

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

Effective Date:	10/1/2023
------------------------	------------------

[POLICY RATIONALE](#)
[DISCLAIMER](#)
[POLICY HISTORY](#)

[PRODUCT VARIATIONS](#)
[DEFINITIONS](#)
[CODING INFORMATION](#)

[DESCRIPTION/BACKGROUND](#)
[BENEFIT VARIATIONS](#)
[REFERENCES](#)

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 individuals 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 **investigational** 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 general 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 general conclusion concerning the health outcomes or benefits associated with multiple courses of pulmonary rehabilitation services.

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

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

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.

Individual 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 2.380 Diagnosis and Treatment of Post-Acute Sequelae COVID (PASC)

MP 9.014 Heart/Lung Transplant

MP 9.015 Lung and Lobar Lung Transplant

II. PRODUCT VARIATIONS

[TOP](#)

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

FEP PPO: Refer to FEP Medical Policy Manual. 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

[TOP](#)

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.

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

In 2013, 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.”¹ PR programs are intended to improve the patient’s functioning and quality of life. Most research 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

[TOP](#)

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 2 systematic reviews of RCTs. 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 a systematic review of RCTs. 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.

Although most published evidence on outpatient pulmonary rehabilitation for chronic pulmonary diseases assesses COPD, observational studies have reported on outcomes from pulmonary rehabilitation for other chronic pulmonary diseases. Clinical guidelines from pulmonary organizations have supported the use of outpatient pulmonary rehabilitation for individuals who are experiencing disabling symptoms and have significantly diminished quality of life despite

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

optimal medical management. Therefore, outpatient pulmonary rehabilitation 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 pulmonary rehabilitation is an appropriate component of care for patients with COPD before undergoing lung volume reduction surgery. Also, pulmonary rehabilitation is considered the standard of care in individuals undergoing lung transplantation to maximize preoperative pulmonary status. Thus, pulmonary rehabilitation may be considered medically necessary for individuals considered appropriate candidates for lung volume reduction surgery 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 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 a case series. 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 2 RCTs. 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,

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

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 an RCT. Relevant outcomes are symptoms, functional outcomes, and quality of life. This small RCT had methodologic limitations and did not report inpatient and outpatient outcomes separately; it also lasted only 3 weeks. 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

[TOP](#)

N/A

VI. BENEFIT VARIATIONS

[TOP](#)

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 Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

[TOP](#)

Capital Blue Cross'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 Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

VIII. CODING INFORMATION

[TOP](#)

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:

Procedure Codes							
G0305							

Covered when medically necessary:

Procedure Codes							
94625	94626	G0237	G0238	G0239	G0302	G0303	G0304
S9473							

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

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

ICD-10-CM Diagnosis Codes	Description
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.89	Other specified chronic obstructive pulmonary disease
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
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

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

ICD-10-CM Diagnosis Codes	Description
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

[TOP](#)

