NCCRA | North Carolina Cardiopulmonary Rehabilitation Association

Program Administration: Knowledge Challenge

CARDIAC AND PULMONARY REHABILITATION

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Discussion Topics

- Coding and Billing Issues in PR
  - Covered Dx
  - Billing code guidelines: PR vs. ORS
  - What about commercial plans
  - Benefit verification – quick guide
  - Examples of possible 1:1needs
  - Daily Notes – Time increments
- ITP
  - Required components
  - Justification for 1:1 – examples
- Reimbursement rates
- Essential elements
- Audit Tips and Tricks
- Reimbursement Toolkit

Patient Selection and Enrollment

Pulmonary Rehab:
Two Separate Programs Under One Umbrella

1. Pulmonary Rehabilitation (PR)
   - Billed when patient meets criteria for PR with their specific insurance
   - Eligibility varies among payers
   - Medicare Rules CFR 410.47

2. Outpatient Respiratory Services (ORS)
   - Billed when patient has a diagnosed chronic, symptomatic respiratory disease/disorder, but does not meet policy-specific criteria for PR
   - Commercial insurance may or may not provide specific guidance for ORS
   - Medicare Rules (Palmetto GBA) LCD 34430 / LCA 56717

Medicare allows (2) Diagnoses in Pulmonary Rehab

1. **COPD**
   - Moderate to very severe COPD (defined as GOLD classification II, III, and IV)
   - PFT required for eligibility – no time limit on PFT (*table next slide)
2. **Post COVID-19**
   - Patient with confirmed or suspected COVID-19, experiencing persistent symptoms that include respiratory dysfunction for at least 4 weeks
   - The 4 week "wait" may begin with symptom onset
   - PFTs are NOT required
   - Positive COVID-19 test is NOT required
   - Hospitalization is NOT required

*Both diagnoses count toward the 72 PR sessions (total lifetime) allowed by Medicare.

CLASSIFICATION OF AIRFLOW LIMITATION SEVERITY IN COPD (BASED ON POST-BRONCHODILATOR FEV_1)

In patients with FEV1/FVC < 0.70:		
GOLD 1:	Mild	$FEV_1 \geq 80\%$ predicted
GOLD 2:	Moderate	$50\% \leq FEV_1 < 80\%$ predicted
GOLD 3:	Severe	$30\% \leq FEV_1 < 50\%$ predicted
GOLD 4:	Very Severe	$FEV_1 < 30\%$ predicted

Both criteria must be met!

*From Global Initiative for Chronic Obstructive Lung Disease. www.goldcopd.org

Pulmonary Rehab Coding

- When using COPD diagnosis, (1) ICD-10 diagnosis code is used
  - From Federal Register 410.47 Pulmonary rehabilitation program: Conditions for coverage: "Medicare covers pulmonary rehabilitation for beneficiaries with moderate to very severe COPD (defined as GOLD classification II, III and IV)…
  - ICD-10 code for COPD, unspecified is J44.9

- When using Post-COVID 19 diagnosis, (2) ICD-10 diagnosis codes are needed
  - First code = specific symptom(s) or condition(s) related to the COVID-19 infection
    - Examples listed in ICD-10 coding manual include:

      J96.1 – Chronic respiratory failure (not acute)

