Pulmonary Rehab Putting the Pieces Together by Chris Garvey, FNP, MSN, MPA

Garvey C. Pulmonary Rehab: Putting the Pieces Together. *RT: For Decision Makers in Respiratory Care*. 2009;23(1):10-13.

Pulmonary rehabilitation has seen at least a partial victory in its battle to win coverage from CMS. What are the details?

Over the past 3 decades, pulmonary rehabilitation (PR) clinicians, respiratory care practitioners (RCPs), physicians, and patients with chronic lung disease have worked vigorously to address inconsistent and limited national and local coverage of pulmonary rehabilitation. After years of legislative and advocacy efforts by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), American Thoracic Society (ATS), American College of Chest Physicians (ACCP), American Association for Respiratory Care (AARC), National Association for Medical Direction of Respiratory Care (NAMDRC), American Lung Association (ALA), state societies, and patient organizations, Congress passed legislation making Medicare coverage "the law of the land" in July 2008, with the benefit slated to take effect January 1, 2010.

The final rule for coverage of PR was published by the Centers for Medicare and Medicaid Services (CMS) in early November 2009 in two sets of related regulations. There are links for the Physician Fee Schedule (PFS), www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf, and the Hospital Outpatient Prospective Payment System (HOPPS), www.federalregister.gov/OFRUpload/OFRData/2009-26499_PI.pdf, that outline coverage and payment rules.

The legislative and advocacy efforts over the past 3 decades mirror the decades of development of evidence supporting the effectiveness of PR, which is outlined in three guideline statements:

- The Global Initiative for Chronic Obstructive Lung Disease (GOLD)[1]
- American Thoracic Society/European Respiratory Society (ERS) Statement on PR[2]
- American College of Chest Physicians/American Association of Cardiovascular and Pulmonary Rehabilitation joint evidence-based clinical practice guidelines[3]

These national and international guidelines identify PR as the standard of care for people with symptomatic chronic obstructive pulmonary disease (COPD). Additionally, the ATS/ERS statement on PR and the ACCP/AACVPR evidence-based guidelines address the appropriateness of PR for other chronic lung diseases.

Not Enough

The landmark law for PR coverage became a reality in July 2008 when Congress voted overwhelmingly to override a veto by President George W. Bush to make PR a permanent part of the Medicare benefit. Despite a strong message from Congress that PR would be available for people with chronic lung disease, CMS published proposed PR coverage and payment rules in July 2009 that would reduce existing PR payment by approximately 78% to an estimated $15 per hour. Additionally, patients with very severe COPD (FEV_1 or forced expiratory volume in 1 second of less than 30% predicted and FEV_1/FVC or forced vital capacity ratio of less than 70% predicted) and non-COPD pulmonary diseases were excluded from the proposed coverage. Other challenges included a substantial increase in the physician role in PR and use of a bundled HCPCS (Healthcare Common Procedure Coding System) code to cover all services that were previously separately billable, such as a 6-minute walk test. These proposed rules would have made providing PR a nonviable option for most providers, essentially eliminating PR in the United States. The proposed rules also would have excluded current existing coverage for PR for very severe COPD and some non-COPD diagnoses, which are currently covered by many local Medicare contractors.

Following publication of the proposed CMS rule for PR, representatives of AACVPR, ATS, AARC, and NAMDRC met with the leadership of CMS coverage and reimbursement on August 4, 2009, to address these concerns. The result of this and other meetings, as well as written responses from the professional and scientific societies and individuals' comments, yielded substantial modification in the final rule.

All Bundled Up

The final rule goes into effect January 1, 2010, and uses a new "bundled" HCPCS code G0424 for PR coverage. The code covers 1 hour of PR, which must include monitored exercise. No specific definition of monitoring requirements is included. The new G code crosswalks to a new APC (ambulatory payment classification) 0102 and pays approximately $50.46 per 1-hour unit. The rule allows for up to two PR sessions per day, per beneficiary, and, what is important, every 1-hour session must include aerobic exercise. Up to 36 visits are covered. CMS notes that additional services may be appropriate in certain circumstances and that another 36 visits may be considered for coverage by local contractors based on clinical need. There is no specific limit on the duration of the PR program.

Specific mandatory components for PR, based on the legislation, are outlined in the final rule and include:

- Physician-prescribed exercise
- Education or training
- Psychosocial assessment
- Outcome assessment

CMS has identified specific requirements in these four areas. The PR program must be reasonably expected to improve or maintain the individual patient's condition and functional level. CMS identifies techniques such as exercise conditioning, breathing retraining, and step and strengthening exercises as appropriate components of PR in the final rule. Some aerobic exercise must be included in each pulmonary rehabilitation session.

Education or training needs to be closely and clearly related to the individual patient's care and treatment and tailored to meet the patient's needs. Skills training and education should encourage changes in behavior that will lead to improved health and long-term adherence. Examples of education include management of respiratory problems, proper use of medications, and nutrition counseling. Other examples of education and training identified in the proposed rule include respiratory techniques for physical energy conservation, work simplification, and relaxation techniques. The education should address the patient's achievement of individual goals toward independence in activities of daily living (ADL), strategies for adapting to limitations, and improving quality of life. If brief smoking cessation counseling is appropriate, it can be included in the education but would not be separately billable outside the bundled PR HCPCS code.

