

# LCD - Respiratory Care (L34149)

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## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

## LCD Information

### Document Information

**LCD ID**  
L34149

**AMA CPT / ADA CDT / AHA NUBC Copyright  
Statement**

**LCD Title**

Respiratory Care

**Proposed LCD in Comment Period**

N/A

**Source Proposed LCD**

[DL34149](#)

**Original Effective Date**

For services performed on or after 10/01/2015

**Revision Effective Date**

For services performed on or after 11/05/2023

**Revision Ending Date**

N/A

**Retirement Date**

N/A

**Notice Period Start Date**

09/21/2023

**Notice Period End Date**

11/04/2023

**Issue****Issue Description**

Ease of access, consolidation of policies and standardization of coverage policies between jurisdictions.

**CMS National Coverage Policy**

Language quoted from the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act, §1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, §1861(cc)(1) discusses CORF facility services.

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Title XVIII of the Social Security Act, §1861(s)(2)(B) provides coverage of services incident to physician's services furnished to hospital patients.

Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

42 CFR 485.70-CORF personnel qualifications- lists qualifications for respiratory therapists.

Federal Register: December 31, 2002 (Volume 67, Number 251) p 79999-80000 Final rule revisions to payment policies specific to G0237-G0239

CMS Manual System, Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 6, §§20.4-20.4.1

CMS Manual System, Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 8, §50.8.2

CMS Manual System, Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 12, §§10, 20, 20.1, 20.2, 30, 30.1, and 40.5

CMS Manual System, Pub 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, §240.7 and §240.8

CMS Manual System, Pub 100-20, One Time Notification, Transmittal 477, dated April 24, 2009, Change Request 6338

## **Coverage Guidance**

### **Coverage Indications, Limitations, and/or Medical Necessity**

Respiratory care (respiratory therapy) is defined as those services prescribed by a physician or a non-physician practitioner for the assessment and diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

Monitoring is defined as the periodic checking of the equipment in actual use to ascertain proper functioning; real time tracking the individual's condition to assure that he/she is receiving effective respiratory therapy services; and periodic evaluation of the patient's progress in improvement of respiratory function.

Respiratory care (respiratory therapy) services may include but are not limited to the following:

- application techniques to support oxygenation and ventilation in an acute illness (e.g., establish/maintain artificial airway, ventilatory therapy, precise delivery of oxygen concentrations, aid in removal of secretions from pulmonary tree)
- therapeutic use/monitoring of medicinal gases, pharmacologically active mists and aerosols, and equipment (e.g., resuscitators, ventilators)
- bronchial hygiene therapy (e.g., deep breathing, coughing exercises, IPPB, postural drainage, chest percussion/vibration, and nasotracheal/endotracheal suctioning)
- diagnostic tests ordered by and for the evaluation by a physician or NPP (e.g., pulmonary function test, spirometry, and blood gas analyses etc.)
- pulmonary rehabilitation techniques (e.g., exercise conditioning, breathing retraining, and patient education regarding management of patient's respiratory problems) and
- periodic assessment of the patient for the effectiveness of respiratory therapy services.

For Pulmonary Rehabilitation services, please refer to Noridian's Billing and Coding: Pulmonary Rehabilitation Services Local Coverage Article under Related Documents at the end of this policy.

The above services may be performed by respiratory therapists, physical therapists, nurses, and other qualified personnel as described by relevant state practice acts. Documentation in the medical record must clearly support the need for respiratory therapy services to be separately reimbursed.

Respiratory care (respiratory therapy) services can be considered reasonable and necessary for the diagnosis and treatment of a specific illness or injury. The service provided must be consistent with the severity of the patient's documented illness and must be reasonable in terms of modality, amount, frequency, and duration of treatment. The treatment must be generally accepted by the professional community as safe and effective for the purpose used, and recognized standards of care should not be violated.

Medicare coverage of respiratory care (respiratory therapy) provided as outpatient hospital or extended care services depends on the determination by the attending physician (as part of his/her plan of treatment) that for the safe and effective administration of such services the procedures or exercises in question need to be performed by a respiratory therapist, physical therapists, nurses, and other qualified personnel as described by relevant state practice acts as listed above. In addition, Medicare may cover postural drainage and pulmonary exercises furnished by a respiratory therapist as incident to a physician's professional service.

Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary for the treatment of the patient's condition and can usually be given to a patient during the course of treatment by any of the health personnel involved, (e.g., physician, nurse, respiratory care practitioner or other qualified personnel). *These educational instructions are bundled into the covered service and separate payment is not made.* Separate billing for one-on-one education is rarely necessary and is usually only reasonable at the start of the treatment plan. Initially, for outpatient care where a series of visits provides "... an individualized physical conditioning and exercise program using proper breathing techniques..." separate billing for one-on-one intervention is both reasonable and necessary. Provision of more information than is ordinarily provided during the course of a treatment (e.g., extensive theoretical background in the pathology, etiology, and physiological effects of the disease) is not considered reasonable and necessary. Group sessions that only offer generalized (i.e., non-individualized) education and training are not covered.

Therapeutic procedures with an individualized physical conditioning and exercise program using proper breathing techniques can be considered for a patient with activity limitations. Breathing retraining, energy conservation, and relaxation techniques are often used. Ventilatory muscle training (VMT) may be considered reasonable and necessary in a very select population of pulmonary patients who demonstrate significantly decreased respiratory muscle strength and who remain symptomatic despite optimal therapy. Routine exercise, or any exercise, without a documented need for skilled care, is not covered.

## **Pulmonary Function Tests**

Pulmonary Function Tests (PFTs) are a broad range of diagnostic procedures that measure two components of the respiratory system's functional status: 1) the mechanical ability to move air in and out of the lungs, and 2) the effectiveness of providing oxygen to the body and removing carbon dioxide.

Pulmonary function tests are divided into five general areas:

- Spirometry,
- Lung Volume,

- Diffusion Capacity,
- Lung compliance, and
- Pulmonary Studies during Exercise Testing.

General indications for any of the pulmonary function tests include:

- To determine the presence of lung disease or abnormality of lung function;
- To determine the type of abnormality;
- To determine the extent of abnormality;
- To determine the extent of disability due to abnormal lung function, and
- To determine and evaluate one or more courses of therapy in the treatment of the particular condition.

General limitations for any of the pulmonary function tests include:

- All diagnostic tests payable by Medicare must be ordered by a treating physician and used in patient care. Community standards always apply.
- The various modalities to assess pulmonary function must be used in a purposeful and logical sequence.
- Tests performed as components rather than a single test will be denied.
- **Medicare does not cover screening tests.** Medicare coverage excludes routine (screening) tests for asymptomatic patients with or without high risk of lung disease (e.g., prolonged smoking history). It also excludes studies as part of a routine exam, and studies as part of an epidemiological survey.

**Medical necessity is an overriding requirement for Medicare coverage of diagnostic testing.** When a diagnosis or evaluation can be made clinically or when test results are not necessary to manage the patient's disease, then Pulmonary Function Testing is not reasonable and necessary. In addition, on routine visits for other medical conditions, when a patient claims to be stable or does not report clinically meaningful changes in pulmonary status, a physical exam and interview confirm this, repeat testing is unlikely to be necessary. Noridian has found that in many patients routine use of PFTs at each office visit is not a necessary and reasonable clinical practice and as such, cannot be reimbursed.

Providers should pay particular attention to guidelines for the usage of the CPT codes relative to Medicare's standards of reasonable and necessary care found in the Billing and Coding article attached under Related Local Coverage Documents below.

## 1. Spirometry:

Spirometry is performed by having the patient breathe into a mouthpiece that is connected to an instrument called a spirometer. The spirometer records the amount of air and the rate that it is breathed in and out over a specified amount of time (approximately 10 seconds). Some of the test measurements are obtained by normal breathing and other measurements require forced inhalation and exhalation.

Spirometry is most useful for assessing obstructive lung diseases such as asthma and chronic obstructive pulmonary disease (COPD).

Refer to the Billing and Coding article attached under Related Local Coverage Documents below for the CPT codes for Spirometry. Routine and/or repetitive billing for unnecessary batteries of tests is not clinically reasonable.