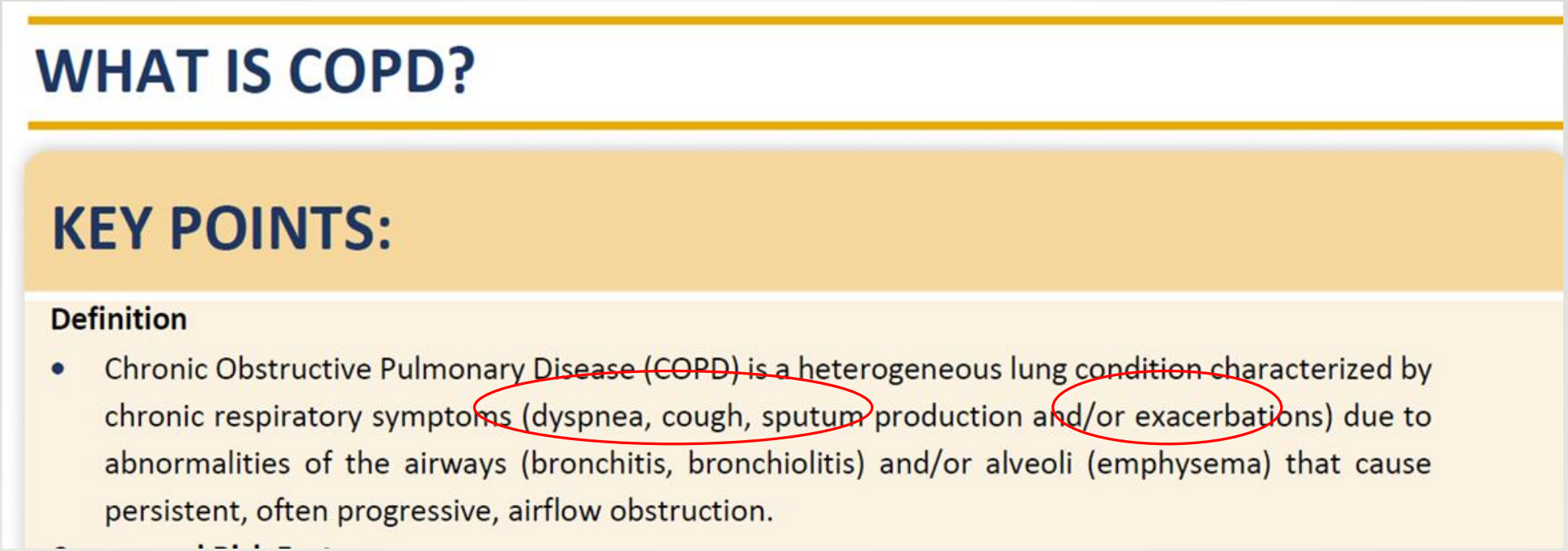
      J12.82 – Pneumonia due to coronavirus disease

      M35.81 – Multisystem inflammatory syndrome

      R06.09 – Other forms of dyspnea

      R06.02 – Shortness of breath
  - Second code = U09.9 (Post-COVID 19 condition, unspecified)

What Diagnoses does MC consider COPD?



WHAT IS COPD?

KEY POINTS:

Definition

- Chronic Obstructive Pulmonary Disease (COPD) is a heterogeneous lung condition characterized by chronic respiratory symptoms (dyspnea, cough, sputum production and/or exacerbations) due to abnormalities of the airways (bronchitis, bronchiolitis) and/or alveoli (emphysema) that cause persistent, often progressive, airflow obstruction.

*From Global Initiative for Chronic Obstructive Lung Disease. www.goldcopd.org

Pulmonary Rehabilitation (PR) and Medicare

- Medicare (MC) allows 36 sessions over 36 weeks per referral
  - 72 maximum sessions, based on medical necessity
  - KX modifier is needed starting with session #37 (billed to MC after 1/1/2010)
  - After 72 PR sessions have been billed to MC, additional sessions will be denied
- *Individualize* your plan of care
  - More beneficial to attend all (or most) of available sessions *now?*
  - Better to "save" some sessions for later?
- MC does not grant additional sessions "per event" as they do in Cardiac Rehab… 72 is all we get!

Pulmonary Rehab and Medicare

- Up to (2) sessions of Pulmonary Rehab may be billed per day
- 1 session = 31 minutes to 90 minutes; 91 minutes or more = 2 sessions (must bill)
- Some form of exercise must be included in each billed "session" (document)
  - If billing for (2) sessions, documentation should clearly show that exercise was included in the first 31 minutes *and* in the last 60 minutes of the session.
  - If someone unfamiliar with your program looks (audits) it should be *obvious* to them
- A "session" means the time in the rehab area, NOT just exercise time
- *Any* type of exercise counts (6MWT, strength training, hall walking, etc.)
- If no exercise is completed/documented, no charge may be submitted (even if considerable time was spent with the patient)

Pulmonary Rehab Billing

- Two codes available for Pulmonary Rehab (replaced G0424 on 1/1/22)
  - **94625** – Pulmonary Rehab *without* continuous pulse oximetry monitoring
  - **94626** – Pulmonary Rehab *with* continuous pulse oximetry monitoring
    - No other charges may be submitted to Medicare in Pulmonary Rehab
    - Some commercial payors approve only the 94626 code
    - Reimbursement is the same for both codes
    - PR billing is similar to CR billing (with/without ECG monitoring)
- *If* you use 94626 (continuous), make sure documentation supports
  - Auditors interpret regulations *literally,* and perhaps not as MC intended
  - Does your documentation clearly show that pulse oximetry was continuous?
  - Consider: Does the patient *require* continuous pulse ox?
    - Are you (or the patient) relying too heavily on the "numbers" rather than helping them learn to monitor and manage their "symptoms?"

