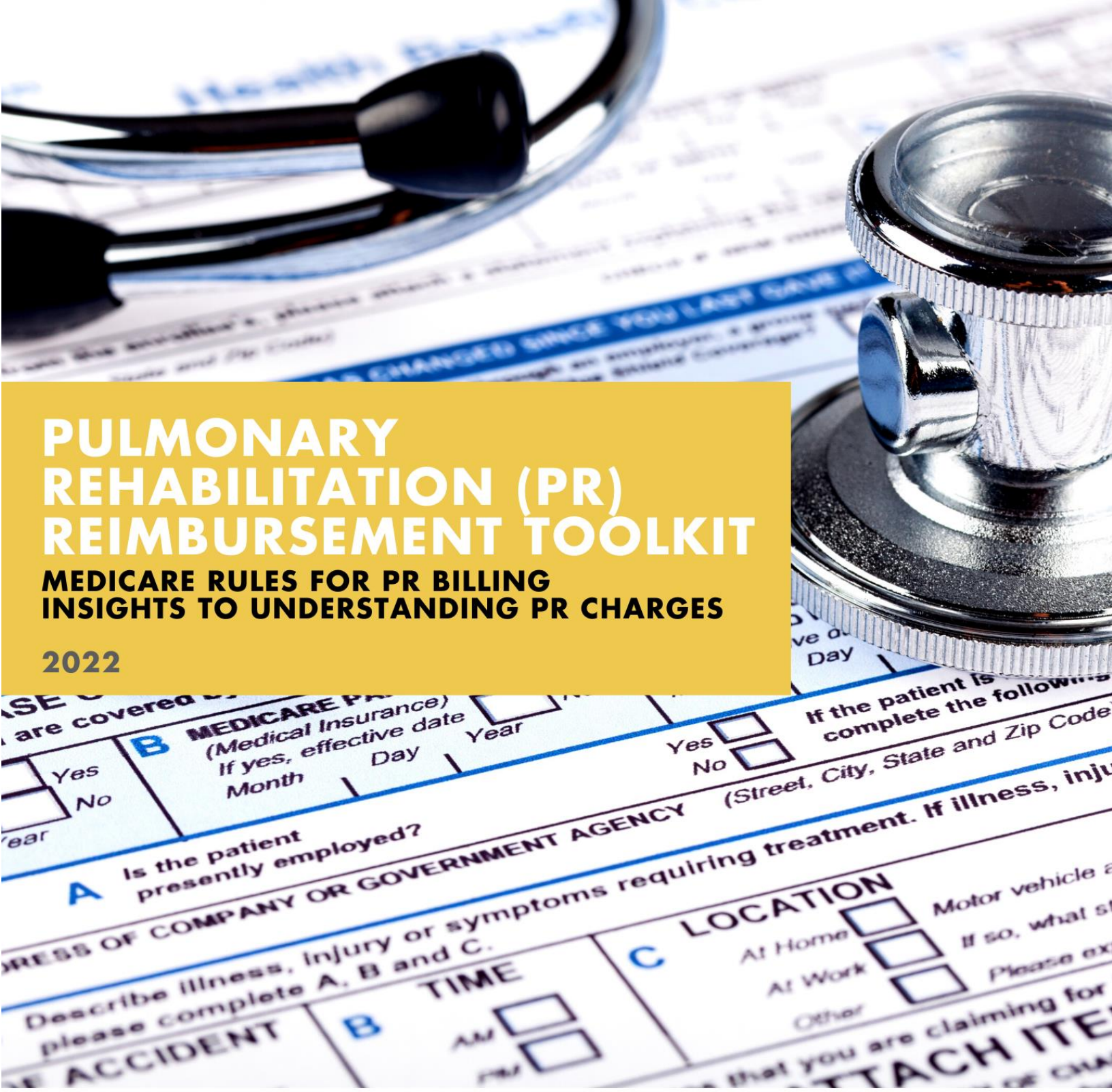

PULMONARY REHABILITATION (PR) REIMBURSEMENT TOOLKIT

MEDICARE RULES FOR PR BILLING
INSIGHTS TO UNDERSTANDING PR CHARGES

2022

AACVPR
American Association of Cardiovascular and Pulmonary Rehabilitation

American Association for Respiratory Care

ATS
American Thoracic Society

CHEST
American College of Chest Physicians

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INTRODUCTION

This toolkit has been updated to give hospital-based providers tools, insights, and resources regarding payment for Medicare's comprehensive pulmonary rehabilitation (PR) benefit implemented by the Centers for Medicare & Medicaid Services (CMS) and new CPT codes for PR that became effective January 1, 2022. It is essential for financial stability and equity that PR charges reflect the complexity of PR services as well as both billable and unbillable costs of comprehensive PR.

OVERVIEW – TRANSITION TO NEW CODES

G0424

When Medicare implemented the pulmonary rehabilitation benefit in 2010, it created a temporary code, G0424, *Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day,* to bill for beneficiaries with moderate, severe, and very severe COPD (GOLD Guidelines/2022 Report/Page 29). Because there was no data for this newly covered service, CMS estimated payment rates for the first two years until data was obtained from hospital cost reports. Once claims data became available, Medicare set the payment rate ***based on two sources of information provided to CMS by hospitals submitting bills for G0424:***

METHODOLOGY	PAYMENT RATE	SOURCE
Median Cost	$150	Claims data
Cost-to-Change Ratio applied to Median Charge	$57	Hospital cost reports

CPT 94625 and CPT 94626

CMS has acknowledged the similarities and parallels between cardiac rehabilitation (CR) and PR. PR reimbursement inequities despite these similarities led a multi-society group of experts to propose new CPT codes that more closely resemble CR codes. Effective January 1, 2022, the new codes are:

- **94625** – *Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)*
- **94626** – *Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)*