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.* Oct 15 2013; 188(8): e13-64. PMID 24127811
2. Puhan MA, Gimeno-Santos E, Cates CJ, et al. Pulmonary rehabilitation following exacerbations of chronic obstructive pulmonary disease. *Cochrane Database Syst Rev.* Dec 08 2016; 12(12): CD005305. PMID 27930803
3. McCarthy B, Casey D, Devane D, et al. Pulmonary rehabilitation for chronic obstructive pulmonary disease. *Cochrane Database Syst Rev.* Feb 23 2015; (2): CD003793. PMID 25705944
4. Rugbjerg M, Iepsen UW, Jørgensen KJ, et al. Effectiveness of pulmonary rehabilitation in COPD with mild symptoms: a systematic review with meta-analyses. *Int J Chron Obstruct Pulmon Dis.* 2015; 10: 791-801. PMID 25945044
5. Román M, Larraz C, Gómez A, et al. Efficacy of pulmonary rehabilitation in patients with moderate chronic obstructive pulmonary disease: a randomized controlled trial. *BMC Fam Pract.* Feb 11 2013; 14: 21. PMID 23399113
6. Gottlieb V, Lyngsø AM, Nybo B, et al. Pulmonary rehabilitation for moderate COPD (GOLD 2)--does it have an effect?. *COPD.* Oct 2011; 8(5): 380-6. PMID 21936683
7. Liu X-D, Jin H-Z, Ng B-P, et al. Therapeutic effects of qigong in patients with COPD: a randomized controlled trial. *Hong Kong J Occup Ther.* Aug 9 2012; 22(1): 38-46
8. van Wetering CR, Hoogendoorn M, Mol SJ, et al. Short- and long-term efficacy of a community-based COPD management programme in less advanced COPD: a randomised controlled trial. *Thorax.* Jan 2010; 65(1): 7-13. PMID 19703824
9. Dowman L, Hill CJ, May A, et al. Pulmonary rehabilitation for interstitial lung disease. *Cochrane Database Syst Rev.* Feb 01 2021; 2(2): CD006322. PMID 34559419
10. Yu X, Li X, Wang L, et al. Pulmonary Rehabilitation for Exercise Tolerance and Quality of Life in IPF Patients: A Systematic Review and Meta-Analysis. *Biomed Res Int.* 2019; 2019: 8498603. PMID 31016200
11. Cheng L, Tan B, Yin Y, et al. Short- and long-term effects of pulmonary rehabilitation for idiopathic pulmonary fibrosis: a systematic review and meta-analysis. *Clin Rehabil.* Oct 2018; 32(10): 1299-1307. PMID 29843523

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

12. Lee AL, Hill CJ, McDonald CF, et al. Pulmonary Rehabilitation in Individuals With Non-Cystic Fibrosis Bronchiectasis: A Systematic Review. *Arch Phys Med Rehabil.* Apr 2017; 98(4): 774-782.e1. PMID 27320420
13. Araújo AS, Figueiredo MR, Lomonaco I, et al. Effects of Pulmonary Rehabilitation on Systemic Inflammation and Exercise Capacity in Bronchiectasis: A Randomized Controlled Trial. *Lung.* Jun 2022; 200(3): 409-417. PMID 35543710
14. Fishman A, Martinez F, Naunheim K, et al. A randomized trial comparing lung-volume-reduction surgery with medical therapy for severe emphysema. *N Engl J Med.* May 22 2003; 348(21): 2059-73. PMID 12759479
15. Hoffman M, Chaves G, Ribeiro-Samora GA, et al. Effects of pulmonary rehabilitation in lung transplant candidates: a systematic review. *BMJ Open.* Feb 03 2017; 7(2): e013445. PMID 28159852
16. Morano MT, Araújo AS, Nascimento FB, et al. Preoperative pulmonary rehabilitation versus chest physical therapy in patients undergoing lung cancer resection: a pilot randomized controlled trial. *Arch Phys Med Rehabil.* Jan 2013; 94(1): 53-8. PMID 22926460
17. Benzo R, Wigle D, Novotny P, et al. Preoperative pulmonary rehabilitation before lung cancer resection: results from two randomized studies. *Lung Cancer.* Dec 2011; 74(3): 441-5. PMID 21663994
18. Bradley A, Marshall A, Stonehewer L, et al. Pulmonary rehabilitation programme for patients undergoing curative lung cancer surgery. *Eur J Cardiothorac Surg.* Oct 2013; 44(4): e266-71. PMID 23959742
19. Beling J. Improved health-related quality of life after lung volume reduction surgery and pulmonary rehabilitation. *Cardiopulm Phys Ther J.* Sep 2009; 20(3): 16-22. PMID 20467519
20. Wickerson L, Mathur S, Brooks D. Exercise training after lung transplantation: a systematic review. *J Heart Lung Transplant.* May 2010; 29(5): 497-503. PMID 20133160
21. Langer D, Burtin C, Schepers L, et al. Exercise training after lung transplantation improves participation in daily activity: a randomized controlled trial. *Am J Transplant.* Jun 2012; 12(6): 1584-92. PMID 22390625
22. Fuller LM, Button B, Tarrant B, et al. Longer Versus Shorter Duration of Supervised Rehabilitation After Lung Transplantation: A Randomized Trial. *Arch Phys Med Rehabil.* Feb 2017; 98(2): 220-226.e3. PMID 27697429
23. Munro PE, Holland AE, Bailey M, et al. Pulmonary rehabilitation following lung transplantation. *Transplant Proc.* 2009; 41(1): 292-5. PMID 19249538
24. Stigt JA, Uil SM, van Riesen SJ, et al. A randomized controlled trial of postthoracotomy pulmonary rehabilitation in patients with resectable lung cancer. *J Thorac Oncol.* Feb 2013; 8(2): 214-21. PMID 23238118
25. Edvardsen E, Skjønsberg OH, Holme I, et al. High-intensity training following lung cancer surgery: a randomised controlled trial. *Thorax.* Mar 2015; 70(3): 244-50. PMID 25323620
26. Carr SJ, Hill K, Brooks D, et al. Pulmonary rehabilitation after acute exacerbation of chronic obstructive pulmonary disease in patients who previously completed a pulmonary rehabilitation program. *J Cardiopulm Rehabil Prev.* 2009; 29(5): 318-24. PMID 19561523