Pulmonary Rehab and Other Insurers

- **If you follow Medicare policy rules for all your patients, you are missing out on potential clients *and* reimbursement**
- Commercial insurers are typically more *inclusive* with coverage
  - Often include additional diagnoses in their policy
  - May or may not have PFT requirements for COPD diagnosis (or criteria differs from MC)
  - May have a session limit per referral or calendar year; may not have a "lifetime" limit
- State-run Medicaid programs have their own qualifying diagnoses and criteria
- VA establishes and follows their own set of rules

Clinical Data review

- When the referral comes to you, it is up to your department (the experts) to determine…
  - if the diagnosis listed works with PR or ORS or neither and/or
  - if the patient is a valid candidate (not all referrals are)
- **Remember, just because they have a diagnosis that might work, doesn't mean they meet medical necessity**.
  - Examples:
    - Post COVID with brain fog but no respiratory symptoms reported
    - Stage 1 COPD patient with SOB with ADLs and frequent ED visits

Daily Notes

WHY???

- Daily note supports billing of services that were provided during a specific visit vs. Individualized Treatment Plan that supports medical necessity
- Supports billing of timed codes (G0237-G0238) and treatment code (G0239) as well as 94625 and 94626
- Facilitates completion of ITP

WHAT???

- Clear, concise, pt. centered
- Pt must be present for at least 31 minutes in order to charge for visit
- Must perform some exercise each session (pulmonary) or each day (cardiac)
- Continuous vs. intermittent pulse oximetry

Examples of possible 1:1 needs

Asthmatics
Education: Medications, peak flow, action
plan

ILD
Education: ADLs, O2, Lung Transplant, Advance care planning

PAH
Education: Self monitoring, medications, action
plan

Bronchiectasis
Education: Airway clearance techniques, medications, action plan

Lung Cancer
Education: Breathing and relaxation techniques

Special considerations for pulmonary rehabilitation in people with conditions other than chronic obstructive pulmonary disease

	Exercise training	Non-exercise components
Asthma	Assess for exercise-induced bronchospasm If present, pre-medicate with a rapid-acting inhaled β_2-agonist prior to exercise and include a gradual warm-up	Consider breathing retraining techniques with known efficacy in asthma Self-management training includes education, goal setting, a personalised written action plan, self-monitoring of key symptoms and a review of asthma control, treatment and skills
ILD	Ensure supplemental oxygen is available Provide close supervision for individuals with severe disease and marked exercise-induced desaturation In connective tissue-related ILD, consider modifications to avoid joint pain	Consider addressing management of mood disorders, optimising activities of daily living, use of oxygen therapy, lung transplantation and advance care planning Consider linking with support groups and education services appropriate to underlying diagnosis (*e.g.* rheumatoid arthritis)
PAH	A recent history of syncope on exertion is a contraindication to exercise training Monitor PAH-specific symptoms during exercise, *e.g.* palpitations, chest pain, light-headedness and dizziness	Education regarding self-monitoring of PAH symptoms during exercise
Non-CF bronchiectasis	Consider inspiratory muscle training	Initiate or review airway clearance techniques
NSCLC	Duration of pre-operative rehabilitation programme may be shorter than normal so as not to delay cancer treatment Consider alternative forms of exercise training to enhance participation in people undergoing chemotherapy	Ensure a comprehensive interdisciplinary approach Consider nutritional and psychosocial counselling, behavioural change, occupational therapy and progressive relaxation techniques

ILD: interstitial lung disease; PAH: pulmonary arterial hypertension; CF: cystic fibrosis; NSCLC: nonsmall cell lung cancer.

Anne E. Holland, Karin Wadell, Martijn A. Spruit
European Respiratory Review 2013 22: 577-586; **DOI:** 10.1183/09059180.00005613

Cardiac Rehabilitation

- Qualifying dx
- Billing guidelines
- What about other payers?
- Benefit verification – quick guide

Qualifying dx for Medicare*

- Acute myocardial infarction within the preceding 12 months;
- Coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
- Heart or heart-lung transplant;
- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association class II through IV symptoms despite being on optimal heart failure therapy for at least 6 weeks. Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures.

