CHAPTER 22-000 RESPIRATORY THERAPY SERVICES

22-001 Definition: Respiratory therapy (Respiratory Care) is defined as those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. Respiratory therapy services include, but are not limited to -

1. The application of techniques for support of oxygenation and ventilation in the acutely ill patient. These techniques include, but are not limited to -
   a. Establishment and maintenance of artificial airways;
   b. Ventilator therapy and other means of airway pressure manipulation;
   c. Precise delivery of oxygen concentration; and
   d. Techniques to aid removal of secretions from the pulmonary tree.
2. The therapeutic use and monitoring of medical gases (especially oxygen), bland and pharmacologically active mists and aerosols and equipment as resuscitators and ventilators;
3. Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotracheal suctioning;
4. Diagnostic tests for evaluation by a physician, such as pulmonary function tests, spirometry, and blood gas analyses;
5. Pulmonary rehabilitation techniques which include -
   a. Exercise conditioning;
   b. Breathing retraining; and
   c. Patient education regarding the management of the patient's respiratory problems; and
6. Periodic assessment and monitoring of the acute and chronically ill patients for indications for, and the effectiveness of, respiratory therapy services. Respiratory therapy services are performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel. If the services are reasonable and necessary, they are covered regardless of where in the hospital they are provided, such as emergency room, ICU, etc.

22-002 Covered Services: To qualify for reimbursement as respiratory therapy under the Nebraska Medical Assistance Program, the therapy must -

1. Qualify as a covered service (see 471 NAC 22-002.01);
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury (see 471 NAC 22-002.02);

3. Be provided by or under the direct supervision of a respiratory therapist licensed by the Nebraska Department of Health and Human Services Regulation and Licensure, or, if provided out of state, similarly recognized by the respiratory therapy association or licensing entity of that state;
4. Be provided only on written orders by a licensed Nebraska physician, or, if provided out of state, a licensed physician of that state;
5. Be recertified by the physician every 30 days, or more frequently if the patient's condition necessitates; and
6. Be provided in a hospital or nursing facility.

22-002.01 Qualification as a Covered Service: NMAP covers respiratory therapy in the following circumstances:

1. Hospital: When provided by a respiratory therapist or technician, the services are covered as ancillary services. When provided by a nurse, the services are nursing services; and
2. Long Term Care Facilities: See 471 NAC 12-011.04C, Ancillary Services.

22-002.02 Reasonable and Necessary: To be considered reasonable and necessary for the diagnosis or treatment of an individual's illness or injury, respiratory therapy services furnished to a client must be -

1. Consistent with the nature and severity of the client's complaints and diagnosis;
2. Reasonable in terms of modality, amount, frequency, and duration of the treatments; and
3. Generally accepted by the professional medical community as being safe and effective treatment for the purpose used. These criteria are explained in the following parts.

22-002.02A Consistent with the Nature and Severity of the Individual's Complaints and Diagnosis: A patient's primary diagnosis alone may justify the need for respiratory therapy, such as myocardial infarction. There may be cases in which the primary diagnosis alone does not justify the need for respiratory therapy, but medical evidence indicates that the combination of the secondary and primary diagnoses might. There may also be cases in which the documentation indicates that the secondary diagnosis is of a severity that it alone justifies a need for respiratory therapy. Example: A patient who is admitted to the hospital with a secondary diagnosis of chronic obstructive pulmonary disease of a severity that the patient needed and used respiratory equipment before being admitted to the hospital, is considered to require respiratory therapy for that condition during the hospital stay.

22-002.02B Reasonable in Terms of Modality. Amount. Frequency. and Duration of the Treatments: Although respiratory therapy may be considered reasonable and necessary in a particular case based on the nature and severity of the patient's condition, it must also be reasonable and necessary with respect to modality, amount, frequency, and duration of the treatments.

Example: While a patient may require a particular type of modality to accomplish a certain therapeutic objective, the reasonableness and medical necessity may be questionable where more than one type of modality is used at the same time to accomplish the same therapeutic objective, such as IPPB and incentive spirometry.

