Management Bulletin
Jan./Feb. '02

American Association for Respiratory Care

Word on the Web

In this issue, we feature sound bites from recent discussions on the Management Section listserve involving MDI canister reuse, pulmonary rehabilitation maintenance charges, and the stacking of treatments.

Please note that postings have been edited slightly for space and style considerations. And remember, if you have yet to join the listserv, all you have to do to start taking advantage of this valuable membership benefit is visit the Management Section area of AARC Online (www.aarc.org) and follow the directions to sign up.

MDI canister reuse

Manager #1: We are in the process of evaluating the reuse of MDI canisters (e.g., albuterol) among multiple hospital inpatients, with only the mouthpieces and/or holding chambers being single patient use. We are currently reusing the MDI canister with an individual holding chamber in the PFT lab. We would be interested in anyone's experience with this and any concerns that might have been addressed, such as infection control or billing issues.

Manager #2: Get in touch with your Monaghan representative about this. They have protocols and user references for traveling MDI canisters.

Pulmonary rehab maintenance charges

Manager #1: I need to ascertain an average charge for the "maintenance" phase for pulmonary rehab patients. This should not be a Medicare fraud issue since it is not billable to Medicare and is private pay. Our CFO is wanting to raise the monthly amount billed to the patient, and I would like to stay in the ballpark with the rest of the world. We run maintenance 2 days/week and charge $26.50/month. Thanks in advance for your assistance.

Manager #2: Our patients average 1-3 sessions per week (their choice), and the charge is $5 per session.

Manager #3: We charge $3 per visit. We looked at charging by the month, but with ledgers, people who pay a few in advance, credits during hospitalizations . . .

Manager #4: We have a charge of $414/year for 3 days/week, and $303/year for 2 days/week. We offer a 20% discount to our Gold Circle members and also give a 5% discount if they pay for the entire year in advance.

Manager #5: We charge $4 per visit, payable at the visit or billed on a monthly basis. We charge $6 per visit if they use our O_2.

Manager #6: We charge $44 per month, and a 20% discount is applied if they pay in full at the beginning of the month.

Stacking of treatments

Manager #1: When it comes to the problem of stacking treatments, my concern is that with the current difficulties I am having in staffing my department and the high volume of patients, we would be in serious trouble if we went to one-on-one care. Any ideas or suggestions would be greatly appreciated.

Manager #2: We may be in serious trouble if we continue to stack treatments. Medicare is quietly beginning to ask if billing for these treatments individually while doing them simultaneously is double dipping and fraud. It doesn't matter that they pay by DRG. Fraudulent billing can land you in jail. On top of that, if therapists are running from room to room, are they really delivering any special benefit of their skills? If not, why would anyone pay for therapists? We better quit relying on the easy answers, or we will be out of business.

And yes, before you ask, we sometimes have to stack treatments, by virtue of the staffing and productivity history. That history is hard to roll back, even when you can find staff. Administration is not happy when you say, "Well, we did this work last year with XX FTEs, but next year we need more FTEs to do the same work." But we must find a way to work away from stacked therapy, over time if not immediately.

We are moving away from stacked therapy as fast as I can manage. We have set about reducing the allowed level of stacking in policy. We will reduce each year to reduce the financial impact in any one year but move steadily toward no stacking. We are moving to implement the two-minute aerosol treatment as presented at Summer Forum. This will allow us to reduce stacking without boosting staff requirements. More efforts are in development.

"Word on the web" continued on page 2

"Word on the Web" continued from page 1

This problem is overwhelming when viewed in total, but the best way is to approach it like eating an elephant: Don't go for the whole thing, just eat one bite at a time. I don't mean to oversimplify, but we must start somewhere.

Manager #3: I've looked at the two-minute tx data. Everything I have seen revolves around using the 5% solution and using less diluent (.5-1.5 cc). The deposition studies are impressive and show adequate delivery with this method. My problem is that most of my therapy, especially during peak times, is with Atrovent/albuterol. That means 3-3.5 cc total volume, thus eliminating your time savings. Does anyone have a protocol that deals with the combination?

Manager #4: Try the BAN (Breath Actuated Nebulizer) from Monaghan Medical. From what I have read, it has the best effective deposition with the least waste of med volume. We use 0.5 ml undiluted albuterol with 1.0 cc of ns, and this takes two minutes or less to nebulize. Monaghan also has a recyclable aerosol mask you can use with the Aeroeclipse. Warning: the Monaghan stuff costs significantly more than your run-of-the-mill wet nebs. But if you have an "assess and treat" protocol that incorporates switching therapies back and forth to MDIs at the RCP's discretion, you wind up saving even more when you go with multi-patient use MDIs. I feel you need to take a multi-front, interdisciplinary approach to put a program together with facility med compounding in order to see savings in addition to better patient care.