*Commercial insurance companies often vary on covered dx

Billing codes for Cardiac rehabilitation

93797	Cardiac rehab
93798	Cardiac rehab/monitor
G0422	Intens cardiac rehab w/exerc
G0423	Intens cardiac rehab no exer

Billing Guidelines

- Each qualifying dx = 36 sessions
- Traditional: As specified at 42 CFR 410.49(f)(1), the number of CR sessions are limited to a maximum of 2, 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time*.
- ICR: A maximum of 72 session, up to 6 sessions per day. 18 weeks to complete
- ICR and Traditional – Exercise must occur on each day of service

* Beyond 36 sessions and beyond 36 weeks should be a rare to never event

KX modifier

- KX modifiers should be used for traditional Cardiac Rehabilitation services that exceed 36 sessions and ICR services that exceed 72 sessions.
- Despite a different diagnosis, the KX modifier should be used
- HIPAA Eligibility Transaction System **(**HET) counts from zero to infinity, once patient has reached 36/72 sessions, the KX modifier **must** be appended to the appropriate CR CPT® code

Billing Guidelines – doing CMS Math

- In order to report one session of cardiac rehabilitation services in a day, the duration of treatment must be at least 31 minutes.
- Two sessions of cardiac rehabilitation services may only be reported in the same day if the duration of treatment is at least 91 minutes.
  - In other words, the first session would account for 60 minutes and the second session would account for at least 31 minutes if two sessions are reported.

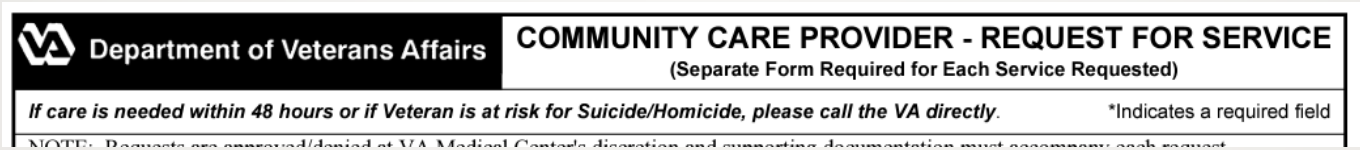
Private payer medical policies

- It's a good practice to try and obtain the medical policy for cardiac rehab for non Medicare payers that are typically seen in your area
- Updates/changes are typically made every 1-2 years so be prepared to look for the updated policy
- Pre-authorization will help you understand -copay amount, eligible diagnoses, # of sessions covered, length of time, outcomes expectations
- Some private payers don't require prior authorization, but you can recommend to patients to call about their coverage, so they better understand what to expect
- Check in with your central business office to understand any organizational policies related to documenting about coverage for a service and presence of a prior authorization

Other

- Medicare advantage organizations (MAOs) must cover what traditional FFS (Fee-for-Service) Medicare does, however, these plans can cover more

- VA - need to have authorization in place prior to starting rehab. They set their own standards as far as covered dx



Department of Veterans Affairs

COMMUNITY CARE PROVIDER - REQUEST FOR SERVICE

(Separate Form Required for Each Service Requested)

If care is needed within 48 hours or if Veteran is at risk for Suicide/Homicide, please call the VA directly.

*Indicates a required field

- Medicaid - AmeriHealth Caritas, Healthy Blue of NC, UnitedHealthcare of NC, WellCare of NC and Carolina Complete Health (region 3, 4, 5)

Benefit verification – quick guide

- Have all necessary information ready – Patient name, DOB, referring dx, hospital NPI/tax ID, patient's policy and plan # and CPT codes that will be used
  - Ensure that your clinical documentation supports medical necessity
- You will need to find out about Benefits as well as Prior authorization/precertification
- Ask "what kind of coverage can the patient expect?"
- How or if you share with the patient is an organization specific decision and how this conversation needs to be documented

Documentation

- ITP
- Session Notes

Individualized Treatment Plan (ITP)

- *Supporting structure for patient's treatment plan*
- *Multi-disciplinary team + patient develop goals and identify strategies for meeting those goals*

Written plan established, reviewed, and signed by a physician every 30 days

- Diagnosis
- Type, amount, frequency, and duration of the items and services furnished under the plan
- Goals set for the individual patient under the plan to include:
  - Exercise
  - Nutrition
  - Psychosocial
  - Oxygen Management (Required for PR)
  - Other Core Components
- Outcomes/ Discharge Plan

Four ITP Steps: *--- Standardized approach is used to develop a personalized treatment plan*

Assessment

Problem statement – Identify specific needs for this patient?