Also, effective January 1, 2022, in addition to the stages of COPD noted above, CMS also covers as part of the PR benefit Medicare beneficiaries who have had confirmed or suspected COVID–19 and experience persistent symptoms that include respiratory dysfunction for at least 4 weeks.

CMS will likely continue to set reimbursement rates for the new CPT codes based on the same methodology used to set payment for G0424, which makes **charge review and adjustment** crucial in the pursuit of adequate reimbursement for PR services. The potential for adequate reimbursement can be achieved but only if equitable PR charges and hospital costs are entered on Medicare cost reports.

This toolkit is designed to focus on sources of payment outlined in the chart above as well as the **hospital charge for billing codes CPT 94625 and CPT 94626.** The information provided here is designed to help providers and hospital financial departments carefully consider and include all the services, supplies and equipment used to provide PR under these codes and establish appropriate charges for PR so CMS can set a payment rate moving forward that more closely aligns with CR payment.

Note: HCPCS Codes G0237, G0238 and G0239, which address improving respiratory function or improving strength or endurance of respiratory muscles, are billed as individual components of PR for Medicare beneficiaries who do not have COPD GOLD 2-4 or meet the COVID-19 criteria. These codes are separate from the new CPT codes 94625 and 94626, which are considered bundled, comprehensive codes that reflect a broad base of services that were previously separately billable.

STRATEGIES TO ADDRESS MEDICARE PAYMENT

Expectations and Timelines

Act now! *There are no easy or quick fixes to this payment issue*.

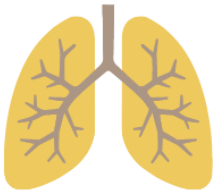
- CMS uses Medicare claims data from the previous year. Previous payment rates for the coming year are typically released in July and finalized in November for the next year.
- It is critical that hospitals act as swiftly as possible to review and adjust their charges for 94625 and 94626 so that claims data submitted to Medicare, which includes a specific column for identification of hospital charges on the UB-04, is accurate.
- Without these adjustment to charges, the payment rate will continue to undervalue the cost of providing comprehensive PR and the complexities of PR patients.