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

27. COPD Working Group. Pulmonary rehabilitation for patients with chronic pulmonary disease (COPD): an evidence-based analysis. *Ont Health Technol Assess Ser.* 2012; 12(6): 1-75. PMID 23074434
28. Güell MR, Cejudo P, Ortega F, et al. Benefits of Long-Term Pulmonary Rehabilitation Maintenance Program in Patients with Severe Chronic Obstructive Pulmonary Disease. Three-Year Follow-up. *Am J Respir Crit Care Med.* Mar 01 2017; 195(5): 622-629. PMID 27611807
29. Wilson AM, Browne P, Olive S, et al. The effects of maintenance schedules following pulmonary rehabilitation in patients with chronic obstructive pulmonary disease: a randomised controlled trial. *BMJ Open.* Mar 11 2015; 5(3): e005921. PMID 25762226
30. Liu XL, Tan JY, Wang T, et al. Effectiveness of home-based pulmonary rehabilitation for patients with chronic obstructive pulmonary disease: a meta-analysis of randomized controlled trials. *Rehabil Nurs.* 2014; 39(1): 36-59. PMID 23780865
31. Vieira DS, Maltais F, Bourbeau J. Home-based pulmonary rehabilitation in chronic obstructive pulmonary disease patients. *Curr Opin Pulm Med.* Mar 2010; 16(2): 134-43. PMID 20104176
32. Stafinski T, Nagase FI, Avdagovska M, et al. Effectiveness of home-based pulmonary rehabilitation programs for patients with chronic obstructive pulmonary disease (COPD): systematic review. *BMC Health Serv Res.* Apr 26 2022; 22(1): 557. PMID 35473597
33. Neves LF, Reis MH, Gonçalves TR. Home or community-based pulmonary rehabilitation for individuals with chronic obstructive pulmonary disease: a systematic review and meta-analysis. *Cad Saude Publica.* Jun 20 2016; 32(6). PMID 27333130
34. 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.* Dec 16 2008; 149(12): 869-78. PMID 19075206
35. Qaseem A, Wilt TJ, Weinberger SE, et al. Diagnosis and management of stable chronic obstructive pulmonary disease: a clinical practice guideline update from the American College of Physicians, American College of Chest Physicians, American Thoracic Society, and European Respiratory Society. *Ann Intern Med.* Aug 02 2011; 155(3): 179-91. PMID 21810710
36. Rochester CL, Vogiatzis I, Holland AE, et al. An Official American Thoracic Society/European Respiratory Society Policy Statement: Enhancing Implementation, Use, and Delivery of Pulmonary Rehabilitation. *Am J Respir Crit Care Med.* Dec 01 2015; 192(11): 1373-86. PMID 26623686
37. Wedzicha JA, Miravittles M, Hurst JR, et al. Management of COPD exacerbations: a European Respiratory Society/American Thoracic Society guideline. *Eur Respir J.* Mar 2017; 49(3). PMID 28298398
38. Holland AE, Cox NS, Houchen-Wolloff L, et al. Defining Modern Pulmonary Rehabilitation. An Official American Thoracic Society Workshop Report. *Ann Am Thorac Soc.* May 2021; 18(5): e12-e29. PMID 33929307
39. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. *Global Initiative for Chronic Obstructive Lung Disease.* 2023
40. Centers for Medicare & Medicaid Services. *National Coverage Determination (NCD) for Pulmonary Rehabilitation Services (240.8).* 2008