- Information from medical record
- Patient interview

Plan: Goals, Physician Orders/Interventions, Education

Goals	Physician Orders/Interventions	Education
• Clear and concise statements based on problem statement • Understandable to patient • Realistic, measurable and achievable • Specific to each patient's needs and includes patient's personal goals	• Team + patient identify strategies (interventions) for achieving identified goals • Ex Rx must include type, amount, frequency, intensity of Ex • MD/DO signature before but no later than first billing date	• What does pt. need to know to better self-manage their condition? • Should be interactive with team – just handout or video not acceptable

Reassessment:

ITP review and MD/DO signature every 30 days from date of MD signature to next MD signature

Is pt. meeting goals? Changes needed?	Describe what was done. Changes needed?	Describe what was provided, pt./family response. What else is needed?

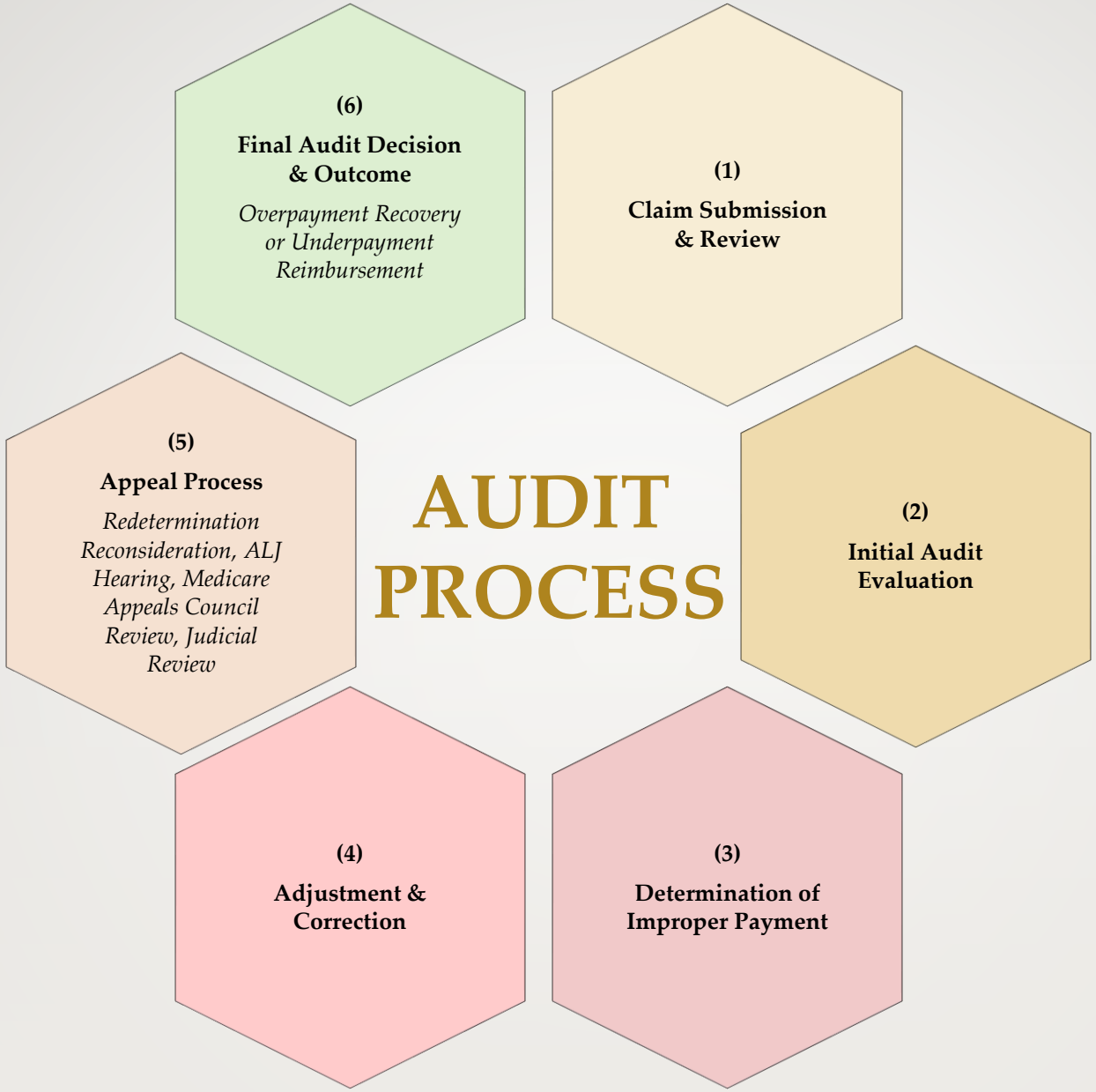
Discharge/Outcomes:

- Were goals met? – include both objective/subjective evidence
- Describe future plans for sustaining gains made during PR

What About Audits?