**Specific indications for spirometry include:**

Diagnostic indications:

- Detect the presence or absence of lung dysfunction suggested by history or clinically significant physical signs and symptoms,
- Detect the presence or absence of lung dysfunction suggested by other abnormal diagnostic tests (e.g., radiography, arterial blood gas analysis).

Monitoring indications:

- Quantify the severity of known lung disease,
- Assess the change in lung function over time,
- Assess the change in lung function following administration of or a change in therapy,
- Assess the risk for surgical procedures known to affect lung function.

**Limitations to performing spirometry are:**

- Routine or repetitive batteries of tests are not clinically reasonable.
- In many scenarios, simple spirometry is a mainstay of pulmonary function testing and is usually sufficient to differentiate between obstructive and restrictive disorders and evaluate their severity. Extensive testing may often not be necessary for adequate clinical assessment.
- Post-bronchodilator spirometry is used to evaluate the reversible component of bronchospasm and to determine if the patient is a bronchodilator therapy candidate. Claims for spirometry will be subject to medical review as follows: there are clinical signs and symptoms consistent with bronchospasm; or spirometry without bronchodilator is abnormal; or reversibility or nonreversibility of bronchospasm has not been demonstrated. Repeat studies are covered only with clinically significant change, necessitating adjustment/augmentation of therapy, appropriately documented.
- General clinical contraindications to spirometry include: hemoptysis of unknown origin, pneumothorax, unstable cardiovascular status, thoracic/abdominal or cerebral aneurysms, recent eye surgery, recent thoracic or abdominal surgery, and presence of acute disease processes that interfere with test performance.

## **2. Lung volume**

The entire lung volume is not measured by simple spirometry because it is larger than the air quantity exhaled/inhaled. Lung volume is measured when a person breathes nitrogen or helium gas through a tube for a specified period of time. The change in concentration of the gas in a chamber attached to the tube is measured before and after test breathing, allowing estimation of the lung volume. Measures include total lung capacity, residual volume, and functional residual capacity.

Lung volume tests are most useful for assessing restrictive lung diseases such as those caused by scarring inside the lungs or by abnormalities in the ribcage or muscles of the chest wall.

CPT codes for lung volume determination may be added when clinically relevant (see Section 4).

**Indications for a lung volume test are as follows, when consistent with community standards of reasonable clinical practice:**

- Evaluation of the type and degree of pulmonary dysfunction,
- Evaluation of dyspnea, cough, and other symptoms,
- Early detection of lung dysfunction,

- Follow-up and response to therapy,
- Preoperative evaluation,
- Track pulmonary disease progression,
- Assess the effectiveness of therapy for pulmonary conditions,
- Pre and post-op evaluations for Lung Volume Reduction Surgery (LVRS).

**Limitations to performing a lung volume test are:**

- Functional Residual Capacity (FRC) may be artificially high if the measurement is taken at a higher lung volume secondary to pain or anxiety,
- Subject cooperation is necessary,
- A complete evaluation may require the use of inhaled gases,
- Repetitive testing of total lung volume is not usually clinically necessary.

**3. Diffusion Capacity**

Diffusion capacity is measured when a person breathes in a measured amount of carbon monoxide for a very short time (often just one breath). While breathing out, the concentration of carbon monoxide is measured. The difference in the amount of carbon monoxide inhaled and the amount exhaled allows estimation of how rapidly gases can travel from the lungs into the blood.

Diffusion capacity tests are most useful for the assessment of how well the lung tissues transfer oxygen from the air inside the lungs, across thin membranes, into the blood.

**Indications for diffusion capacity (DLCO) are as follows, when consistent with community standards of reasonable clinical practice:**

- Evaluate and follow up parenchymal lung diseases associated with dusts or drug reactions or Sarcoidosis,
- Evaluate and follow up emphysema and cystic fibrosis,
- Differentiate between chronic bronchitis, emphysema, and asthma in patient with obstructive patterns,
- Evaluate the pulmonary involvement in systemic diseases (e.g., rheumatoid arthritis, systemic lupus),
- Help in the evaluation of some types of cardiovascular disease (e.g., primary pulmonary hypertension, pulmonary edema, acute or recurrent thromboembolism),
- Predict arterial desaturation during exercise in chronic obstructive pulmonary disease,
- Evaluate and quantify the disability associated with interstitial lung disease,
- Evaluate the effects of chemotherapy agents or other drugs known to induce pulmonary dysfunction,
- Evaluate hemorrhagic disorders.

