
Respiratory Care

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This section contains information about respiratory care services and program coverage (*California Code of Regulations* [CCR], Title 22, Section 51082.1).

Respiratory Care Services

Respiratory care practitioner services are medically necessary services rendered within the scope of practice of a respiratory care practitioner under the supervision of a physician. The services must be for the therapy, management, rehabilitation, diagnostic evaluation and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions. These services include, but are not limited to:

1. Direct and indirect pulmonary care services
2. Direct and indirect respiratory care procedures, including the administration of pharmacological, diagnostic and therapeutic agents necessary to implement treatment, disease prevention, pulmonary rehabilitation or diagnostic regimen prescribed by a physician and surgeon
3. Observation and monitoring of signs and symptoms, general behavior and physiological responses to respiratory care treatment and diagnostic testing
4. Diagnostic and therapeutic services which may include:
 - Administration of medical gases (except general anesthetics), aerosols, humidification and environmental control systems
 - Pharmacologic agents related to respiratory care procedures
 - Mechanical or physiological ventilatory support
 - Bronchopulmonary hygiene
 - Cardiopulmonary resuscitation
 - Maintenance of natural airways
 - Insertion without cutting tissues and maintenance of artificial airways
 - Diagnostic and testing techniques required for implementation of respiratory care protocols
 - Collection and analysis of blood specimens, and specimens from the respiratory tract
 - Analysis of blood gases and respiratory secretions

Program Coverage

The following coverage limitations and billing requirements apply to respiratory care services.

Outpatient Setting

“Respiratory care is covered as a physician service. Respiratory care is subject to authorization except when personally rendered by the physician. Authorization requests shall include clinical justification for the services and the nature, frequency and expected duration of the respiratory care.” (CCR, Title 22, Section 51305[g])

The term “personally rendered by the physician” must include all of the following service conditions:

- The service is rendered directly by a physician or a respiratory therapist or a nurse (trained in respiratory treatment administration) or staff under physician supervision.
- The service is medically necessary.
- The service is additional to separately identifiable Evaluation and Management (E&M) services performed by the physician.
- The physician is present.

Authorization is required if respiratory care is the only service rendered, the physician is not in the office or the service is performed in an outpatient facility by other than the physician as part of a prescribed treatment program. The physician may also bill for any medication or other consumable supplies.

Inpatient Setting

Respiratory care is not covered as a separately billable physician service for recipients in Nursing Facility (NF) Level A or B, subacute care facility or inpatient locations because the care is administered by facility personnel using facility equipment. Reimbursement is included in the per diem rate paid to a long term care facility or in the institutional revenue codes of hospitals.

Exception: Ventilator management services are reimbursable to physicians in an inpatient setting. Refer to “Ventilator Management Services” on a following page.

Claim Submission

Use CPT® codes 94640 thru 94668 to bill all routine services of respiratory care, including intermittent positive pressure breathing. When appropriate, the claim must include the approved *Treatment Authorization Request* (TAR) Control Number, the rendering provider number and, in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, the name and title of the rendering provider and physician's signature. CPT codes 94010 (spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation) and 94060 (bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) are not reimbursable on the same date of service.

CPT codes 94011 (measurement of spirometric forced expiratory flows in an infant or child through 2 years of age) and 94012 (measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age) are not reimbursable on the same date of service.

Note: CPT code 94799 (unlisted pulmonary service or procedure) is not to be used to bill for routine respiratory care procedures, whether delivered on a single occasion or during a prolonged course of treatment.

Frequency Restrictions

CPT code 94640 (pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device), is limited to six in 30 days and code 94642 (aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis) is limited to one in 30 days.

Respiratory Care Practitioner Services

Respiratory care practitioners may be reimbursed for the following CPT codes:

31500/AG	94003	94662
36600/AG	94010*	94664
82375*	94011	94667
86490*	94012	94668
86510*	94013	94680*
86580*	94060*	94681*
90647	94150*	94690*
90648	94200*	94726‡
90655 thru 90658	94450*	94727‡
90662	94618‡	94728‡
90670	«94619»	94729‡
90732†	94640	94760
92950	94642	99070
93005	94644	99202
93041	94645	99212
94002	94660	

Respiratory care practitioner services require a physician's written order or prescription. This information should be retained in the patient's medical records.

Authorization for Injection Codes

Respiratory care codes require authorization when billed by a respiratory care practitioner except for CPT codes, 90655 thru 90658, 90662 and 90732. Respiratory care *Treatment Authorization Requests* (TARs) must be submitted to the TAR Processing Center. A copy of the prescription, signed by the physician ordering the respiratory services, must accompany the TAR.

Injection Codes

The following are the only injection codes reimbursable when billed by a respiratory care practitioner.