What is "facility med compounding"? Glad you asked! Our next move is to have our pharmacy compound our own unit doses so we can tailor-make combo meds (albuterol + ipratropium, ipratropium alone, albuterol + ipratropium + corticosteriod, etc.). This will save us a bundle in the cost of the meds alone! We can also have them produce unit dose tobramycin or anything else that can be compounded appropriately into inhaled solution form. And you can control the total volume in the unit dose vials.

If things work out, I hope to be able to present an abstract on our program at an upcoming meeting. ■

JCAHO Launches Critical Access Hospital Program

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently launched a new accreditation program for Critical Access Hospitals and is currently seeking deemed status for the program from the Center for Medicare and Medicaid Services (CMS).

Critical Access Hospitals, as outlined in the Balanced Budget Act of 1997, are designed to provide limited, but essential, health services to rural communities. These small facilities, with patient censuses of less than 25, are certified by the Secretary of the Department of Health and Human Services as eligible for cost-based reimbursement from the Medicare program. More than 400 existing hospitals nationwide have already converted to Critical Access Hospital status and as many as 1100 organizations may be eligible for this designation.

The new accreditation program is designed to meet the performance improvement and business needs of these particular hospitals, many of which are currently accredited by JCAHO as acute care hospitals. Critical Access Hospitals will be surveyed for compliance with standards that have been specifically adapted for these organizations and are in conformance with Medicare requirements.

For more information about the Critical Access Hospital accreditation program, call Kurt Patton, executive director, Hospital Accreditation Services, JCAHO, at (630) 792-5810 or email kpatton@jcaho.org. ■

Management Bulletin

is published by the
American Association for Respiratory Care
11030 Ables Lane
Dallas, TX 75229-4593
(972) 243-2272
FAX (972) 484-2720
e-mail: info@aarc.org

Debbie Bunch
Bulletin managing editor

Edwards Printing
Bulletin typesetting

Section Chair
Karen Stewart, MS, RRT
(304) 348-4367
karen.stewart@camcare.com

Bulletin *Editor*
John D. Kimble, Jr. , RRT, RCP
Director, Respiratory Care Services &
Sleep Diagnostic Lab
Scott & White Memorial Hospital
2401 S. 31st St.
Temple, TX 76508-0001
(254) 724-2179
FAX (254) 724-7630/724-7572
jkimblerrt@aol.com

CMS Updates RT Codes for Pulmonary Rehab

Editor's Note: *The Centers for Medicare and Medicaid Services recently published the following updated codes for respiratory therapy in the Federal Register. To access the pertinent section on the Internet, go to: http://www.access.gpo.gov/su_docs/fedreg/a011101c.html. Then page down to: Centers for Medicare & Medicaid Services, RULES, Medicare: Physician fee schedule (2002 CY); payment policies and relative value units five-year review and adjustments. Click on 55295-55344 {TEXT}, and then search for the term "Respiratory Therapy Codes" to locate the following section.*

Respiratory Therapy Codes

Respiratory therapists can deliver services incident to a physician's service or in a provider setting such as an outpatient hospital or a comprehensive outpatient rehabilitation facility. In the past, services delivered by respiratory therapists or other health professionals often have not been clearly described by the existing CPT codes. In order to clarify coding of these services, typically delivered by respiratory therapists, but at times delivered by other specially trained health professionals, we are instituting new G codes to describe these services. We developed three codes for use to describe services to improve respiratory function:

G0237 Therapeutic Procedures To Increase Strength or Endurance of Respiratory Muscles, Face-to-Face, One-on-One, Each 15 Minutes (Includes Monitoring).

This service is to be billed when the therapist works with the patient to perform specific exercises aimed at strengthening the main and accessory muscles of respiration. We have provided a specific value for this code based upon the time that a respiratory therapist, who we believe will be the typical professional providing this service, will spend performing this service and practice expenses crosswalked from other similar services. This code will have no physician work.

