Subacute Care Bulletin

July/August '98

HCFA Clarifies Medicare Coverage for RT Services in SNFs

The Balanced Budget Act of 1997 (BBA '97) has caused some confusion regarding the coverage of respiratory care services in skilled nursing facilities. In order to clear up the misunderstanding that have arisen, AARC Director of Government Affairs Cheryl West recently wrote to James K. Kenton, director of the Division of Institutional Postacute Care in the Chronic Care Purchasing Policy Group of the Center for Health Plans and Providers at the Health Care Financing Administration (HCFA) requesting further explanation. His response reads, in part:

"I am responding to your letter . . . regarding the effective date of the expansion of Part A coverage to include services furnished to a SNF resident by a respiratory therapist who is not employed by the SNF's transfer agreement hospital. As explained below, this coverage change becomes effective for services furnished on or after July 1, 1998. The following discussion provides some additional background on this change in Medicare coverage.

Historically, the services of respiratory therapists have been furnished to SNF residents primarily through an agreement with the SNF's transfer hospital under section 1861(h)(6) of the Social Security Act (the Act), due to various long standing restrictions in the Medicare law itself that have largely precluded coverage under the Part A SNF benefit by any other means. However, as explained below, the Balanced Budget Act of 1997 (BBA '97, P.L. 105-33) has amended section 1861(h)(7) of the Act to expand SNF overage in this regard.

Section 1861(h) of the Act describes coverage of 'extended care' (i.e., Part A SNF) services. In addition to the specific service categories set out in paragraphs (1) through (6) of this section, paragraph (7) provides for coverage of other services that are generally provided by SNFs. Until recently, though, the statutory language regarding services that are 'generally provided by' SNFs required not only for a particular service to be 'generally provided'(i.e., for the provision of that type of service to be the prevailing practice among SNFs nationwide), but also for the service to be provided directly 'by' the SNF itself.

However, section 4432(b)(5)(D) of the BBA'97 has now expanded section 1861(h)(7) of the Act to include coverage of services that are generally provided by SNFs or by others under arrangements with them made by the SNF. As a result, the extended care benefit will now cover the full range of services that SNFs generally provide, either directly or under arrangements with any qualified outside source. Accordingly, the services of respiratory therapists (which have until now been specifically coverable as extended care services only when provided by those therapists who are employees of the SNF's transfer agreement hospital under section 1861(h)(6) of the Act), will have now become coverable when provided under arrangements made directly between the SNF and a respiratory therapist, regardless of whether the therapist is employed by the SNF's transfer agreement hospital (see the discussion in the preamble to the interim final rule on the SNF Prospective Payment System (PPS) and Consolidated Billing, 63 FR 26301-02, May 12, 1998).

Finally, I would note that section 4432(d) of BBA '97 provides that the amendments made by section 4432(b) (regarding SNF Consolidated Billing and its conforming changes, including the revision of section 1861(h)(7) of the Act discussed above) apply to items and services furnished on or after July 1, Thus, unlike the effective date for the SNF PPS itself (which is based on the start of the individual SNF's first cost reporting period that begins on or after July 1, 1998), the change in Part A SNF coverage discussed above is effective for services furnished on or after July 1, 1998." ■

American Association for Respiratory Care

AAHSA and AHCA Announce Cooperative Fair Labor Education Effort with Department of Labor

The American Association of Homes and Services for the Aging (AAHSA) and the American Health Care Association (AHCA) plan to intensify their outreach programs in cooperation with the US Department of Labor (DOL) to help educate nursing home operators and staffs about the complexities of the federal Fair Labor Standards Act (FLSA).

In 1997 the DOL's Wage and Hour Division, in consultation with the associations, conducted a study showing that over 70 percent of the long term care facilities surveyed were in full compliance with the FLSA. The remaining facilities were largely found to have technical errors. The two organizations emphasize that the 70 percent compliance rate is equal to that found in other industries.

Among those facilities not in compliance, the most common problem was in the area of overtime, followed by inappropriate use of volunteers and minimum wage issues. Regarding overtime, the DOL's study found that the most common areas needing correction were ensuring that employees are compensated during scheduled meal periods (especially if they are interrupted by residents who need assistance) and during compensable training sessions, and giving "comp time" rather than overtime.

Considering the fact that long term care facilities operate 24 hours a day, can have high turnover rates, and usually promote community involvement through volunteer activity, the two organizations believe current compliance rates are commendable. However, they believe these rates can be improved upon through their joint efforts to provide training sessions focused on complying with the substance of FLSA, as well as understanding and applying the law's many arcane points.

AHCA is a federation of 50 affiliated associations, representing over 11,000 nursing facilities, assisted living facilities, and subacute providers of both proprietary and non-proprietary long term care facilities which are dedicated to improving the health of those needing short-term rehabilitative services, long-term skilled nursing care, or assisted living services.

AAHSA is the association for the nation's not-for-profit long term care and senior housing providers. Its members include over 5,000 nursing homes, assisted living homes, continuing care retirement communities, senior housing, and home and community-based service organizations. (Source: AHCA) ■

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HHS to Reward Reports of Medicare Fraud

HHS Secretary Donna E. Shalala has announced a new regulation which will make citizens who alert Medicare of possible acts of fraud and abuse eligible for rewards if their information leads directly to the recovery of Medicare money.