- Who is at risk?

AUDIT PROCESS



Red Flags

- Providers whose error rates are higher than their peers
  - Comparative billing audits
    - Billing practices
    - Utilization rates (allowables)
- Billing HCPCS or services with high national error rates
- Consistently using one code
- Billing for care not provided
- Unbundling procedures
- Coding based only on reimbursement and not medical necessity of services
- Utilization pattern differs from peers utilization practices

Dates of Service – *tell the whole story of the episode of care*

- *Audits based on specific dates can be triggered by many factors but generally are randomly selected*
- *When specific dates of service are selected it is expected that all documentation leading up to and including those dates of service be submitted so that medical necessity and the need for skilled intervention can be verified*

What to Include in an ADR Response

- Reason for referral
- Date of diagnosis onset/event, if known
- Date & time of initial rehabilitation visit
- Physician's order including physician prescribed exercise
- Initial assessment and treatment plan
  - *Must be signed by MD/DO before or on the date of first billed visit – **NEVER** later than first billed date*
- Attendance record including time-in/time-out
- Progress notes for each visit to include: documentation of education/training including information on respiratory problem management & smoking cessation, if warranted, pt.. response to treatment & progress toward goals, name of supervising physician
- ITP reviewed, dated, signed by Physician – can be a few days early, but **never** later than 30 days from the previous physician signature
- Pulse oximetry/Telemetry
- Discharge summary

42.CFR 410.47: Pulmonary Rehabilitation

Pulmonary Rehabilitation Audit Tool

Element	Error Question	Granular Error	Response
	Is the physician's order/referral to admit to Pulmonary Rehabilitation Services present?	There is no physician's order/referral for admission to Pulmonary Rehabilitation Services present.	
	Is there documentation present for all dates of services billed?	The documentation is missing for one or more of the dates of service billed.	
	Does the patient have moderate to severe chronic obstructive pulmonary disease (COPD) defined as GOLD classification II, III, and IV per 42 CFR 410.47 or COVID symptoms lasting at least 4 weeks?	The documentation submitted does not represent a patient with moderate to severe chronic obstructive pulmonary disease (COPD) as defined by the GOLD classification II, III, and IV per 42 CFR 410.47.	
	Does documentation show post-bronchodilator pulmonary function studies where fev1 is less than 80% of predicted and FEV1/FVC is less than 0.70 if admit diagnosis is COPD GOLD Stages II, III or IV?	The documentation of post-bronchodilator pulmonary function studies does not meet the documentation requirement of FEV1 less than 80% of predicted and FEV1/FVC less than 0.70.	
	Is the supervising physician immediately available and accessible for medical consultations and emergencies at all times when services are being provided under the program as defined in 42 CFR 410.47?	The documentation submitted does not indicate the supervising physician was available and accessible for medical consultations and emergencies at all times when services were being provided under the program as defined in 42 CFR 410.47?	
	Is there an individualized treatment plan signed by a physician and reviewed every 30 days as required by 42 CFR 410.47 present in record?	The documentation submitted does not represent an individualized treatment plan signed by a physician and reviewed every 30 days as required by 42 CFR 410.47.	
	Does the Pulmonary Rehabilitation program contain mandatory components as defined in 42 CFR 410.47?	The Pulmonary Rehabilitation program does not contain the mandatory components as defined in 42 CFR 410.47.	
	Is there a physician-prescribed exercise program?	There is no physician-prescribed exercise program present in the documentation.	
	Is there documentation of the patient's education or training as it relates to care and treatment?	There is no documentation of the patient's education or training as it relates to care and treatment.	
	Is there a psychosocial assessment of the individual's mental and emotional functioning as it relates to their rehabilitation or respiratory condition?	There is no psychosocial assessment of the individual's mental and emotional functioning as it relates to their rehabilitation or respiratory condition.	
	Is there an outcomes assessment of the patient's progress related to the respiratory condition?	There is no outcomes assessment of the patient's progress related to the rehabilitation.	
	Does documentation reflect pulmonary rehabilitation services up to 36 sessions and no more than two sessions per day as defined in 42 CFR 410.47?	The documentation submitted does not meet the requirements for pulmonary rehabilitation services up to 36 sessions and no more than 2 sessions per day as defined in 42 CFR 410.47.	
	Does documentation reflect pulmonary rehabilitation services up to 72 sessions, with KX modifier and no more than two sessions per day as defined in 42 CFR 410.47?	The documentation submitted does not meet the requirements for pulmonary rehabilitation services up to 72 sessions, with KX modifier and no more than two sessions per day as defined in 42 CFR 410.47.	