"CMS Updates" continued on page 3

"CMS Updates" continued from page 2

G0238 Therapeutic Procedures To Improve Respiratory Function, Other Than Ones Described by G0237, One-on-One, Face-to-Face, per 15 Minutes (Includes Monitoring)

G0239 Therapeutic Procedures To Improve Respiratory Function, Two or More Patients Treated During the Same Period, Face-to-Face (Includes Monitoring)

Codes G0237 and G0238 are billed in 15-minute increments. The method for "counting" the 15 minutes will be consistent with the method for counting minutes in many of the 97000 series CPT codes (see PM-01-68 for details). These codes would describe activities, such as monitored exercise, that improve respiratory function. Both G0238 and G0239 would be carrier-priced. The carriers have the authority to request information about the specific nature of the services delivered. CPT codes G0237-G0239 may not be billed with codes G0110 and G0111, which are restricted to services in the National Emphysema Treatment Trial (NETT), since they represent the same services. These codes are designed to provide more specific information about the services being delivered. The availability of codes for services to improve respiratory function will make billing of CPT codes 97000-97799 inappropriate for professionals involved in treating respiratory conditions, unless these services are delivered by physical and occupational therapists and meet the other requirements for physical and occupational therapy services. We recognize that speech and language pathologists also occasionally treat patients to improve respiratory function as part of their treatment of speech and language disorders. Because the primary goal of these services is not to improve respiratory function, but to restore speech and communication, these services should be coded with 92507, "treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation, individual)." (Source: Federal Register, vol. 66, no. 212, page 55311) ■

ED Good Place to Spot Adverse Drug Reactions

A new study finds emergency departments are often the best place to identify adverse and potential drug reactions among the elderly. Canadian researchers found that about 10% of 283 emergency department visits of people 65 years and older were directly related to an adverse drug reaction, and 30% of the patients had potential adverse drug interactions.

The five most frequently found potential adverse drug interactions noted in the study involved the following medications:

- Furosemide and digoxin potentially leading to electrolyte disturbances and arrhythmia.
- Salicylic acid interfering with the antihypertensive effect of beta-blockers by inhibiting renal prostaglandins.
- Salicylic acid decreasing insulin requirements.
- Enalapril and potassium supplements predisposing electrolyte imbalances and arrhythmia.
- Acetaminophen increasing the anticoagulant effect of warfarin. ■

HHS Invests $50 Million to Improve Patient Safety

HHS Secretary Tommy G. Thompson has released $50 million to fund 94 new research grants, contracts, and other projects to reduce medical errors and improve patient safety. The initiative represents the federal government's largest single investment to address the estimated 44,000 to 98,000 patient deaths related to medical errors each year.

The six major categories of awards include:

Supporting Demonstration Projects to Report Medical Errors Data: These activities include 24 projects to study different methods of collecting data on errors or analyzing data that are already collected to identify factors that put patients at risk of medical errors.

Using Computers and Information Technology to Prevent Medical Errors: These activities include 22 projects to develop and test the use of computers and information technology to reduce medical errors, improve patient safety, and improve quality of care.

Understanding the Impact of Working Conditions on Patient Safety: These activities include eight projects to examine how staffing, fatigue, stress, sleep deprivation, and other factors can lead to errors.

Developing Innovative Approaches to Improving Patient Safety: These activities include 23 projects to research and develop innovative approaches to improving patient safety at health care facilities and organizations in geographically diverse locations across the country.

Disseminating Research Results: These activities include seven projects to help educate clinicians and others about the results of patient safety research.

Additional Patient Safety Research Initiatives: The remaining projects will cover other patient safety research activities, including supporting meetings of state and local officials to advance local patient safety initiatives and assessing the feasibility of implementing a patient safety improvement corps. ■

Study Highlights Medication Problems

A new study from the Agency for Healthcare Research and Quality (AHRQ) highlights the problem of inappropriate prescribing in elderly patients in the United States. According to the findings, which were published in a recent issue of *JAMA*, about one fifth of the approximately 32 million elderly Americans not living in nursing homes in 1996 used at least one or more of 33 prescription medicines considered potentially inappropriate. Nearly one million elderly used at least one of 11 medications which a panel of geriatric medicine and pharmacy experts advising the researchers agreed should always be avoided in the elderly. These 11 medications include long-acting benzodiazapines, sedative or hypnotic agents, long-acting oral hypoglycemics, analgesics, antiemetics, and gastrointestinal antispasmodics. ■

Bulletin Deadlines

Issue	Date editor must have copy
January/February	December 1
March/April	February 1
May/June	April 1
July/August	June 1
September/October	August 1
November/December	October 1

Tool Identifies Low-Risk Residents

Researchers in Missouri have designed a new tool that they believe will allow nursing homes to better determine which patients with lower respiratory infection are at low risk for death and thus may be treated safely without transferring them to a hospital. The study, which was funded in part by the Agency for Healthcare Research and Quality (AHRQ), was published in the November 21 issue of the *Journal of the American Medical Association*.