"Senior citizens are our first line of defense in the battle to fight Medicare fraud. They can be our eyes and ears in the field," Shalala said. "This program is another weapon in our fight against fraud and abuse — and protecting the Medicare Trust Fund."

The final regulation detailing the Incentive Program for Fraud and Abuse Information, created in the Health Insurance Portability and Accountability Act, was published in the Federal Register late last spring. Under this program, which starts in January 1999, rewards of up to $1,000 will be paid to Medicare beneficiaries and others who report fraud and abuse in the Medicare program.

"It is critical that we enlist the support of Medicare beneficiaries in our fight against health care scams and unscrupulous providers," said Nancy-Ann DeParle, administrator of the Health Care Financing Administration. "Working with the Administration on Aging, one of our partners in Operation Restore Trust, and its national aging network across the nation, thousands of volunteers have been trained to recognize and report fraud and abuse in nursing homes and other long-term care settings as well as local communities."

"This new program underscores the continuing contributions that older Americans continue to make to our country, by enabling them to work closely with their family members, colleagues and peers to fight fraud and abuse," said Jeanette Takamura, assistant secretary for aging. "It is truly a people's campaign."

To receive a reward, the information reported on fraud and abuse must directly contribute to the recovery of Medicare funds for fraudulent activity not already under investigation by law enforcement agencies, the HHS Inspector General, state agencies or Medicare's contractors.

Rewards will be for ten percent of the recovered overpayment or a $1,000 maximum and will be financed from the collected overpayments, after all other fines and penalties have been recovered. Program funds will be used for the administrative costs of the incentive program.

Some examples of the types of potential fraud that HCFA believes Medicare beneficiaries and others can help spot include: Medicare being billed for services that were never provided, being billed twice for the same procedure, being billed for a more expensive procedure than the one received, or being billed for a procedure that is not medically necessary; providers using Medicare card numbers that they obtained deceptively; and telemarketing scams.

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The incentive program is the latest step in the Clinton Administration's unprecedented focus on fighting Medicare fraud, waste, and abuse. Medicare alone saved more than $7.5 billion through anti-fraud and abuse efforts in fiscal 1997, and with its law enforcement partners returned another $1 billion to the Medicare Trust Fund. Efforts of the highly successful Operation Restore Trust anti-fraud program identified $23 in money owed back to the Trust Fund for every $1 spent on fraud detection and recoveries. Lessons learned in that pilot project are now being applied nationwide. (Source: HHS) ■

Gazing into the Crystal Ball

The past decade hasn't been all that kind to health care professionals — RCPs included — and the wear and tear is beginning to show. As managed care has changed the way we care for patients, just about everyone has become infected with the "woe is me" syndrome.

But are RCPs really on their professional sickbed? Not if you consider statistics reported in a recent AARC white paper:

- The U.S. Department of Labor, Bureau of Labor Statistics projects a conservative increase in demand for respiratory care practitioners of 48 percent by the year 2005.
- The substantial growth of the middle-aged and elderly population will heighten the incidence of cardiopulmonary disease.
- By the year 2030, the portion of the population age 65 and over will increase to almost 25 percent, up from just 12.2 percent in 1987.
- In gross numbers, there will be 35 million people age 65 or older by the year 2000; 4.6 million will be over 85.
- The over-85 age group is the fastest growing segment of the population.
- The elderly are the most common sufferers from respiratory ailments and cardiopulmonary diseases such as pneumonia, chronic obstructive pulmonary disease (COPD), emphysema, and heart disease. ■

JCAHO Accreditation Reports

What areas are Joint Commission surveyors likely to concentrate on during a long term care survey? Recent postings on the AARC web site, AARC Online, suggest that the following areas are receiving attention from surveyors:

- Resident and staff education
- Resident education documentation by the multidisciplinary team
- Competencies for RT staff.
- LTC/Subacute care rehab

Visit AARC online to see the complete JCAHO Visit Report Form responses (http://www.aarc.org/members area/resources/jcaho.html). If you would like to share information with your peers about your survey, contact Kelli Hagen at the AARC executive office to get a JCAHO Visit Report Form and return it to the AARC at the address listed on page 2. ■

The AARC and UCSD Offer Patient Driven Protocols Manual

The AARC is proud to partner with the University of California San Diego (UCSD) in offering the university's Patient Driven Protocols Manual. UCSD's Respiratory Services developed the manual to serve as a resource for respiratory care providers in developing, implementing, or refining care plans which are implemented by bedside practitioners based on patient evaluations and responsive interventions.

The original protocol program was developed at UCSD in 1993 and has expanded from 2 protocols to more than 25. Each of them has been successfully implemented at UCSD as part of a hospital-wide program. In fact, the manual serves as a daily reference for respiratory therapists, physicians, nurses, and other medical staff at the university's hospital.

This protocol manual includes guidelines for oxygen, secretion management, percussionaire, autogenic drainage, extubation, and post-op laparotomy.