Adapted from CMS 42 CFR 410.47

Cardiac Rehabilitation Audit Tool

Element	Error Question	Granular Error	Response
	Is the physician's order/referral to admit to Cardiac Rehabilitation Services present?	There is no physician's order/referral for admission to Cardiac Rehabilitation present.	
	Is there documentation present for all dates of services billed?	The documentation is missing for one or more of the dates of service billed.	
	Does the patient have a covered dx? Acute MI within the preceding 12 months, CABG, Current Stable Angina Pectoris, Heart Valve Repair or Replacement, PTCA, Coronary Stenting, Heart or Heart-Lung Transplant, Stable CHF w/≤ 35% EF?	The documentation submitted does not represent a patient with qualifying diagnosis.	
	Is the supervising physician immediately available and accessible for medical consultations and emergencies at all times when services are being provided under the program as defined in 42 CFR 410.49?	The documentation submitted does not indicate the supervising physician was available and accessible for medical consultations and emergencies at all times when services were being provided under the program as defined in 42 CFR 410.49?	
	Is there an individualized treatment plan signed by a physician and reviewed every 30 days as required by 42 CFR 410.49 present in record?	The documentation submitted does not represent an individualized treatment plan signed by a physician and reviewed every 30 days as required by 42 CFR 410.49.	
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	Is there documentation of the patient's education or training as it relates to care and treatment?	There is no documentation of the patient's education or training as it relates to care and treatment.	
	Is there a psychosocial assessment of the individual's mental and emotional functioning as it relates to their rehabilitation or cardiac condition?	There is no psychosocial assessment of the individual's mental and emotional functioning as it relates to their rehabilitation or cardiac condition.	
	Is there an outcomes assessment of the patient's progress related to the cardiac condition?	There is no outcomes assessment of the patient's progress related to the rehabilitation.	
	Does documentation reflect cardiac rehabilitation services up to 36 sessions and no more than two sessions per day as defined in 42 CFR 410.49? If ICR, no more than 6 sessions per day . Complete 72 sessions within 18 months?	The documentation submitted does not meet the requirements for cardiac rehabilitation services up to 36 sessions and no more than 2 (6 if ICR) sessions per day as defined in 42 CFR 410.49 or 72 sessions within 18 months.	
	Does documentation reflect cardiac rehabilitation services up to 72 sessions, with KX modifier and no more than two sessions per day as defined in 42 CFR 410.49?	The documentation submitted does not meet the requirements for cardiac rehabilitation services up to 72 sessions, with KX modifier and no more than two sessions per day as defined in 42 CFR 410.49.	

Adapted from CMS 42 CFR 410.49

Tips and Tricks for Making Audits Less Stressful

- Tell the complete story – referral to outcomes
  - not just notes for DOS requested in ADR letter
- All records must be legible
  - No missing pages
- Never alter medical records after a notice of audit
- Are internal audits a part of your department's PI ?
- Establish relationship with your HIM/Billing staff
- Make sure Compliance Dept. communicates any denials to you and you help them find the records
- Become familiar with NCDs/LCDs/LCAs that apply to your location

Test your knowledge

- What is your cost to provide a session of CR/PR?

2024 Final Payment Rates for Hospital Outpatient Services

Service	Procedure Code	APC	Payment Rate	Patient/Secondary Insurance Amount
Cardiac rehab w/o monitor	93797	5771	$126.03	$25.21
Cardiac rehab w/monitor	93798	5771	$126.03	$25.21
Intens cardiac rehab w/exer	G0422	5771	$126.03	$25.21
Intens cardiac rehab no exer	G0423	5771	$126.03	$25.21
Therapeutic Procedures – strength/endurance	G0237	5731	$28.41	$5.69
Other Resp Procedures - Individual	G0238	5731	$28.41	$5.69
Other Resp Procedures – Group	G0239	5732	$38.26	$7.66
Pulmonary Rehabilitation w/o Continuous Oximetry Monitoring	94625	5733	$58.34	$11.67
Pulmonary Rehabilitation w/Continuous Oximetry Monitoring	94626	5733	$58.34	$11.67
Peripheral Vascular Rehab	93668	5733	$58.34	$11.67

Case study 1

71-year-old male with SOB on exertion referred to your pulmonary rehabilitation program. FVC 82% of predicted, FEV1 69% of predicted, FEV1/FVC ratio 90% of predicted.