Important Facts about Pulmonary Rehabilitation Billing, Charges and CMS Payment

Although clinicians may feel challenged or overwhelmed by Medicare billing rules, without your involvement, payment is unlikely to accurately reflect the expenses associated with the delivery of PR services. Using the resources provided can help facilitate improved reimbursement and enhance program financial stability. Below are **5 key points** to help providers understand important yet less straightforward aspects of PR billing and charges.

1. LOW CHARGES = LOW REIMBURSEMENT

- PR payment is 50% less than CR because PR providers submit low charges
- Average PR charge per unit = $200 - $300, far below cardiac rehab
- Medicare uses an average charge (geometric mean) to define PR payment
- Example: PR mean = $45 per unit of G0424 vs $160 for CR despite services being similar



2. PR PATIENTS AND SERVICES ARE COMPLEX

- Disabling symptoms and multiple comorbidities
- Need for supplemental oxygen
- Need for self-management training
- Patient complexities far exceed those of most CR patients

3. A CHARGE IS NOT A CHARGE

- Services are bundled and need to include all *direct* and *indirect* PR costs
- Include PR session PLUS:
  - Cost of assessment
  - 6MWT
  - Staff salary and benefits
  - Training
  - PTO
  - Exercise and monitoring equipment
  - Oxygen
  - AED or crash cart
  - Supplies
  - Medical director
  - LCSW or psychologist
  - IT
  - Marketing
  - Conferencing
  - Housekeeping
  - Administration

4. UNDERSTANDING CHARGES VS. PAYMENT IS NOT SIMPLE

- Hospitals charge 4-7 times the payment rate for most services like:
  - PFTs
  - EKGs
  - Echocardiograms

5. PR IS VERY SAFE AND EFFECTIVE

- Significant improvement in function, symptoms, and depression
- Improved quality of life
- Reduced mortality in COPD when PR occurs within 90 days post-hospitalization, and in fibrotic lung disease patients who attend ≥80% of planned PR visits

ESTABLISHING APPROPRIATE CHARGES

Start with a Checklist

- [ ] Obtain and review your chargemaster prices for CPT codes 94625 and 94626. A revised article from CMS can be helpful.

CPT 94625	Physician or other qualified health care professional for out-pt. PR; **without** continuous oximetry monitoring (per session)
CPT 94626	Physician or other qualified health care professional for out-pt. PR; **with** continuous oximetry monitoring (per session)
G0237	Therapeutic procedures to increase strength/endurance of respiratory muscles, face to face, 1:1, 15 min. each (includes monitoring).
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, face to face, 1:1, 15 min. each (includes monitoring).
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)

- [ ] Schedule a meeting with your administrative partner (e.g., manager or director) and invite them to help you with the calculations. This is crucial if they are responsible for the budget and can provide actual department expenditure data. This may be your supervisor or department director. Prepare these resources and discuss a charge increase that can lead to increased reimbursement for PR and respiratory services.

- [ ] Calculate an updated (all-inclusive/bundled) charge for 8 weeks of prescribed PR. For example:

All provider time including prepping for a session, face-to-face and documentation time, obtaining patient insurance info and explaining PR, goals, expectations, etc.. ITP development, administering, collecting/reviewing and scoring outcome measures. Explaining results to patients and outlining the treatment plan. Reporting findings to referral sources when needed.
Referral and appointment management, appt. check in, consenting co-pay collection – non-clinical staff as well
Equipment needed for service delivery, exercise, oximetry, oxygen regulators
Supply costs – oxygen and delivery interfaces such as nasal cannulas and masks, oximeters and sensors, disposable devices - blood pressure cuffs, face shields and masks, resistance bands, free weights, education materials and handouts, etc.

Any recharges to your cost center for adjunct staff services i.e., dietitian, medical director or supervising physician time, psych-social providers
Include time needed to conduct 6 min walk testing (two initial walks meeting ATS recommendations), oxygen needs assessments and develop prescription recommendations.
Include reassessment (actual provider) time as well time requirements for conducting reassessments during those sessions
Meeting and huddle time to facilitate continuity of care

☐ Identify the department and person(s) needed to direct your request. This may be someone in the business office assigned to your area who is responsible for the chargemaster.

