MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP-8.008

Original Issue Date (Created):	**3/28/2005**
Most Recent Review Date (Revised):	**3/27/2020**
Effective Date:	**10/1/2020**

I. POLICY

A single course of pulmonary rehabilitation in the outpatient setting may be considered **medically necessary** for outpatient treatment of chronic pulmonary disease for patients with moderate-to-very severe disease.

Candidates for pulmonary rehabilitation should be medically stable and not limited by another serious or unstable medical condition.

Contraindications to pulmonary rehabilitation include:

- 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).

A single course of pulmonary rehabilitation may be considered **medically necessary** in an outpatient setting as a preoperative conditioning component for those considered appropriate candidates for lung volume reduction surgery and for lung transplantation.

Pulmonary rehabilitation programs are considered **medically necessary** following lung transplantation.

Pulmonary rehabilitation programs are considered **investigationa**l following other types of lung surgery, included but not limited to lung volume reduction surgery and surgical resection of lung cancer. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with other situations.

Multiple courses of pulmonary rehabilitation are considered **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. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with multiple courses of pulmonary rehabilitation services.

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Home-based pulmonary rehabilitation programs are considered **investigational**. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with home-based pulmonary rehabilitation services.

Pulmonary rehabilitation programs are considered **investigational** in all other situations. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with other situations.

Policy Guidelines

A pulmonary rehabilitation outpatient program is a comprehensive program that generally includes team assessment, patient training, psychosocial intervention, exercise training, and follow-up. The overall length of the program and the total number of visits for each component may vary from program to program.

Team assessment includes input from a physician, respiratory care practitioner, nurse, and psychologist, among others.

Patient training includes breathing retraining, bronchial hygiene, medications, and proper nutrition.

Psychosocial intervention addresses support system and dependency issues.

Exercise training includes strengthening and conditioning and may include stair climbing, inspiratory muscle training, treadmill walking, cycle training (with or without ergometer), and supported and unsupported arm exercise training. Exercise conditioning is an essential component of pulmonary rehabilitation. Education in disease management techniques without exercise conditioning does not improve health outcomes of patients who have chronic obstructive pulmonary disease.

Follow-up to a comprehensive outpatient pulmonary rehabilitation program may include supervised home exercise conditioning.

Candidates for pulmonary rehabilitation should be medically stable and not limited by another serious or unstable medical condition.

Cross-references:

MP-9.014 Heart/Lung Transplant
MP-9.015 Lung and Lobar Lung Transplant

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital BlueCross please see additional information below, and subject to benefit variations as discussed in Section VI below.

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FEP PPO: Refer to FEP Medical Policy Manual MP-8.03.55, Outpatient Pulmonary Rehabilitation. The FEP Medical Policy Manual can be found at https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION/BACKGROUND

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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.

The American Thoracic Society (ATS) and the European Respiratory Society (ERS) define pulmonary rehabilitation 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." PR programs are intended to improve the patient's functioning and quality of life. The vast majority of study has focused on patients with chronic obstructive pulmonary disease (COPD), although there has been some interest in PR in patients with asthma, cystic fibrosis, or bronchiectasis.

PR is also routinely offered to patients awaiting lung transplantation and lung volume reduction surgery (LVRS). 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 non-compliance, poor health, or other reasons.

IV. RATIONALE

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Summary of Evidence

Chronic Pulmonary Disease Rehabilitation

For individuals with moderate-to-severe 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 (i.e., 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 outcomes 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 nonexercise control conditions immediately after the intervention. The evidence is insufficient to determine the effects of the technology on health outcomes.

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.

PR 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 postsurgery. 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 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 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.

V. DEFINITIONS

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N/A

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital BlueCross. Members and providers should consult the member's health benefit plan for information or contact Capital BlueCross for benefit information.

VII. DISCLAIMER

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Capital BlueCross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit

information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital BlueCross' Provider Services or Member Services. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered:

HCPCS Code	Description
G0305	Post discharge pulmonary surgery services after LVRS, minimum of 6 days of services

Covered when medically necessary:

HCPCS Code	Description
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, 2 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
G0424	Pulmonary Rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day.
S9473	Pulmonary rehabilitation program, non-physician provider, per diem

