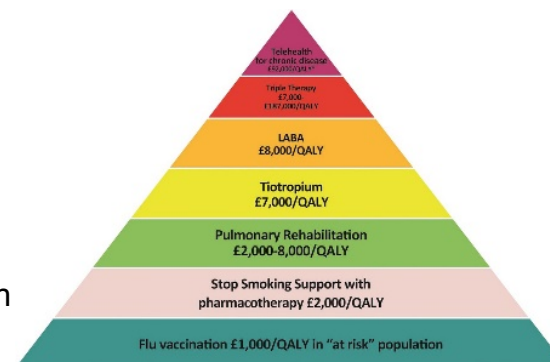


Pulmonary Rehabilitation – California as a Leader in Improving Reimbursement and Awareness

by Chris Garvey NP, Richard Casaburi PhD, MD and Phil Porte

Reimbursement – What Isn't Working, Why it Matters and How to Fix It

- Pulmonary rehabilitation (PR) is clinically effective, safe, and cost effective (1,2), and results in improvement in exercise capacity, dyspnea and quality of life better than other therapies (3) as well as shorter hospitalization length of stay in COPD (4).
- Despite the high prevalence of symptomatic lung disease and the benefits of PR, inadequate reimbursement threatens PR availability, with only about 3% of Medicare beneficiaries with COPD receiving PR (5)
- Decline and stagnation of payment for PR is complex. **Rigorous analysis has found that hospitals are undercharging for PR, which has at least in part led to inadequate reimbursement that does not cover the cost of providing PR services.**
- ATS, California Society for Pulmonary Rehabilitation and other scientific and professional societies have taken the lead in addressing PR reimbursement and awareness inequities.
- **A priority to address poor coverage is for pulmonologists to both partner with PR clinicians and *meet with hospital financial leads to educate them of the need for PR, its value, and that availability of this effective intervention requires adequate hospital charges to survive.***



The evidence of clinical effectiveness of pulmonary rehabilitation (PR) is strong and continues to grow, yet inadequate reimbursement and limited availability challenge effective PR delivery in the United States (1). Only about 3% of

Medicare-eligible COPD patients in the US have received PR (5). Low reimbursement has the potential to influence availability of what is widely acknowledged as the standard of care in chronic lung disease.

Reasons for the decline in PR reimbursement are complex. It is at least in part tied to a Medicare change in PR reimbursement in 2010, when a new “bundled” payment code “G0424” for COPD was introduced. The code pays for one hour of PR including all costs of staff, medical director, gym, etc. In 2010, Medicare arbitrarily established a payment rate of \$50 for one unit of G0424. Medicare acknowledged in 2011 that *failure to carefully construct the charge for G0424 that reports a combination of services previously reported separately under-represents the cost of providing the service described by G0424 and can have significant adverse impact on future payments* (6).

Historically, PR had been paid for in 15-minute increments for most services. A recent review of charges for PR for COPD patients submitted to Medicare in 2015 from claims billed by 1350 U.S. hospitals found that the majority of PR providers and hospitals never adequately modified PR charges to reflect the nearly fourfold increase in time and resources used for the “bundled” G0424 billing code. Medicare uses of PR charges (as well as information from the hospital cost report) to calculate PR payment. One consequence of this is that cardiac rehabilitation reimbursement is now double that of PR (table 1).

CMS Final CY 2017 Outpatient Services Payment Rates

| HCPCS Code (APC) | Short Descriptor | Amount paid for service |
|-------------------------|-------------------------|--------------------------------|
|-------------------------|-------------------------|--------------------------------|

| | | |
|--------------|----------------------------------|----------|
| 93798 (5771) | Monitored Cardiac rehabilitation | \$110.18 |
| G0424 (5733) | Pulmonary rehab with exercise | \$54.53 |

A critical concept when calculating appropriate charges is that the amount paid for services is typically a small fraction of the amount charged by health care systems. Below is an example of amount charged for services versus the amount paid.

Examples of Medicare Outpatient Prospective Payment System Hospitals for 2015

| Ambulatory Payment Classifications (APC) / Description | Average Estimated Submitted Charges | Average Total Payments |
|---|--|-------------------------------|
| 0269 - Level I Echocardiogram Without Contrast | \$2,386.36 | \$409.22 |
| 0369 - Level II Pulmonary Function | \$1,354.23 | \$229.25 |

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Outpatient2015.html> accessed 10/1/18

PR needs your help. Hospital administrators set charge rates for all hospital services, including PR. They need to be aware of the concerns regarding G0424 billing and the impact of undervalued charges on Medicare payment. A [Pulmonary Rehabilitation Toolkit](#) that details resources for PR billing is available.