Once identified submit a request to increase charges. Expect to justify the increased charge adjustments.
If meeting in person, prepare these resources and bring calculations to discuss your charge adjustment needs, ideally in collaboration with your administrative partner which may also include your administrative director and medical director.
If a partner(s) is lacking, use the tools to make projected estimate calculations then make a formal request to update charges, a contact in whatever department is responsible for the charge master is still needed.
Be aware changes in the chargemaster may take place at specific times of the fiscal year.
Most likely this will need to be approved by someone in the business office and later in the IT department for charges to be reflected in your EMR/Billing platform (i.e., EPIC, Cerner, etc.). This may require a face-to-face meeting.
Track until completed by circling back around after all steps are completed and request to see a copy of the UB-04 to review a claim for verification of changes.
Review the chargemaster at a minimum annually.
Keep in mind CMS has openly recognized that hospital cost reports (geometric means) are low at $45/session. This means the reimbursement rate is a direct result of low charge claim submission to CMS, meaning we are the root cause by undercharging and valuing our comprehensive services.

METHODOLOGY TO CALCULATE A FAIR AND RESPONSIBLE CHARGE FOR 94625/94626

Think about what services you are providing that you would charge for separately (unbundled).

Make a list of all services and number of times that you would perform that service in a typical pulmonary rehab program. Example: If the patient would attend 36 (or number provided by your program) group exercise sessions, list 36 (or appropriate number of units based on your program average) charges of **G0239**.

Include charge for six-minute walk, oxygen assessments, oxygen and oxygen supplies, MDI instructions, spacers, and other devices, **(see appendix list of supplies).**

Refer to your current charge master and note the charge for each code on your list (note how many times you do other things noted above as well). Example: If the charge for G0239 is "X", multiply "X" times 36.

Add up all the charges. Divide by the number of sessions in your program and this is your proposed charge for one unit of 94625/94626.

The number you have calculated represents one charge of 94625/94626.

If you think that the charge that you have calculated is too high, think of all of the services you provide that receive no reimbursement.

UNCOMPENSATED SERVICES

Examples of Uncompensated Services include the following:

- Procurement of PR prescription and medical records
- Insurance verification including available number of visits from Medicare, co-pays, co-insurance, etc.
- Explaining PR to the patient including what to expect, benefits, safety, expectations and patient goals.
- Development of Individualized Treatment Plan (ITP)
- Psychosocial assessment and questionnaires
- On-going assessment of nicotine dependence
- Patient-centered outcome measurement, pre- and post-program
- Evaluation of current exercise prescription, including hypoxemia and oxygen needs, with updating each session
- Procurement of educational materials and purchasing/copying costs
- Documentation on ITP including educational sessions.
- Physician supervision with oversight of development and approval of follow-up ITPs with review and immediate availability during PR sessions.
- Team conference, related care planning and documentation
- Discharge planning and long-term exercise prescription, including discharge instructions and summary to patient and provider
- Purchasing and upkeep of exercise equipment
- Cost of physical space and utilities
- Patient support including support group, linkage to community resources

ACKNOWLEDGEMENTS

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APPENDIX

GLOSSARY OF TERMS

Ambulatory Payment Classifications (APCs): A group of services that are clinically similar and require similar resource utilization. Payment for hospital outpatient services is tied to APCs with payment rates developed prospectively. For example, applying a cast for a fractured radius requires similar resource utilization as applying a cast for a fractured ulna.

Bundled Codes: Combining CPT or HCPCS codes into one service provided at the same time, and often clinically go together.

Charge Master: A list of all the services that a hospital offers and the charges associated with those services. Medicare requires that these charges be identified on the claims data submitted for payment for outpatient services.

Cost-to-Charge Ratio: The total cost required to operate a hospital divided by the sum of operating revenues. CMS uses two key pieces of data to determine payment rates. First, they examine Medicare claims data to collect information regarding "charges." Once the median charges are determined by a review of claims data from a given year, CMS applies a "cost to charge ratio" to determine final payment rates. The source of data for CMS calculations of the "cost to charge ratio" is the hospital cost report.