The work builds on earlier research funded by AHRQ and conducted by the Patient Outcomes Research Team (PORT) on Community-Acquired Pneumonia. PORT developed and validated the Pneumonia Severity Index (PSI), which is used to identify pneumonia patients living in the community who can be treated safely at home. Because the PSI assigns higher risk based on age and other variables common to elderly people, it predisposes most nursing home residents with respiratory conditions to hospitalization, whether or not their condition actually warrants it.

To make the new tool more sensitive to residents of nursing facilities, the researchers gave more weight to variables such as activities of daily living (ADLs), mood decline, and markers of poor nutritional status.

The researchers caution that since all facilities in the study were in central or eastern Missouri, the tool will have to be validated in other states, where factors affecting mortality may be different. ■

New Jersey Addresses Worker Shortages

A new nursing and allied health recruitment center opened by the New Jersey Hospital Association (NJHA) hopes to make a dent in the state's shortage of nurses and other health care professionals. The center, which went into operation last fall, will focus on a wide range of outreach efforts aimed at students, mid-career adults, and health professionals who for some reason have chosen not to work in their field of expertise. Partnerships with educational programs, businesses, and others also will be fostered to develop scholarships, job shadow programs, and statewide career days. A library of recruitment and retention resources will be available through the center, and a web site will provide information on everything from career advancement to financial aid. For more information, visit the NJHA web site at: http://www.njha.com. ■

Anesthesiology Device Safety

The Food and Drug Administration (FDA) recently published a document in the Federal Register that it believes will provide "reasonable assurance of the safety and effectiveness" of anesthesiology devices. "Class II Special Controls Guidance Document: Indwelling Blood Gas Analyzers; Final Guidance for Industry and FDA'' covers the following devices:

- Indwelling blood carbon dioxide partial pressure analyzers (21 CFR 868.1150).
- Indwelling blood hydrogen ion concentration analyzers and indwelling blood oxygen partial pressure analyzers.

A final rule on reclassifying indwelling blood gas analyzers was published at the same time. For more information, go to: http://www.gpo.ucop.edu. ■

OIG Says Post-Acute Care Transfer Policy Not Working

The Office of the Inspector General (OIG) has released a report suggesting that the Centers for Medicare & Medicaid Services (CMS) have no controls in place to prevent excessive payments to prospective payment system (PPS) hospitals for erroneously coded patient discharges that are followed by post-acute care, such as care in a skilled nursing facility or by a home health agency.

Medicare policy calls for inpatient payment rates to be reduced when PPS hospitals discharge beneficiaries in ten specified diagnosis related groups (DRG) to such settings. But the OIG estimates that Medicare has paid approximately $52.3 million nationwide in excessive DRG payments to PPS hospitals as a result of erroneously coded discharges. In addition to recovery of overpayments, the OIG is recommending that CMS establish edits in its Common Working File to compare beneficiary inpatient claims potentially subject to the post-acute care policy with subsequent claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

CMS officials concurred with the OIG findings and recommendations. The final audit report is available at: http://oig.hhs.gov/oas/cats/hcfa.html. ■

Hospital Using the Web to Attract Nurses

St. Peters Health Care Services of Albany, NY, has found a unique way to attract nurses to its facility. The hospital is now letting nurses bid for shifts and wages on the Internet.

The web site, which went into operation last fall, lists shifts available to full and part time employees and accepts bids according to factors like the nurse's skill level, shift schedule, past performance, and offering price. To see the site in action, visit: http://rnjobs.stpetershealthcare.org. ■

Best Hospitals for Working Moms

Working Mother magazine recently honored six hospitals on its annual list of the top 100 places to work for mothers. Among the mom-friendly facilities were Baptist Health Systems of South Florida in Coral Gables; Bon Secours in Richmond, VA; Health System, BryanLGH Medical Center in Lincoln, NE; Inova Health System in Falls Church, VA; Novant Health System in Winston-Salem, NC; and, Northwestern Memorial Hospital in Chicago, IL.

The magazine's rankings are based on the employer's flexibility, opportunities for advancement for working mothers, and distribution of benefits. ■

JCAHO Includes Experts in Development of New Disease-Specific Care Certification Program

The Joint Commission on the Accreditation of Healthcare Organizations is looking to a wide range of experts to help develop its new Disease-Specific Care Certification Program. Among the participants are representatives from the National Chronic Care Consortium, the Disease Management Association of America, the Disease Management Purchasing Consortium, and other leadership organizations playing a role in this new area of care. JCAHO hopes to begin offering Disease-Specific Care Certification in February 2002 for chronic care services provided by health plans, hospitals, and disease management service companies. ■

Health Care Job Categories to See Growth

New projections from the Bureau of Labor Statistics indicate that three health care job categories will grow by 28% within the next ten years. Health care professional, technical, and support jobs are expected to employ 12.2 million people by the end of the decade. Health care practitioner and technical occupations are projected to grow by 1.6 million jobs by 2010. This sector will be led by 561,000 new RN positions, with new and replacement openings for RNs expected to total more than 1 million.