**Limitations to performing a diffusion capacity test are:**

- Mental confusion or muscular incoordination preventing the subject from adequately performing the maneuver,
- Single breath DLCO requires breath holding at maximal inhalation. Some patients may be limited by syncopal symptoms triggered by an associated Valsalva or Muller maneuver which may slow the heart rate.

**4. Lung Compliance**

Lung compliance studies are performed only when all other PFTs give equivocal results or results which must be confirmed by additional lung compliance testing. Lung compliance measures the elastic recoil/stiffness of the lungs.

It is more invasive than other PFTs, because the patient is required to swallow an esophageal balloon.

## **5. Pulmonary Studies during Exercise Testing:**

Pulmonary stress testing is done in two (2) forms.

- The simple pulmonary stress testing is a test that allows quantification of workload and heart rate activity, while measuring the degree of oxygen desaturation. This test is undertaken to measure the degree of hypoxemia or desaturation that occurs with exertion. It is also used to optimize titration of supplemental oxygen for the correction of hypoxemia.
- A more complex protocol involves the measurements of oxygen uptake, CO<sub>2</sub> production, and O<sub>2</sub>. Indications for this protocol include the following:
  - To distinguish between cardiac and pulmonary causes for dyspnea;
  - To determine the need for and dose of ambulatory oxygen;
  - To assist in developing a safe exercise prescription for patients with cardiovascular or pulmonary disease;
  - To predict the morbidity of lung resection; or
  - To titrate optimal settings in selected patients who have physiologic pacemakers.

### **Qualifications of personnel**

Personnel who perform all pulmonary function tests should have verifiable training in all aspects of spirometry, lung volume, diffusion capacity, lung compliance, and pulmonary exercise testing, including equipment operation, quality control, and test outcomes relative to diagnosis and medical history.

This A/B MAC would anticipate that clinical practices with heavy emphasis on extensive batteries of complex pulmonary function tests and primary focus on treating severe pulmonary disease would often be managed by pulmonologists or by other physicians with specialized experience in respiratory disorders, and that such pulmonary testing centers would often have staff with specific training in respiratory therapy (for example, associate degree in respiratory therapy, licensure as a Respiratory Care Practitioner, or National Board of Respiratory Care (NBRC) certification).

According to National Regulations, clinics which are (a) not physician owned and which are (b) billing Medicare primarily for diagnostic tests may be required to enroll as IDTFs. For example, a nonphysician owner who establishes a diagnostic PFT clinic by leasing office space, equipment, and hiring technicians, and hires a retired ophthalmologist to provide off-site (general) supervision of diagnostic testing without treatment would be more appropriately enrolled as an IDTF.