CPT Code	Description
90647	Hemophilus influenza type b vaccine (Hib), PRP-OMP conjugate 3 dose schedule, for intramuscular use
90648	Hemophilus influenza type b vaccine (Hib), PRP-T conjugate 4 dose schedule, for intramuscular use
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 ml dosage, for intramuscular use
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 ml dosage, for intramuscular use
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 ml dosage, for intramuscular use
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 ml dosage, for intramuscular use
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13-valent, for intramuscular use
90732	Pneumococcal polysaccharide vaccine 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 ml dosage, for intramuscular use

Note: Providers must use modifier SK to indicate that the recipient meets Medi-Cal program criteria for high risk for the disease preventable by the vaccine. Providers must also document in the written patient care record what criteria are met to justify the immunization. Additionally, vaccine procedure codes must be billed with modifier SL if the vaccine has been supplied by the VFC program.

Technical Component

Respiratory care practitioners will be reimbursed only for the technical component (modifier TC) for services that have both a professional and technical component. Services requiring Clinical Laboratory Improvement Amendment (CLIA) certification may only be billed by providers with the appropriate certification.

Note: Respiratory care practitioner services are included in the reimbursement for inpatient hospitals, NF-A, NF-B, and pediatric and adult subacute care facilities, and are not separately reimbursable.

Billing Individual or Group Provider Number

Respiratory care practitioners may bill as individuals or as group providers. Individuals must be licensed by the Respiratory Care Board of California and comply with applicable standards in CCR, Title 22, Section 51225.5.

In addition, providers billing with a group provider number must enter the individual provider number for the provider rendering the service in the *Other Physician ID* field (Box 78)/*Additional Claim Information* field (Box 19) of the claim.

Incentive Spirometry

Incentive spirometry for hospital inpatients is not separately reimbursable from hospital charges.

Inpatient Services

Initial instructions and management may be provided by respiratory care practitioners for the recipient and nursing personnel and is included in the hospital per diem reimbursement rate. Separate billing and reimbursement will be denied. Subsequent administration of inpatient incentive spirometry may be assumed by the recipient or nursing personnel as part of the hospital services reimbursed as part of the per diem reimbursement.

Outpatient Services

Outpatient claims involving incentive spirometry by respiratory care practitioners require an approved TAR and may be subject to audit and recoupment if not supported by sufficient medical justification.

Pulmonary Rehabilitation

The following covers requirements for pulmonary rehabilitation services.

Eligibility for Outpatient Pulmonary Rehabilitation

Recipients are eligible for pulmonary rehabilitation if they meet the following conditions:

- Chronic obstructive pulmonary disease (COPD) as defined by the ratio of forced expiratory volume in one second (FEV1)/forced vital capacity (FVC) < 0.7 diagnosed by pulmonary function testing completed within the past year, and no COPD exacerbation within the past four weeks
- Patients eligible for lung transplant
- «Post COVID-19 pulmonary sequelae»

Pulmonary rehabilitation programs must consider whether recipients with major comorbidities or limitations that would prevent safe and efficient completion of exercise training should be excluded from participation when establishing individualized treatment plans.

Note: While recipients may begin their pulmonary rehabilitation during a hospitalization, Medi-Cal will only reimburse pulmonary rehabilitation sessions delivered in an outpatient setting.

Pulmonary Rehabilitation Component Requirements

In order to receive reimbursement, pulmonary rehabilitation programs must include the following components:

Physician-prescribed exercise – This physical activity includes aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual recipients by a physician each day pulmonary rehabilitation items/services are furnished.

- The prescription should include:
 - Mode of exercise
 - Target intensity
 - Duration of each session
 - Frequency of sessions per week

- Documentation of each day of therapy should include:
 - Whether the prescription was carried out
 - A reasonable clinical explanation if the exercise prescription was not carried out
 - The signature credentials of the individual who directly supervised the exercise

Outcomes Assessment – This should include:

- At minimum, assessments from the commencement and conclusion of pulmonary rehabilitation, based on recipient-centered outcomes which must be measured by the physician immediately at the beginning and end of the program.
- Objective clinical measures of the effectiveness of the pulmonary rehabilitation program for the individual recipient, including exercise performance and self-reported measures of exercise tolerance. The person doing the assessment must sign these notes with his or her credentials on the day the assessment was done.

An individualized treatment plan – This plan should be recorded in the medical record within one week after the recipient first receives pulmonary rehabilitation services. The plan should be tailored to each individual recipient and include:

- A description of the individual's diagnosis.
- The type, amount, frequency and duration of the pulmonary rehabilitation items and services furnished.
- The exercise set for the individual under the plan. The individualized treatment plan must be established, reviewed and signed by a physician every 30 days.

Further documentation must be provided by the treating physician at least every 30 days which describes the outcomes assessment and any modifications needed in the plan of care previously prescribed, or the reason(s) to continue the present plan.