In most circumstances, the need for therapy decreases with improvement of the condition, or increases if the condition worsens. In most instances, respiratory therapy is not considered reasonable and necessary when provided in the same amount and/or frequency throughout the client's hospital stay. It is expected that the level and intensity of the care is modified as discharge nears. If the amount and frequency of respiratory therapy provided throughout the hospital stay remains constant and the primary or secondary diagnosis indicates that, under normal circumstances, a decline in amount and frequency could be anticipated, the provider shall submit an explanation to the Department.

22-002.02C Generally Accepted by the Professional Community as Being Safe and Effective Treatment for the Purpose Used: In the absence of evidence to the contrary, it may be presumed that respiratory therapy is an accepted treatment and may be covered under the Nebraska Medical Assistance Program.

22-002.03 Additional Guidelines for Coverage Criteria: While there are many conditions for which respiratory therapy may be indicated, NMAP does not cover respiratory therapy services when performed on a mass basis with no distinction made as to the individual patient's actual condition and need for services. In addition, NMAP makes a distinction between respiratory therapy services and routine nursing services. The following parts illustrate some examples of the application of the coverage criteria.

22-002.03A Intensive Care and Recovery Room Patients: Intensive care and recovery room patients may require respiratory monitoring, support, and therapy. These respiratory care services (including equipment and maintenance thereof) qualify for reimbursement when reasonable and necessary. Frequency, intensity, and duration of monitoring and maintenance services will vary with the patient's illness, age, and underlying state of health.

22-002.03B Preoperative Bronchial Hygiene Therapy: NMAP does not consider bronchial hygiene therapy provided on a routine basis to preoperative patients to be reasonable and necessary and does not cover these services. Circumstances under which preoperative bronchial hygiene therapy may be reasonable and necessary include those situations when it is provided to patients with acute or chronic pulmonary disease which by itself requires respiratory therapy. In the absence of a presumptive condition, preoperative respiratory therapy could be reasonable and necessary if the prescribing physician adequately documents the medical necessity for it, for example, heavy smokers with chronic cough and sputum production. In these cases, the medical necessity for respiratory therapy is established if the documentation submitted adequately supports the therapy. A statement that respiratory therapy "is needed" or "is necessary based on diagnosis" is unacceptable.

22-002.03C Postoperative Bronchial Hygiene Therapy: Routine procedures such as deep breathing and cough instruction, frequent repositioning, and early ambulation provide for adequate bronchial hygiene in the majority of postoperative patients. Bronchial hygiene therapy services, in addition to those cited above when provided on a routine basis to most postoperative patients is not considered necessary and is not covered under NMAP.

Respiratory therapy services aiding bronchial hygiene, such as, IPPB, aerosol therapy, postural drainage, chest percussion and vibration, and nasotracheal suctioning, may be reasonable and necessary in the postoperative patient with identifiable pulmonary complications or in patients with underlying pulmonary diseases. In addition, the therapy may be required for several postoperative days for those patients. In these cases, the Medicaid provider must document the medical necessity for the therapy when billing the Department. It is reasonable to expect changes in modalities and decreases in frequency of therapy if pulmonary complications are not medically evident after several days of therapy postoperatively. Since the need for postoperative bronchial hygiene therapy cannot be identified presumptively, all therapy must be adequately documented by the physician.

22-002.03D Setting Up Equipment and Instructing Patients in Its Use: When appropriate, setting up respiratory equipment and instructing patients in the use of equipment or on postural drainage and breathing exercises are considered reasonable and necessary services. Once patients have been instructed in the use of the equipment or carrying out the postural drainage and breathing exercises themselves, services of a respiratory therapist or nurse are not reasonable and necessary, and are not covered by the Department. Any monitoring of the equipment or of the effects of the treatment is expected to be carried out by a staff nurse as part of his/her regular nursing activities. Use of a respiratory therapist for these activities is considered a duplication of services and is not covered. Payment may be made for use of the equipment and covered gases or drugs used in connection with the equipment.

22-002.03E Oxygen Therapy: Oxygen therapy is administered utilizing many devices ranging from the simple nasal cannula to progressively complex techniques providing controlled oxygen concentrations. These devices are usually applied, maintained, and monitored by respiratory therapists and technicians. These services are covered if the need and the effectiveness is documented.