### **Summary of Evidence**

NA

### **Analysis of Evidence (Rationale for Determination)**

NA

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# **General Information**

## **Associated Information**



## Sources of Information

1. American Association of Respiratory Care (AARC) website – <http://www.aarc.org>- information about accredited respiratory care programs and online CRCE (continuing respiratory care education).
2. Filart RA, Bach JR. Pulmonary physical medicine interventions for elderly patients with muscular dysfunction. *Clinics in Geriatric Medicine*. 2003; 19(1):189-204.
3. *International Classification of Functioning, Disability and Health (ICF)*. Geneva: World Health Organization; 2001. <http://www.who.int/classifications/icf/en/>
4. Mahler DA, Fierro-Carrion G, Baird JC. Evaluation of dyspnea in the elderly. *Clinics in Geriatric Medicine*. 2003;19(1):19-33. Describes that the prevalence of dyspnea in the elderly could be as high as 38% and raises the question of how much of this is related to obesity and deconditioning as opposed to actual pulmonary impairments.
5. Taiwo OA, Cain HC. Pulmonary impairment and disability. *Clinics in Chest Medicine*. 2002;23(4):841-851. Describes the role of both PFTs and CPET in the evaluation of pulmonary impairments.
6. Commission of Accreditation of Allied Health Education Programs. Available at: [www.caahep.org](http://www.caahep.org) Accessed 03/13/2012.
7. Cystic-L. PFTs Explained For You. Available at: [www.cystic-l.org/handbook/html/pft\\_s\\_explained\\_for\\_you.htm](http://www.cystic-l.org/handbook/html/pft_s_explained_for_you.htm) Accessed 03/13/2012.
8. Puritan Bennett. Reimbursement: Spirometry. Available at: <http://www.puritanbennett.com/remb/spirometry.aspx> Accessed 03/13/2012.
9. Respiratory Care Board of California. Available at: [www.rcb.ca.gov/applicants/education\\_regs.shtml](http://www.rcb.ca.gov/applicants/education_regs.shtml) Accessed 03/13/2012. [www.rcb.ca.gov/licensees/scopeofprac.shtml](http://www.rcb.ca.gov/licensees/scopeofprac.shtml) Accessed 03/13/2013.
10. University of Maryland Medical Center. Pulmonary Function Tests. Available at: [www.umm.edu/ency/article/003853](http://www.umm.edu/ency/article/003853) Accessed 03/13/2013.
11. WebMD Health. Lung Function Tests. Available at: [www.webmd.com](http://www.webmd.com) Accessed 3/13/2013.
12. This contractor's prior LCDs "Pulmonary Function Tests", (L10375, L10412) which will be retired once this policy becomes effective.
13. Other contractors' LCDs including Healthnow (L3929, in particular for pulmonary exercise testing), BCBS Arkansas (L13428), and Trailblazer (L11908).
14. Contractor Medical Director