Pulmonary Rehabilitation Sessions Frequency Limitations

Only pulmonary rehabilitation sessions that are exercise-based are reimbursable. Pulmonary rehabilitation exercise sessions are limited to up to 2 one-hour sessions per day for up to 36 sessions for any provider. An additional 36 sessions (a maximum of 72 sessions per lifetime) may be reimbursed with a *Treatment Authorization Request* (TAR) if medically necessary.

For lung transplant candidates, pulmonary rehabilitation begins when the member is approved for a transplant by Medi-Cal and continues for six weeks after transplantation.

Pulmonary Rehabilitation Program Setting Requirements

Pulmonary rehabilitation services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician physically present and immediately available and accessible for medical consultations and emergencies at all times when items/services are being furnished under the program.

Pulmonary Rehabilitation Program Physician Requirements

Physicians responsible for pulmonary rehabilitation programs are identified as medical directors who oversee or supervise the pulmonary rehabilitation program at a particular site. The medical director, in consultation with staff, is involved in directing the progress of individuals in the program. The medical director, as well as physicians acting as the supervising physician, must also possess all of the following:

- Expertise in the management of individuals with pulmonary pathophysiology.
- Cardiopulmonary training in basic life support or advanced cardiac life support.
- License to practice medicine in the state in which the pulmonary rehabilitation program is offered. Direct physician supervision may be provided by a supervising physician or the medical director.

Billing Requirements

Professional claims containing the following billing requirements will be reimbursable under Medi-Cal:

- «Coverage for CPT code 94625 (physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring [per session]) and 94626 (physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring [per session]) includes therapeutic services and all related monitoring services to improve respiratory function.»
- Provider types who can bill for these services include physicians (doctor of medicine and doctor of osteopathic medicine), physician assistants, nurse practitioners and physical therapists.
- The ICD-10-CM diagnosis code on the claim must be one of the following: J41.0 thru J41.8, J43.0 thru J43.9, J44.9, «U07.01,» Z76.82 or Z94.2

Ventilator Management Services

Ventilator management services (CPT codes 94002 and 94003) are reimbursable to physicians in an inpatient setting. Reimbursement for these codes will be adjusted or denied, however, if reimbursement for the following CPT and HCPCS codes is made to the same provider, for the same recipient and date of service. For the purpose of Medi-Cal, ventilator management is not just writing orders, but includes actually adjusting the ventilator settings for the 24 hours being billed.

CPT Code	Description
«99221 thru 99223, 99227 thru 99233»	Evaluation and Management (E&M) services
«99252 thru 99275»	Inpatient consultation services
99281 thru 99288	Emergency department services
99291 or 99292	Critical care services
99295 thru 99298	Neonatal intensive care services
«99358 99359»	Prolonged physician services
99460 thru 9946, 99464 or 99465	Newborn care services
99468, 99471, 99475	Initial inpatient neonatal/pediatric critical care, per day
99469, 99472, 99476	Subsequent inpatient neonatal/pediatric critical care, per day
99477	Initial hospital care, per day
99478 thru 99480	Subsequent hospital care, per day

Reimbursement for codes 94002 (ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day) and 94003 (ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; subsequent days) will be denied if anesthesia services (CPT codes 00100 thru 01999) are billed for the same time period. Claims must show that ventilator and anesthesia services were performed at different times. When billing for both ventilator management and anesthesia services for the same provider, same recipient and date of service, providers must document the times of the anesthesia services and the times of ventilator management in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.

Fractional Exhaled Nitrous Oxide (FeNO)

CPT code 95012 (nitrous oxide expired gas determination) is used to bill for fractional exhaled Nitrous oxide (FeNO) measurement. FeNO is a noninvasive and simple test thought to reflect eosinophilic airway inflammation.

Medi-Cal has developed guidelines for appropriate use and reimbursement of FeNO measurement:

- For diagnosis of asthma when there is diagnostic uncertainty after initial assessment and the recipient has either
 - Normal spirometry, or
 - Obstructive spirometry with a negative bronchodilator reversibility (BDR) test.
- For management of asthma in patients who are symptomatic despite using inhaled corticosteroids, when used as an adjunct with spirometry.

There is a frequency limit of five times per year for the same recipient, any provider. FeNO is limited to recipients 5 years and older only. An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

«Legend»

«Symbols used in the document above are explained in the following table.»

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
†	This code requires modifier SL (state-supplied) and/or modifier SK (member of high-risk population) and medical justification in the recipient's medical record. Modifier SL is also required when billing for Vaccines For Children (VFC) vaccines. Providers billing with modifier SL must include the age of the recipient. See the <i>Modifiers</i> section in the appropriate Part 2 manual for more information.
‡	These codes require a <i>Treatment Authorization Request (TAR)</i> to be a benefit for the respiratory therapist. These codes are split-billable. When billing for <u>both</u> the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC
*	These codes have both a technical and professional component, but only the technical component may be billed by the respiratory care practitioner. Modifier TC must be used when billing these codes.