Current Procedural Terminology (CPT) Codes: A universal list of medical procedures or services that are billed by healthcare systems to insurance. These five-digit codes are owned by the American Medical Association.

Healthcare Common Procedure Coding System (HCPCS) codes: A universal list of separate services, drugs, or supplies that are not included in CPT codes. These are overseen by the American Medical Association. These are five characters but always start with a letter. An example was the previous code for pulmonary rehabilitation of COPD patients, G0424.

Hospital Charge Data ("charge"): The amount a hospital bills insurance for medical services provided. This amount is set *before* or *independently* of the negotiated payments. A charge is different than the *cost* of delivering care, and it is important to note that reimbursement is often lower than both values.
Charges from all hospitals across the country are used to determine APC payment rates. Hospitals are required to identify charges on the claim's forms submitted for CMS for hospital outpatient services, but this is **not** the amount the hospital expects to receive from Medicare; nor is it the amount Medicare plans to pay.

Hospital Cost Report: A complex report compiled once per fiscal year by hospitals and submitted to CMS. The timing of these reports depends on the hospital's set fiscal year.
Frequently hospitals will use outside consultants to assist and coordinate submission of the hospital cost report. Importantly, this is NOT a request by a hospital to get paid by Medicare – it is a reporting requirement tied to participation in the Medicare program.

Outpatient Prospective Payment System (OPPS): A system that sets reimbursement rates for outpatient hospital-based programs. It is based on adjustments for certain factors, such as relative weights for costlier services and geographic differences. Payment is determined based on HCPCS codes.

UB – 04: This is the standard form used by Medicare (and some private payers) to process claims for hospital outpatient services. A specific field on this form requires the hospital to identify the charge associated with the service.

Status Indicator: Status indicator "S" means a procedure or service, not discounted when multiple/paid under the hospital outpatient prospective payment system (HOPPS)/separate APC payment. Status indicator "Q1" means packaged codes paid under HOPPS. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S". (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.

BILLING CODE LIST WITH REIMBURSEMENT DATA

Adapted from [CPT® (Current Procedural Terminology) | AMA (ama-assn.org)]

G0424 is retired as of 2022. (2017 base payment was $54.53)	Time	APC	Status Indicator	Base Payment (2022)	Co-Pay (2022)
94625 Pulmonary Rehab, including exercise without continuous Sp02 (per session)	60 min	5733	NA	$56.85	$11.37
94626 Pulmonary Rehab, including exercise with continuous Sp02 (per session)	60 min	5733	NA	$56.85	$11.37

G0239 Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)	Time	APC	Status Indicator	Base Payment (2022)	Co-Pay (2022)
		5762	NA	$34.57	$6.92

G0238 Therapeutic procedures to improve respiratory function, other than ones described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring). Education examples below	Time	APC	Status Indicator	Base Payment (2022)	Co-Pay (2022)
Teaching MDI with spacer, DPI or nebulizer	15 min	5732	S	$25.23	$5.05
Teaching of peak flow meter	15 min	5732	S	$25.23	$5.05
Teaching In-Check dial	15 min	5732	S	$25.23	$5.05
Teaching strategies for performing tasks with less effort including activities of daily living (ADLs)	15 min	5732	S	$25.23	$5.05
Teaching airway clearance strategies: huff coughing, secretion mobilization device (i.e. Aerobika, flutter valve, vest, percussion)	15 min	5732	S	$25.23	$5.05
Teaching stair climbing or ramp walking	15 min	5732	S	$25.23	$5.05
Teaching in self-management/action plan	15 min	5732	S	$25.23	$5.05
Teaching in smoking cessation	15 min	5732	S	$25.23	$5.05
Teaching in use of pulse oximetry monitoring	15 min	5732	S	$25.23	$5.05