Cost of the manual (product # PA801) is $85 for members and $99 for nonmembers. Shipping cost is $10. For more information or to order, contact the AARC at (972)243-2272. ■

FYI . . .

Hyperbaric oxygen therapy found effective in brain injury

Treatment in a hyperbaric oxygen chamber can result in improvements in speech, memory, and attention for long-term traumatic brain injury patients, say researchers from the Transitional Learning Community in Galveston, TX. When they compared pre- and post-treatment single photon emission computed tomography (SPECT) scans of five patients who underwent a series of hyperbaric oxygen sessions with those of six controls they found that the treatment group showed increased blood flow in specific areas of the brain after treatment.

The treatment group first underwent 80 sessions in a hyperbaric chamber, followed by a five month rest period. Then they had 40 more sessions. The study showed that improvements peaked at the 80 session mark and were maintained by repeat sessions every one to two weeks. All of the patients in the study were at least three years post-injury.

The study was presented at a recent

"FYI" continued on page 4

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meeting of the Undersea and Hyperbaric Medical Society.

Pulmonary complications high among HIV patients

A retrospective review of 233 autopsy cases of HIV-positive patients conducted by investigators from University Medical Center in Jacksonville, FL, found that over 90 percent had some form of pulmonary complication. Bacterial infection was the most common complication seen among the patients, with the two most common causes being Pseudomonas aeruginosa and Staphylococcus aureus.

Thirty-three percent of the patients had pulmonary mycobacterial infection, 24 percent had Pneumocystis carinii pneumonia, and 13 percent had extrapulmonary involvement. Among the 12 percent of the patients with Kaposi sarcoma (KS), the lung was the most common site; 19 percent of the patients with pulmonary KS showed no evidence of skin involvement at autopsy.

The authors conclude that the high rates of pulmonary complications found in their study indicate a need for greater attention to these complications by clinicians. (Chest 1998;113:1225-1229)

New vent mimics normal breathing

A new, computer-controlled ventilator that more effectively mimics normal breathing could minimize the lung damage that often results from long-term ventilator use.

Researchers from Boston University who developed the device note that the unvarying respiratory rate of conventional mechanical ventilators leaves "many peripheral airways closed . . . thereby creating large collapsed regions." Their computerized device solves that problem by introducing the random variations in respiration rates typically seen in healthy breathing.

Say the researchers, "Partial pressure of arterial oxygen is improved significantly by computer-controlled rather than conventional ventilation." By breaking the chain of injury propagation in acute lung injury, they believe these devices could have a significant effect on morbidity. (Nature 1998;393:127-128)

Do better, say Americans polled about government health programs

For years now health care organizations and health plans have been subjected to customer satisfaction surveys aimed at determining their worth. Now the federal government has gone under the microscope as well – and the results indicate plenty of room for improvement.

A new survey that looked at how Americans view government-sponsored health plans and initiatives found that just 18 percent believe the government is doing a good job of providing high quality, affordable care. Forty-five percent rated government programs as "fair" and 35 percent said they were "poor."

Who does the public blame for this poor performance? Interestingly, not the government itself. Just 45 percent of those who issued a "poor" rating said the government was to blame. Forty-nine percent said the poor performance was more due to the complexity of the health care issue itself.

The feds could be doing a better job, however, say respondents. Only 15 percent said that the government has placed enough emphasis on health care; 75 percent said health care should be bumped up the priority list.

The survey was part of a larger survey conducted by Pew Research Center for the People & the Press to gauge the nation's opinion on a variety of government-related issues. (Hospitals & Health Networks, 4/20/98)

HMOs find that what goes around . . .

You know the old saying, "what goes around, comes around?" HMOs are probably ruefully citing that one behind closed doors these days. The latest figures from InterStudy Publications, Inc., indicate that the go-go years of the early 1990s are over for the nation's health plans. While 90 percent of plans were operating in the black just four years ago, that figure has dropped considerably, and today's best performers are doing well to return margins equal to the average performers of 1994. Middle-of-the-road performers of the past have now migrated to the losing end of the spectrum, posting 1.2 percent margins, on average, through the third quarter of 1997.

Hospitals, physicians, and patients, however, have come around the other side of the bend. The firm reports that medical expense ratios — which indicate how much of an HMO's revenue is paid out to providers and patients — are up. (Hospitals & Health Networks, 5/20/98) ■

Specialty Practitioner of the Year: *Call for Nominations*

Don't forget to make your nominations for the Subacute Care *Specialty Practitioner of the Year.* The winner of this important award will be determined by the Section Chair or a selection committee appointed by the chair, and will be honored during the Awards Ceremony at the AARC Convention. Each nominee must be a member of the AARC and a member of the Section. Mail or FAX a short (500 words or less) essay describing your nominee's qualifications to: Tami Carter, RRT, director of Respiratory Management Services, 501 S.E. Columbia Shores Blvd., Suite 300, Vancouver, WA 98661, (503) 736-3772, Ext. 235 Fax (360) 735-9416, e-mail tcarter@prestige-care.com ■