Support jobs will grow by 1.1 million, becoming the fastest-growing service occupation. ■

Health Care System Not Ready for the Chronically Ill

A new study from researchers at Johns Hopkins University suggests that the health care system is not well prepared to meet the needs of the chronically ill — those who use the most health care resources. The report, published in the November/December issue of *Health Affairs*, says clinicians must be better trained to handle the needs of these patients and insurers must change their coverage and eligibility rules to better accommodate the needs of the chronically ill.

According to the study, many people who suffer from chronic conditions see as many as eight different doctors a year. But the health care system as it exists today won't allow information gleaned during those visits to be shared among those physicians, leading to a disjointed system of care. The problem is further exacerbated by the fact that nursing home services are classified as social expenses and thus are not covered by many insurers. ■

Trauma ICUs Provide Better Care

Trauma-specific intensive care units (ICUs) result in better patient outcomes and reduced costs and hospital stays for trauma patients, say investigators from the University of Alabama at Birmingham (UAB) who published their findings in a recent issue of the *American Surgeon.*

The study is the first to evaluate the benefits of trauma ICUs. "In many hospitals, critically ill trauma patients are admitted to a general purpose surgical ICU," says Gerald McGwin, PhD, assistant professor with the departments of epidemiology and surgery at UAB. "Our study showed that trauma patients did far better when admitted to a 'closed' trauma-specific ICU — one with individual patient rooms managed by surgeons, nurses, and other professionals highly trained in trauma critical care." ■

CD-ROM Addresses End-Of-Life Issues

A new CD-ROM developed at Michigan State University is helping people with advanced illnesses address the important issues they face as they approach the end of life.

The resource, "Completing a Life," is divided into three main content areas:

- Taking Charge: staying active in decisions about health care, family, and everyday living.
- Finding Comfort: easing pain and suffering, and living with dignity at this time of life.
- Reaching Closure: coming to terms with the past, present, and future, and exploring the possibilities for spiritual growth.

A Personal Stories section also features the real-life narratives of people who have confronted terminal illness. To find out more about the CD-ROM, go to: http://www.completingalife.msu.edu ■

CT Scan Encourages Smokers to Quit

Smokers who undergo low-dose helical computed tomographic (CT) scanning for lung cancer may be more motivated than others to quit smoking, say researchers at Memorial Sloan-Kettering Cancer Center and elsewhere. Their study looked at 134 active smokers, all of whom were enrolled in a program that uses low-dose CT scanning to screen high-risk active and former smokers for early stage lung tumors. These individuals did not receive any formal smoking cessation advice or counseling, but following the screening, 87% stated that the screening process had been a major influence in increasing their motivation to quit smoking. Twenty-three percent of the smokers who had the scans reported quitting and another 27% reported decreased smoking. The study was published in the December issue of *Preventive Medicine*. ■

Get It on the Web

Want the latest news from the section in the quickest manner possible? Then access the *Bulletin* on the Internet! If you are a section member and an Internet user, you can get your section newsletter a week and a half to two weeks earlier than you would get it in the mail by going to your section homepage at: http://www.aarc.org/sections/section_index.html. You can either read the *Bulletin* online or print out a copy for later.

The AARC is encouraging all section members who use the Internet to opt for the electronic version of the *Bulletin* over the mailed version. Not only will you get the newsletter faster, you will be helping to save the AARC money through reduced printing and mailing costs. These funds can then be applied to other important programs and projects, such as ensuring effective representation for RTs on Capitol Hill.

To change your option to the electronic section *Bulletin*, send an email to: mendoza@aarc.org. ■

JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the *Bulletin*.

Accreditation visit you are reporting (choose one):

❏ Home Care
❏ Hospital
❏ Long Term Care
❏ Pathology & Clinical Laboratory Services

Inspection Date: _____

Facility Name: _____

Contact: _____
(Please provide name and e-mail address.)

1. What was the surveyors' focus during your site visit? _____

_____

_____

_____

2. What areas were cited as being exemplary?

_____

_____

_____

3. What suggestions were made by the surveyors?

_____

_____

_____

4. What changes have you made to improve compliance with the guidelines?

_____

_____

_____

Additional comments:

_____

_____

_____

_____

Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229-4593
FAX (972) 484-2720