## Bibliography

NA

## Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
11/05/2023	R13	This LCD is being presented for notice. No changes were made from the Proposed LCD that was presented for comment.	<ul style="list-style-type: none"> <li>• Provider Education/Guidance</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
10/01/2019	R12	<p>The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD.</p> <p>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	<ul style="list-style-type: none"> <li>Other (The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD.)</li> </ul>
10/01/2019	R11	<p>As required by CR 10901, all billing and coding information has been moved to the companion article, this article is linked to the LCD.</p> <p>09/18/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	<ul style="list-style-type: none"> <li>Revisions Due To Code Removal</li> </ul>
10/01/2019	R10	<p>Effective date of service 7/9/18 added:</p> <ul style="list-style-type: none"> <li>Z48.290 – Encounter for Aftercare Following Bone Marrow Transplant</li> <li>Z76.82 – Awaiting Organ Transplant Status</li> <li>Z94.81 – Bone Marrow Transplant Status</li> <li>Z94.84 – Stem Cell Transplant Status</li> </ul> <p>Effective 10/01/2019, added and revised the following ICD-10 codes per the 2019 ICD-10-CM updates:</p> <p>Additions:</p> <ul style="list-style-type: none"> <li>I26.93 Single subsegmental pulmonary embolism without acute cor pulmonale</li> <li>I26.94 Multiple subsegmental pulmonary emboli without acute cor pulmonale</li> </ul> <p>Code Revision:</p> <ul style="list-style-type: none"> <li>From J44.0 - Chronic obstructive pulmonary disease with acute lower respiratory infection to J44.0 -</li> </ul>	<ul style="list-style-type: none"> <li>Creation of Uniform LCDs Within a MAC Jurisdiction</li> <li>Revisions Due To ICD-10-CM Code Changes</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		<p>Chronic obstructive pulmonary disease with (acute) lower respiratory infection.</p> <p>9/16/18 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	
10/01/2018	R9	<p>9/4/18 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Effective date of service 07/09/2018 added: I-10 code G47.33 and in Revision HX number 7 corrected R85.59 to E85.59. This ICD-10-CM code is correct in the ICD-10 Codes that Support Medical Necessity section above.</p> <p>Effective date of service 10/01/2018 added E88.02 per the 2018 ICD-10-CM annual update.</p>	<ul style="list-style-type: none"> <li>• Creation of Uniform LCDs Within a MAC Jurisdiction</li> <li>• Revisions Due To ICD-10-CM Code Changes</li> <li>• Typographical Error</li> </ul>
07/09/2018	R8	<p>06/27/18 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Corrected ICD-10 code I27.9 noted in R7 Revision History to I27.29.</p>	<ul style="list-style-type: none"> <li>• Typographical Error</li> </ul>
07/09/2018	R7	05/07/18 - At this time 21st Century Cures Act will apply	<ul style="list-style-type: none"> <li>• Creation of Uniform LCDs Within a MAC</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		<p>to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>This Draft to Final LCD is new for Jurisdiction E Part B and is effective 07/09/2018 for both Part A and Part B. LCD updated to clarify the ordering of Respiratory Therapy services and the medical necessity in the article text. Added and the following CPT codes new for 2018 because they are within the coverage indications of this LCD effective DOS 10/01/2017: 96417 and 96418 and 96420 was deleted effective for DOS 10/01/2017. Added the following ICD-10 codes new for 2018 because they are within the coverage indications of this LCD: E85.81, E85.82, R85.89, I27.20-I27.24, I27.9, I27.83 and R06.03 .</p> <p>The following ICD-10 codes were deleted with the 2018 ICD-10 code updates: E85.8 and I27.2.</p> <p>Also, the description for the following ICD-10 codes changed effective for DOS 01/01/2018: I50.1, M33.01 and M33.11</p>	<p>Jurisdiction</p>
01/01/2018	R6	<p>11/29/17: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Added procedure codes 94617 and 94618 effective 01/01/2018 and deleted 94620 effective 12/31/2017.</p>	<ul style="list-style-type: none"> <li>• Revisions Due To CPT/HCPCS Code Changes</li> </ul>
10/01/2017	R5	<p>08/24/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Effective DOS 10/01/2017 the following ICD-10-CM codes</p>	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		<p>were added, deleted and had a description change:</p> <p>Added:</p> <ul style="list-style-type: none"> <li>• E85.81</li> <li>• E85.82</li> <li>• E85.89</li> <li>• I27.20</li> <li>• I27.21</li> <li>• I27.22</li> <li>• I27.23</li> <li>• I27.24</li> <li>• I27.29</li> <li>• I27.83</li> </ul> <p>The following ICD-10 codes were deleted from the ICD-10 Codes that Support Medical Necessity field: E85.8 was deleted from Group 1 I27.2 was deleted from Group 1</p> <p>The following ICD-10 code descriptions were changed in the ICD-10 Codes that Support Medical Necessity field: I50.1 descriptor was changed in Group 1 M33.01 descriptor was changed in Group 1 M33.11 descriptor was changed in Group 1</p>	
10/01/2016	R4	The LCD is revised to add new ICD-10 codes and remove deleted code effective 10/1/2016: J95.860, J95.861, J95.862, J95.863, J98.51 and J98.59 added. Deleted code J98.5.	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>
02/01/2016	R3	R3-LCD revised to delete CPT codes 31500 & 92950 effective 2/1/16 and added ICD-10 code J44.9 effective 10/1/15.	<ul style="list-style-type: none"> <li>• Typographical Error</li> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>
10/01/2015	R2	The LCD is revised to add ICD-10 code R91.1 to group 1, effective 10/1/2015.	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>
10/01/2015	R1	CPT code 94669 added due to the 2014 CPT/HCPCS codes update.	<ul style="list-style-type: none"> <li>• Revisions Due To CPT/HCPCS Code Changes</li> </ul>

## Associated Documents

## Attachments

N/A

## Related Local Coverage Documents

### Articles

[A57224 - Billing and Coding: Respiratory Care](#)

[A59531 - Response to Comments: Respiratory Care](#)

### LCDs

[DL34149 - Respiratory Care](#)

## Related National Coverage Documents

N/A

## Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
09/15/2023	11/05/2023 - N/A	Currently in Effect (This Version)
01/29/2020	10/01/2019 - 11/04/2023	Superseded
09/20/2019	10/01/2019 - N/A	Superseded

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

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## Keywords

- Respiratory care
- respiratory therapy
- RT