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ICD-10-CM Diagnosis Codes	Description
D38.1	Neoplasm of uncertain behavior of trachea, bronchus and lung
D86.0	Sarcoidosis of lung
D86.1	Sarcoidosis of lymph nodes
D86.2	Sarcoidosis of lung with sarcoidosis of lymph nodes
D86.9	Sarcoidosis, unspecified
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
I27.0	Primary pulmonary hypertension
I27.20	Pulmonary hypertension, unspecified
I27.23	Pulmonary hypertension due to lung diseases and hypoxia
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J41.8	Mixed simple and mucopurulent 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
J60	Coalworker's pneumoconiosis
J61	Pneumoconiosis due to asbestos and other mineral fibers
J62.0	Pneumoconiosis due to talc dust
J62.8	Pneumoconiosis due to other dust containing silica
J63.0	Aluminosis (of lung)
J63.1	Bauxite fibrosis (of lung)
J63.2	Berylliosis
J63.3	Graphite fibrosis (of lung)
J63.4	Siderosis
J63.5	Stannosis
J63.6	Pneumoconiosis due to other specified inorganic dusts
J65	Pneumoconiosis associated with tuberculosis
J66.0	Byssinosis

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ICD-10-CM Diagnosis Codes	Description
J66.1	Flax-dressers' disease
J66.2	Cannabinosis
J66.8	Airway disease due to other specific organic dusts
J67.0	Farmer's lung
J82	Pulmonary eosinophilia, not elsewhere classified
J82.8	Pulmonary eosinophilia, not elsewhere classified
J82.89	Other Pulmonary Eosinophilia, not elsewhere classified
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
J84.115	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
J84.178	Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere
J84.2	Lymphoid interstitial pneumonia
J84.89	Other specified interstitial pulmonary diseases
J84.9	Interstitial pulmonary disease, unspecified
J98.4	Other disorders of lung
J99	Respiratory disorders in diseases classified elsewhere
Z76.82	Awaiting organ transplant status
Z94.2	Lung transplant status
Z94.3	Heart and lungs transplant status

IX. REFERENCES

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X. POLICY HISTORY

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MP 8.008	**CAC 11/30/04**
	CAC 9/27/05
	CAC 11/29/05
	CAC 11/28/06
	CAC 1/29/08
	CAC 5/26/09
	CAC 5/25/10 Consensus
	CAC 7/26/11 Adopting BCBSA. Changed title to match BCBSA-Outpatient Pulmonary Rehabilitation (formerly Outpatient Pulmonary Rehabilitation and Pulmonary Function Tests). Changed disease severity range indication from moderate-to-severe disease to moderate-to-very severe disease.

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	Changed policy statement for multiple courses of pulmonary rehab from "not medically necessary" to "investigational". Deleted the limit of 18 sessions. Deleted statement indicating this therapy is not medically necessary for other diagnosis. Deleted information related to pulmonary functions testing, patient initiated spirometry, transtelephonic or home PFTs. Deleted benefits information indicating noncoverage for maintenance programs including health club fees and exercise equipment. Deleted statement indicating ST, PT, OT and cardiac rehab is not covered in conjunction with pulmonary rehab unless for an unrelated condition. Added statement indicating home-based pulmonary rehabilitation programs are considered investigational. Deleted paragraph indicating patients with severe pulmonary impairment are not appropriate candidates.
	Administrative posting 3/22/12. Policy revised for clarification eliminating some restrictive clinical verbiage that is not found in the GOLD document.
	Administrative change 6/14/12.Deleted Medicare variation. LCD L31483 retired.
	Administrative change 7/23/12 Added Medicare variation referencing Claims Processing Manual. Added FEP variation referencing FEP policy manual.
	CAC 6/4/13 Consensus review. Administrative code review complete.
	CAC 3/25/14 Consensus. Added statement "Pulmonary rehabilitation programs are considered **investigational** in all other situations". Policy guideline section created and guideline statements moved into that section. Added rationale section. Updated references. Coding reviewed.
	CAC 3/24/15 Minor revision. Statement added that pulmonary rehabilitation is considered medically necessary following lung transplantation and investigational following other types of lung surgery. References and rationale updated. Policy coded.
	CAC 5/31/16 Consensus review. No changes to the policy statements. Rationale and references updated. Coding reviewed.
	Admin update 1/1/17 Variation reformatting
	CAC 7/25/17 Consensus review. No changes to the policy statements. Rationale and references updated**.** Coding updated
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies.
	5/14/18 Consensus review. Policy statements reordered, but unchanged. FEP variation removed as policy archived 10/15/2016. Description/Background, Rationale and Reference sections updated.
	10/1/18 Admin Update: Removed deleted ICD-10 codes, and added new ICD-10 codes effective 10/1/18.
	3/28/19 Consensus policy. No changes made to policy statement. References updated.

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	8/1/19 Coding update. Diagnosis list revised.
	3/27/2020 Consensus review. Added FEP variation**.** No changes made to policy statement.
	9/1/20 Administrative update. Added ICD 10 code J84.178, J82.89, J82.8

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