G0237 Therapeutic procedures to increase strength and endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring). Therapeutic examples below	Time	APC	Status Indicator	Base Payment (2022)	Co-Pay (2022)
Proper technique performing strength / endurance training	15 min	5732	S	$25.23	$5.05
Breathing retraining: PLB, DB, pace breathing, panic breathing	15 min	5732	S	$25.23	$5.05
Inspiratory Muscle trainer (IMT)	15 min	5732	S	$25.23	$5.05
Incentive Spirometer (IS)	15 min	5732	S	$25.23	$5.05

Other procedure type and description	Time	APC	Status Indicator	Base Payment (2022)	Co-Pay (2022)
G0436: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.	3-10 min	5821	S		
G0437: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.	>10 min	5821	S		
82962: Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use.					
94618: Pulmonary Stress Test/Simple (Six minute walk) with analysis including data conversion to MET level. May include oxygen titration with exercise.	NA	5734	Q1		
94664: Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered-dose inhaler with/without holding chamber, dry powder inhaler or IPPB device.	NA	5791	Q1		
94640: MDI or Nebulizer treatments.	NA	5722	Q1		
94667: Manipulation chest wall, such as chest PT, e.g. percussion and vibration to facilitate lung function, initial demonstration and or evaluation, use of positive expiratory pressure device (Acapella, TheraPEP, Flutter), Vest or other device to promote secretion clearance					
94760, 94761: Pulse Oximetry with appropriate documentation, including determination of oxygen needs at rest and with activity					
96152: Health and behavior intervention, each 15 minutes, face-to-face; individual.					
96153: Health and behavior intervention, each 15 minutes, face-to-face; group.					

97001: Physical Therapy evaluation includes assessment and treatment planning.					
97003: Occupational Therapy for evaluation includes assessment and treatment planning.					
97802: Medical nutrition therapy, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes including management of cachexia, obesity, follow-up with medical team.					
97803: Medical nutrition therapy, reassessment and intervention, individual, face-to-face with the patient, each 15 minutes including management of cachexia, obesity, follow-up with medical team.					
97804: Medical nutrition therapy, reassessment and intervention, group (2 or more individuals), each 30 minutes including management of cachexia, obesity, follow-up with medical team.					
99211-99215: E & M codes previously used for initial evaluation and development of individualized treatment program (ITP). Includes patient evaluation, individualized goal, ongoing reassessment, discharge instruction and exercise prescription.					
98960: Education and training for patient self-management, face-to-face with the patient, each 30 minutes, including prevention and management of exacerbations, action plan, disease self management strategies, management of panic, anxiety and depression, end of life planning, control of airway irritants and allergens.					
98961: Education and training for patient self-management, 2-4 patients, each 30 minutes, including prevention and management of exacerbations, action plan, disease self- management strategies, management of panic, anxiety and depression, end of life planning, control of airway irritants and allergens					
98962: Education and training for patient self-management 5-8 patients, each 30 minutes, including prevention and management of exacerbations, action plan, disease self- management strategies, management of panic, anxiety and depression, end of life planning, control of airway irritants and allergens.					

LIST OF SUPPLIES/EQUIMENT TO CONSIDER IN CHARGE CALCULATION

Equipment	QTY	COST	TOTAL
NuSteps			
Treadmills			
Air Dyne bikes			
Stationary bikes			
Recumbent bikes			
Elliptical trainers			
Recumbent elliptical trainers			
Rowing machines			
Steppers			
Arm ergometers			
Free weights (dumbbells, kettle bells)			
Elastic bands or tubing (Theraband)			
Wall pulleys			
Resistance equipment (Bow Flex, Hydrofit)			
Universal weight machine			
Shoulder wheel			
Mats, knee pads (for assist in getting up/down)			
Balls for resistance exercises on mat			

Department Equipment/Supplies	QTY	COST	TOTAL
Blood pressure cuffs			
Stethoscope			
Oximeters (stationary, hand held and finger oximeter, probes and replacement oximeter sensors finger, earlobe and forehead)			
Timers, clipboards			
Oxygen (piped in oxygen, portable liquid, gas tanks &/or portable oxygen concentrators			
Oxygen system for storage and refill			
Oxygen strollers and holders			
Oxygen delivery of refills			
Nasal cannulas			
High flow nasal cannula			