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

41. Blue Cross Blue Shield Association Medical Policy Reference Manual. 8.03.05, Outpatient Pulmonary Rehabilitation. April 2023

X. POLICY HISTORY

[TOP](#)

MP 8.008	CAC 11/30/2004
	CAC 09/27/2005
	CAC 11/29/2005
	CAC 11/28/2006
	CAC 01/29/2008
	CAC 05/26/2009
	CAC 05/25/2010 Consensus
	CAC 07/26/2011 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. 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 03/22/2012. Policy revised for clarification eliminating some restrictive clinical verbiage that is not found in the GOLD document.
	Administrative change 06/14/2012. Deleted Medicare variation. LCD L31483 retired.
	Administrative change 07/23/2012 Added Medicare variation referencing Claims Processing Manual. Added FEP variation referencing FEP policy manual.
	CAC 06/04/2013 Consensus review. Administrative code review complete.
	CAC 03/25/2014 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.

MEDICAL POLICY

POLICY TITLE	OUTPATIENT PULMONARY REHABILITATION
POLICY NUMBER	MP 8.008

	CAC 03/24/2015 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 05/31/2016 Consensus review. No changes to the policy statements. Rationale and references updated. Coding reviewed.
	Admin update 01/01/2017 Variation reformatting
	CAC 07/25/2017 Consensus review. No changes to the policy statements. Rationale and references updated. Coding updated
	01/01/2018 Admin Update: Medicare variations removed from Commercial Policies.
	05/14/2018 Consensus review. Policy statements reordered, but unchanged. FEP variation removed as policy archived 10/15/2016. Description/Background, Rationale, and Reference sections updated.
	10/01/2018 Admin Update: Removed deleted ICD-10 codes, and added new ICD-10 codes effective 10/1/18.
	03/28/2019 Consensus review. No changes made to policy statement. References updated.
	08/01/2019 Coding update. Diagnosis list revised.
	03/27/2020 Consensus review. Added FEP variation. No changes made to policy statement.
	09/01/2020 Administrative update. Added ICD 10 code J84.178, J82.89, J82.8
	05/19/2021 Consensus review. No change to policy statements. References, description/background and rationale sections updated. FEP policy number corrected.
	12/02/2021 Administrative update. Added new codes 94625 and 94626 and removed G0424; effective 1/1/22.
	04/18/2022 Consensus review. No change to policy statement. Cross-reference added. References reviewed and added.
	4/5/2023 Consensus review. No change to policy statement. References reviewed and updated. Rationale and FEP statement updated. No coding changes.
	8/30/2023 Administrative review. Added J4489 to ICD-10-CM codes as part of new code update. Effective 10/1/2023.

[Top](#)

Health care benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company[®], Capital Advantage Assurance Company[®], and Keystone Health Plan[®] Central. Independent licensees of the Blue Cross BlueShield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.