1) Does this pt. meet enrollment criteria for PR?

2) Do you need any additional information?

3) What is the time requirement for PFTs?

4) What HCPCS/CPT codes would you use to bill for services?

Answers – Case 1

1) Does this pt. meet enrollment criteria for PR?

   Possibly, but you need to know the actual FEV1/FVC ratio, not the % predicted ratio

2) Do you need any additional information?

   Is there post-bronchodilator spirometry data?

3) What is the time requirement for PFTs?

   There currently is no PFT time requirement as long as available data is clinically relevant.

4) What HCPCS/CPT codes would you use to bill for services?

   If COPD 94625/94626 or if ORS G0237-G0239

Case study 2

46-year-old female tested positive for COVID-19 8 weeks ago. Pt. continues to report SOB, chest tightness, fatigue.

1) Does this pt. qualify for PR? What would be different if she were 68?
2) Would she be eligible for PR if she had no respiratory sx, just fatigue and brain fog?

Answers – Case Study 2

1) Does this pt. qualify for PR? What would be different if she were 68?

   Insurance coverage should be verified. She would most likely be covered by a commercial plan, employer plan or Medicaid.

   She would likely be eligible for Medicare benefits if she were 68 years old.

2) Would she be eligible for PR if she had no respiratory sx, just fatigue and brain fog?

   Would not be eligible for PR (no respiratory symptoms), but may be eligible for PT.

Case Study 3

- Ms. W is referred for cardiac rehab after an MI that was 12/1/2023
- Patient is a recent graduate of CR after a previous MI 7/4/23
- She has Medicare only
- Does Ms. W qualify?

Case Study 3

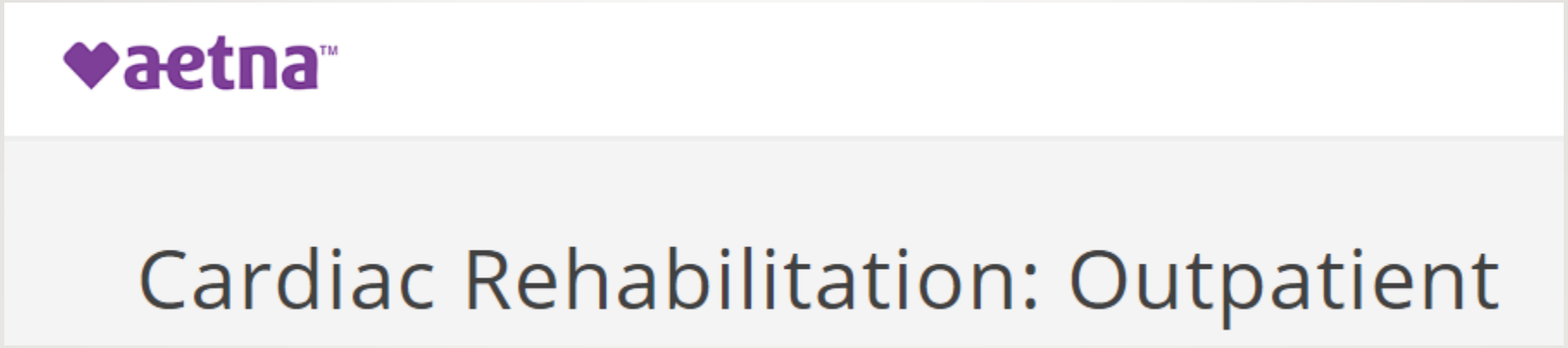
- Yes, she qualifies for another round of cardiac rehabilitation
  - Note: If she received her full 36 sessions last time, you will need to use a KX modifier for this round

Case Study 4

- Patient was referred for cardiac rehab after cardiac arrest
- Patient has Aetna
- Do they qualify?

Case Study 4 Answers

- Yes



Eligibility includes:

5. Sustained ventricular tachycardia or fibrillation, or survivors of sudden cardiac death; *or*

Questions?

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