Oximyzer pendent and cannula			
OxyArm			
Oxymask			
System for nasal cannula			
EKG monitoring capacity (defibrillator w/oscilloscope or telemetry)			
Crash (emergency) cart with defibrillator or AED			
FDA approved blood glucose monitor and quality assurance system			
Scale with calibration capability			
Rollator			
Quad cane			
4 point walker			
Cane			
Wheelchair			
Accapella high flow/low flow			
Aerobika			
PEP valves			
Vest device			
Peak Flow meters			
Hand sanitizer - wall mount			
Sani-wipes for equipment			
Gloves - wall mount			
First Aid supplies			
Audio system			

Software	**QTY**	**COST**	**TOTAL**
Krames on demand			
Epocrates			

Written Material	**QTY**	**COST**	**TOTAL**
Krames or other comprehensive PR education booklet			
Materials in other languages			

Books	QTY	COST	TOTAL
AACVPR PR Guidelines – most recent edition			
ACSM Guidelines for Exercise Testing and Prescription			

Department Furniture and Accessories	QTY	COST	TOTAL
Notebooks for class			
Files for patient charts			
File cabinets			
Computers			
Office for clinician			
Chairs and tables for education room			
Chairs for waiting room			
Dry erase boards and markers for education room and exercise room			
DVD and TV for education room			
TV for exercise room			
Benches/chairs for exercise room			
Files for patient exercise cards in exercise room			
Desk for charting in exercise room			
Phones			
Printer			
Copy/fax machine			
Coffee maker			
Sink for patients and staff to wash hands			
Bottled water			
Wall clocks			
Refrigerator			
Water dispenser and disposable cups			

Other items included in charge	QTY	COST	TOTAL
Gym and hallways for 6 minute test			
Staff orientation, vacation, retirement, healthcare, worker's comp			
Medical director including ITP review and signature, if used: PT, OT, nutritionist, social work, psychologist			

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
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22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

LIST OF SUPPLIES/EQUIMENT TO CONSIDER IN CHARGE CALCULATION

Examples of PR actual costs (direct and Indirect)			
Salaries	PR staff*	3.5 FTE	$425,639
	Medical Director		$25,000
	Registry		$250
	Benefits		
	Pension		
	Vacation, holidays, sick leave		$70,355
Equipment	Capital		$15,000
	Non-capital equipment		$3,500
Supplies	Clinical supplies		$7,200
	Administrative supplies		$1,000
	Cleaning/sterilization supplies		$425
	Postage/Freight (outbound)		$305
Miscellaneous	Patient parking*		
Total expenses			$485,000

*program dependent

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

VIRTUAL SERVICES

- **Telehealth services:** Virtual visits conducted between a provider and a patient defined by CMS as two-way, audiovisual-real-time communications technology. Use of two-way, real-time interactive audio/video telecommunication capability is needed.
- Bill professional claims for all telehealth services and for the duration of the public health emergency or PHE) to Medicare with place of service (POS) equal to what it would have been had the service been furnished in-person (example: POS 11 for office or POS 19 for provider-based outpatient hospital).
- Bill appropriate covered telehealth service code(s).
- Modifier 95 should be applied to claim lines for services furnished via telehealth.
- Only 94625 and 94626 have been added to the list of Covered Telehealth Services

AACVPR RESOURCES

- American Association of Cardiovascular and Pulmonary Rehabilitation. Guidelines for pulmonary rehabilitation programs. Fifth Edition. Champaign, IL: Human Kinetics; 2019. https://www.aacvpr.org/Publications
- AACVPR Outpatient Pulmonary Rehabilitation Registry
- AACVPR Resources for Professionals
- AACVPR COVID-19 Resources for CR/PR Professionals

