Wisconsin Physician Services (WPS), the Medicare Administrative Contractor for Jurisdiction 5 and Jurisdiction 8 finally agreed to a conference call with Susan Flack and Janie Knipper, IACPR, to discuss cardiac rehab (CR) and pulmonary rehab (PR) reimbursement. The call was held on June 2, 2016. Questions related to reimbursement were submitted to WPS prior to the call; however the representatives from WPS chose to not respond to any questions during the call, but rather provide written feedback.

The AACVPR MAC Liaison Task Force created a PowerPoint presentation on CR and PR for the purpose of educating MACs about these services. Janie presented the PowerPoint during the call. The WPS representatives on the call commented that none of the presentation was a surprise to them; they found the information to be consistent with their understanding of CR and PR. WPS representatives included Mary Sue Gardner, RN/BSN, WPS Provider and Outreach Education (POE) Specialist, Dr. Cheryl Ray, WPS J5 Medical Director, and 2 people from the claims department. Dr. Noel, J8 Medical Director was invited to attend but declined. We asked the claims representatives if they had noticed anything in CR and PR billing practices that raised a red flag, and they denied seeing any red flags.

The written responses from WPS were received on June 24, 2016, and are summarized below with comments from Janie. The answers pertain primarily to pulmonary rehab. There were no issues related to cardiac rehab, other than the question of Nonphysician Providers independently ordering CR & PR, and clarification for WPH about # of CR session/week.

1. Nonphysician Provider (NPP) – Can NPPs independently order CR/PR?
   a. No – the regulation wording states “physician” referral.

2. Number of CR Sessions per Week:
   a. WPS is aware of and in agreement with the removal of the requirement for CR patients to participate in a minimum of 2 CR sessions each week. Public Law 110-275, effective 1-1-2010, allows up to 36 sessions of CR over 36 weeks.

3. The Individualized Treatment Plan (ITP):
   a. Must be signed prior to the patient’s first exercise rehab treatment session
   b. WPS views the first visit to be the “initial assessment” for evaluation of the patient, and not a treatment session. In my opinion, the initial assessment has to include some type of exercise evaluation to allow us to write the exercise prescription. However, there is no way to charge for that initial evaluation, unless you charge for a 6-Minute Walk Test (6MWT), which you could do if you are not charging for a “treatment” session.
   c. WPS did include cardiac rehab in their response regarding the ITP being signed prior to the patient’s first treatment session. We will be seeking further clarification on this, as this is not in the CR regulations. I would not change your practice at this point; but wait for further clarification.
4. **Pulmonary Rehab – Direct Patient Contact by the Physician:**
   
   a. Must be done during each 30-day period. The regulation is not at 30 days, but *within* that 30 day period.
   
   b. In the event a patient is not present in rehab on the day the physician will be establishing or re-evaluating the ITP, it is necessary to reschedule the day for the direct contact within that 30 days. **Note:** the regs do not state the ITP needs to be signed the same day physician sees patient. We will be requesting clarification on this.

5. **Log of Supervising Physician:**
   
   a. CMS does not dictate the format of the log for documenting physician supervision. However, the documentation regarding the supervising physician should be documented somewhere in the medical record for that day of service. Logs are acceptable, however, this information could be contained anywhere in your documentation, so long as it is reproducible if selected for medical review. **This differs from a 2011 response stating it did not need to be in the medical record; we will seek clarification.**

6. **PFT Requirements for COPD Diagnosis for Participation in PR:**
   
   a. There are **NO timeline requirements** for completing the PFTs prior to starting a PR program, only that the GOLD classification requirements must be met (moderate to very severe COPD). **In other words, if you require new patients to have PFTs within 6 or 12 months prior to starting PR, this is not correct. There is no such requirement anymore.**
   
   d. There are **NO** regulations that state PFTs need to continue on a yearly basis. Medicare would only cover services that are reasonable and necessary for the treatment of a patient at the time of service. **Janie recommends changing your practice/policies if you still require PFTs within a year prior to enrollment in PR.**

7. **Billing for 1:1 Respiratory Therapeutic Services:**
   
   a. If 1:1 supervision of the patient is not medically necessary or indicated, it should not be billed to Medicare. The situation is the same with a group session or class and only one patient shows up for the session – this may not be billed as individual or 1:1 care.

8. **Documentation of Daily Sessions:**
   
   a. All items must be documented in the ITP or an updated treatment plan. It must be ordered and signed by the physician prior to the session. This was in response to our question that arose from the audit done by the Office of Inspector General (OIG) in October 2015. The OIG seemed to want all documentation to be done in the ITP, and didn’t care about other documentation. WPS seems to agree. **We will seek clarification on this since the ITP requirements are for a “reassessment of progress made toward goal achievement”, not details from every session. However, we should all review our ITPs and make sure there is adequate documentation of the services provided.**