It is time for the pulmonary medicine and scientific community to bring these concerns to their hospital administration. It is also time for pulmonologists to partner with PR clinicians and administrators to determine if charges for PR services reasonably represent the complexity of the intervention, the acuity of the target population and the value of this evidence-based intervention.

References

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Make the Referral: A Majority of Our Patients Will Benefit from Pulmonary Rehabilitation

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Key Summary Points:

- Pulmonary rehabilitation (PR) should be an integral part of the treatment plan for patients with chronic respiratory disease.
- Although the benefits of pulmonary rehabilitation in patients with COPD are widely accepted, we need to increase awareness that others with chronic respiratory disease are likely to benefit.
- We must push for better reimbursement for PR to stimulate growth of existing programs and foster development of new programs in order to improve patient access.

The American Thoracic Society and the European Respiratory Society have defined pulmonary rehabilitation as a "comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include,

but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.”[1] Today the benefits of pulmonary rehabilitation (PR) are widely accepted amongst clinicians and scientists for patients with chronic obstructive pulmonary disease (COPD). We must now increase awareness of the growing literature that all patients with symptoms of dyspnea from chronic respiratory conditions with reduced functional capacity or quality of life can gain a great deal from this multimodal program.

Patients with chronic lung disease mainly complain of shortness of breath and fatigue. In those with COPD, studies also demonstrate an increased risk of depression and anxiety. Pulmonary rehabilitation consists of an exercise program and an educational curriculum covering topics on oxygen use, medications, nutrition and breathing techniques. Education focuses on long term behavioral change including maintenance of exercise and physical activity. In addition, PR provides a social support system that helps recognize and address psychological stressors. This forum allows for peer interaction and an open communication with the health care team.

In patients with COPD, PR has shown to improve exercise performance, reduce symptoms of dyspnea and improve health related quality of life (HRQL). Data demonstrates that patients with interstitial lung disease (ILD), bronchiectasis, cystic fibrosis, asthma, pulmonary arterial hypertension, lung cancer and lung transplantation also benefit. For instance, those with ILD may learn techniques to conserve energy and use equipment to assist with activities of daily living. Patients with bronchiectasis may acquire knowledge for secretion clearance with nebulizer education and acapella valve teaching. Despite its broadening scope, PR may not be appropriate for everyone. Those with significant orthopedic, cardiac, psychiatric or neurologic conditions that limit mobility may not be able to participate. Furthermore, pulmonary rehabilitation has been shown to reduce utilization of health care resources. Patients with COPD who undergo PR have a lower number of unscheduled clinic visits, emergency department visits and hospital admissions.

Pulmonary rehabilitation should be an integral part of the treatment plan for patients with chronic respiratory disease. In addition to smoking cessation, oxygen therapy and inhaler medications, we need to consider this intervention early in the disease course.

With increased awareness of its many benefits, we hope for better PR reimbursement to allow for program development and improved patient access.

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Pulmonary Rehabilitation Resources in California

1. ATS recently published two editorials highlighting poor PR utilization and reimbursement as significant barriers to PR availability and ultimately improved patient outcomes.

<https://www.atsjournals.org/doi/abs/10.1164/rccm.201809-1711ED>

<https://www.atsjournals.org/doi/abs/10.1513/AnnalsATS.201809-641ED>

2. Livebetter.org

ATS and the *Gawlicki Family Foundation* are working together to increase awareness of pulmonary rehabilitation

3. <https://www.aacvpr.org>

American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

CTS member *Trina Limberg* at UCSD is a member of the AACVPR BOD. *Karen Lui* is a former President as are *Brian Carlin* and *John Hodgkin*. *Rich Casaburi*, *Chris Garvey* and *Andy Ries* are among current AACVPR Fellows hailing from California.

4. <https://www.cspr.org>.

The **California Society for Pulmonary Rehabilitation (CSPR)** is led by Aimee Kizziar, UC Davis, Lynn McCabe, Carlsbad, CA and Missy Von Luehrte, El Camino Hospital.

CSPR's annual meeting is being held **May 3-4, 2019** in Sacramento and features an outstanding lineup of speakers from throughout the state including Josh Mooney (Stanford) and Justin Oldham (UC Davis) .

<https://www.cspr.org/register-2019.html>

Access: <https://www.cspr.org/find-a-program.html>

5. <https://www.copdfoundation.org/Learn-More/I-am-a-Person-with-COPD/Pulmonary-Rehabilitation.aspx>