PR REFERENCES

1. Spruit MA, Singh SJ, Garvey C, *et al*. An official American Thoracic Society/European Respiratory Society statement: key concepts and advances in pulmonary rehabilitation. Am J Respir Crit Care Med 2013;188:e13–64.
2. Rochester CL, Vogiatzis I, Holland AE, Lareau SC, Marciniuk DD, Puhan MA, *et al*.; ATS/ERS Task Force on Policy in Pulmonary Rehabilitation. An official American Thoracic Society/European Respiratory Society policy statement: enhancing implementation, use, and delivery of pulmonary rehabilitation. *Am J Respir Crit Care Med* 2015;192:1373–1386.
3. American Association of Cardiovascular and Pulmonary Rehabilitation. Guidelines for pulmonary rehabilitation programs. Fifth Edition. Champaign, IL: Human Kinetics; 2019.
4. American College of Sports Medicine. *ACSM's Guidelines* for Exercise Testing and Prescription. Philadelphia :Lippincott Williams & Wilkins, 2017.
5. Global Initiative for Chronic Obstructive Lung Disease. *Global Strategy for the Diagnosis,Management, and Prevention of Chronic Obstructive Pulmonary Disease*.; 2022. Accessed May 27, 2022. 2022 GOLD Reports - Global Initiative for Chronic Obstructive Lung Disease. https://goldcopd.org
6. Lindenauer PK, Stefan MS, Pekow PS, et al. Association Between Initiation of Pulmonary Rehabilitation After Hospitalization for COPD and 1-Year Survival Among Medicare Beneficiaries.*JAMA*. 2020;323(18):1813-1823. doi:10.1001/jama.2020.4437
7. Maddocks M, Kon SSC, Singh SJ, Man WDC. Rehabilitation following hospitalization in patients withCOPD: can it reduce readmissions? *Respirol Carlton Vic*. 2015;20(3):395-404.doi:10.1111/resp.12454

8. Nici L, Raskin J, Rochester CL, et al. Pulmonary rehabilitation: WHAT WE KNOW AND WHAT WE NEED TO KNOW. *J Cardiopulm Rehabil Prev*. 2009; 29(3):141-151. doi:10.1097/HCR.0b013e3181a85cda

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1. Mosher,C, Nanna M, Jawitz O, Raman V, Farrow N, Aleem S, Casaburi R, MacIntyre, N;Palmer, S, Myers, E MD, MPHCost-effectiveness of Pulmonary Rehabilitation Among US Adults with Chronic Obstructive Pulmonary Disease. *JAMA Network Open.* 2022;5(6):e2218189. doi:10.1001/jamanetworkopen.2022.18189.
2. Holland A, Cox N, Houchen Wolloff L, Rochester C, Garvey C, et al. Defining Modern Pulmonary Rehabilitation. An Official American Thoracic Society Workshop Report. Ann ATS 2021;18: 12-29. https://doi.org/10.1513/AnnalsATS.202102-146ST
3. Maltais F, Bourbeau J, Shapiro S, *et al*. Effects of home-based pulmonary rehabilitation in patients with chronic obstructive pulmonary disease: a randomized trial. Ann Intern Med 2008;149:869–78.
4. Holland AE, Mahal A, Hill C, et al. Home-based rehabilitation for COPD using minimal resources: a randomised, controlled equivalence trial. Thorax 2017;72:57–65. doi:10.1136/thoraxjnl-2016-208514.
5. Bhatt S, Patel S, Anderson E, et al. Video Telehealth pulmonary rehabilitation intervention in Chronic Obstructive Pulmonary Disease reduces 30-day readmissions. Am J Respir Crit Care Med. 2019:15;200:511-513.
6. Nici L, Singh SJ, Holland AE, ZuWallack RL. Opportunities and challenges in expanding pulmonary rehabilitation into the home and community. *Am J Respir Crit Care Med* 2019;200:822–827.

AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

ATS American Thoracic Society

CHEST AMERICAN COLLEGE of CHEST PHYSICIANS

www.aacvpr.org www.aarc.org www.thoracic.org www.chestnet.org