Psychosocial assessment requires a written evaluation of patients' mental and emotional function that relates to the rehabilitation or their respiratory conditions. The assessment needs to include aspects of patients' family and home situations that affect their rehabilitation treatment. The evaluation also needs to include the patients' responses to and rates of progress under the treatment plan.

Outcomes assessment requires evaluation of the patient's progress related to the rehabilitation. The outcomes must include objective clinical measures of effectiveness of PR for the patient, including exercise performance, self-reported measures of shortness of breath, and behaviors. The physician must be involved in conducting both the initial and final evaluations, which are based on patient-centered outcomes.

The Doctor Is In

Significant physician involvement is required in the PR program and includes expertise in management of patients with lung disease, knowledge of the patient's condition, and involvement in directing the progress of the patient's care. Additionally, the physician has significant responsibility and involvement in developing the individualized treatment plan (ITP) in conjunction with the interdisciplinary team. Specific requirements of the ITP include the patient's diagnosis and scope of services, including the type, amount, frequency, and duration of services and patient goals. Individualized treatment is furnished based on an ITP, which is established by, reviewed by, and signed by the physician every 30 days and modified as necessary. If the plan is established by the referring physician, the PR medical director must review and sign the plan every 30 days.

The physician must be immediately available and accessible at all times for both medical consultation and medical emergencies while the PR program is in operation. In the hospital outpatient setting, the physician must be on the premises of the provider-based department and immediately available to furnish assistance and direction during PR program operation, although not necessarily in the room where PR is performed. (*Author's Note: In the case of hospital-based programs provided on the main hospital campus, physician availability is presumed.*) When PR is provided away from the main hospital campus, the physician must be in the provider-based department, although not necessarily in the same room. Supervision must be provided by a doctor of medicine or osteopathy and cannot be provided by a nonphysician such as a nurse practitioner.

PR services furnished in physicians' offices require that the physicians are in their office suite and immediately available during PR sessions, although not necessarily in the same room. For PR provided in the physician's office, reimbursement is approximately $18.46 per session.

Some Clarification

PR coverage has been expanded to include individuals with very severe COPD and will now cover those with moderate to very severe COPD or FEV_1 <80% predicted and FEV_1/FVC ratio of <70% predicted. For other pulmonary disorders, CMS has identified the National Coverage Determination (NCD) process for further coverage. Until the NCD process is complete, the respiratory services previously allowed by local contractors for other medical conditions under other Medicare Part B benefit categories remain in effect. In the case of existing individual respiratory services that are reasonable and necessary, a local contractor can still cover these services. Clinicians should refer to their own Local Coverage Determination based on Medicare Administrative Contractor or MAC region.

Depending on geography and a program's Medicare contractor, individuals with other pulmonary-related diseases may be eligible for coverage of pulmonary rehabilitation services, but they will be billed as respiratory care services using the current, existing coding mechanisms, HCPCS codes G0237, G0238, and G0239. This may lead to some short-term confusions where some beneficiaries will fall into one billing methodology and others, even though they receive the same service, will be subject to other billing procedures.

Other clarifications in the final rule include that physical therapists can no longer bill for PR using PT codes (97000 series). Because the new G code is "bundled," PR programs cannot bill separately for the 6-minute walk test or smoking cessation as part of the PR program. The new final rule does not impact CORFs (comprehensive outpatient rehabilitation facilities) that will continue to bill using HCPCS codes G0237, G0238, and G0239.

The PR final rule does not have specific requirements for staff to patient ratio or maximum number of patients in a PR session. Clinicians should use national guidelines such as the AACVPR Guidelines for Pulmonary Rehabilitation Programs (3rd edition). A fourth edition of the guidelines that will include information on the new PR final rule will be published in 2010.

Calling All RTs

Respiratory therapists are at the forefront of educating other clinicians and patients about PR effectiveness and coverage changes. The professional and scientific societies will continue to work together and with CMS to address concerns raised by the final rule, including coverage concerns for non-COPD lung disease, reimbursement for physician office-based practices, and other areas. It is critical for RTs to become members of national organizations such as AACVPR and/or AARC to understand and use the new final rule for PR, receive important updates, and become involved in the processes that made many of these advances a reality.

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Resources for Interpreting and Implementing the Final Rule

AACVPR Legislative and Regulatory Resources: www.aacvpr.org/PolicyReimbursement/.../Default.aspx

ATS Pulmonary Rehabilitation: Final Rule Sets Medicare Coverage and Reimbursement Policy: www.thoracic.org/sections/about-ats/advocacy/washington-letter/letters/september-7-2009.html.

Medicare Administrative Contractor Information: www.cms.hhs.gov/MedicareContractingReform/01_Overview.asp

Other PR Resources

Guidelines for Pulmonary Rehabilitation Programs, 3rd Edition

www.humankinetics.com/products/all-products/guidelines-for-pulmonary-rehabilitation-programs-3rd-edition?isbn=0736055738

AACVPR Program Certification

www.aacvpr.org/Certification/tabid/63/Default.aspx

References

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3. Ries AL, Bauldoff GS, Carlin BW, et al. Pulmonary rehabilitation: joint ACCP/AACVPR evidence-based clinical practice guidelines. *Chest.* 2007;131(15 suppl):4S-42S.