The goal of oxygen therapy is to maintain adequate tissue and cell oxygenation while trying to minimize the danger of oxygen toxicity. Periodic measurement of the arterial PO_2 or oxygen saturation at rest and/or during exercise aids in determining the appropriate amount of oxygen to be administered, and is necessary until the client has achieved a stable status.

If the Department notes the use of continuous oxygen without periodic assessment of arterial PO_2 or oxygen saturation, it will request additional documentation to determine the medical necessity for the service. The physician's order must state the oxygen device and/or the specific flow rate or concentration of oxygen desired. A prescription for "oxygen as needed" does not meet these requirements. An intermittent or PRN oxygen therapy order must include time limits and specific indications for initiating and terminating therapy.

22-002.04 Structured Patient Education Program: While instructing a patient on the use of equipment, breathing exercises, etc., is considered reasonable and necessary to the treatment of the patient's condition, unless these activities are of a complexity that warrants a structured patient education program, the instructions can usually be given a patient during the course of his/her treatment by any of the health personnel involved such as the physician, nurse, or respiratory therapist. The patient activities involved in the management of respiratory problems are not ordinarily of the complexity that warrant a structured program. A structured program generally is not considered reasonable and necessary and is not covered by NMAP. Structured patient education programs which provide information over and beyond that ordinarily provided during the course of a treatment, such as extensive theoretical background in the pathology, etiology, and physiological effects of the disease, are not considered reasonable and necessary to the management and treatment of illnesses under NMAP.

22-003 Documentation: Respiratory therapy services may be subjected to pre-and/or postpayment utilization review. To help determine medical necessity for the treatments provided by the therapist, the following documentation must accompany each outpatient hospital claim:

1. A copy of the respiratory therapist's progress notes and anticipated goals; and

2. Information on the claim or as an attachment which includes -

   a. The location where the services were provided;
   b. The date of onset of the patient's condition; and
   c. The patient's diagnosis.

Each case is considered on its own merits. The Medicaid Division shall make the final determination, based upon the submitted documentation and whether the therapy is reasonable and necessary. The Department reimburses only for medically necessary therapy (see 471 NAC 22-002.02 and 22-002.03).

Any claim denied by Medicare for Medicare/Medicaid-eligible individuals will also be denied by the Department.

22-004 Payment for Respiratory Therapy Services: NMAP limits payment for respiratory therapy services to services provided in a hospital to a hospital patient or in a nursing home to a nursing home resident. NMAP does not reimburse the respiratory therapist directly; payment is made to the hospital or nursing home. Under certain extreme conditions, when medical necessity is documented, the Department may make exceptions to this policy. Prior authorization by the Medicaid Division is required.

For reimbursement as a hospital service, see 471 NAC 10-010, Payment for Hospital Services.

For reimbursement as a service in a nursing home, see 471 NAC 12-011, Rates for Nursing Facility Services.

22-005 Billing Requirements

22-005.01 Procedure Codes: The provider shall use the appropriate American Medical Association's Current Procedural Terminology (CPT) or HCPCS procedure codes when billing the Department.

22-005.02 Medicare or Other Insurance Coverage: If the client is eligible for Medicare or has other insurance which may cover respiratory therapy, the provider shall bill the Medicare carrier or the insurance company before submitting a bill to the Department.

22-005.03 Required Claims: Depending on the place of service, the provider shall use the claims required by the Department as follows:

1. If the service is provided in a hospital, the hospital makes payment to the respiratory therapist. The hospital submits claims to the Department for respiratory therapy services provided in the hospital to inpatients and outpatients on Form CMS-1450 or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837); or
2. If the service is provided in a long term care facility, the facility shall contract for services not readily available in the facility. Depending on the type of provider, reimbursement is claimed as follows:

a. If services are provided by another licensed facility (hospital or rehabilitation agency), the long term care facility makes payment to the provider. The long term care facility is reimbursed for the payment as an allowable cost under the long term care reimbursement plan; or
b. If services are provided by a facility staff member or by an individual under contract to the facility, the long term care facility makes payment to the individual. The facility is reimbursed under the long term care reimbursement plan.

22-005.04 Interval of Billing: To keep payment current, providers may submit claims to the Department on a monthly basis.