



August 30, 2011

RE: **CMS-1525-P**

The American Association for Cardiovascular and Pulmonary Rehabilitation, the American Association for Respiratory Care, the American College of Chest Physicians, the American Thoracic Society and the National Association for Medical Direction of Respiratory Care submit this joint statement in response to the proposed reduction in payment for pulmonary rehabilitation in the proposed rule for Hospital Outpatient Prospective Payment published in the July 18, 2011 *Federal Register* [**Medicare Programs: Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital-Value Based Purchasing Program; Physician Self-Referral; and Provider Agreement Regulations on Patient Notification Requirements**]. Our societies are interdisciplinary and represent more than 100,000 physicians and allied health professionals in the practice of pulmonary care in the United States, treating millions of Americans with chronic obstructive pulmonary disease.

In the notice, CMS has proposed reducing payment for G0424, the HCPCS code created in 2009 to accommodate the broad services identified in Section 144 of PL 110-275, from approximately \$63 to \$38. CMS points to 2010 claims data as the primary source for its calculations.

**Background:** New code G0424, cross walking to new APC 0102, became active for payment in 2010, and understandably CMS had no historical data for the new code on which to base payment. CMS determined that long standing codes G0237 – 39 could serve as “proxy” codes and provide CMS important data on which to base payment for

G0424. That decision was supported by the pulmonary community, with several important distinctions between G0237-39 and G0424:

- **G0237-39** are “unbundled” codes, often accompanied by a limited number of ancillary services such as CPT codes 94620 [Pulmonary stress testing; simple (e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)]; 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device); and 94667 (Manipulation chest wall, such as cupping, percussion and vibration to facilitate lung function; initial demonstration and/or evaluation), and all CPT codes for established patient clinic visits, on the same date of service as the HCPCS G-codes.

**G0424** is a bundled code that includes not only the services identified in codes G0237-39 but also includes all of the corollary services associated with pulmonary rehabilitation, particularly the codes identified above, plus work associated with initial assessment, psychosocial assessment, education, outcomes evaluation, and, importantly, physician work mandated by the statute.

- **G0237 & G0238** are both time sensitive codes – 15 minutes each. MACs have discretion to limit the number of codes billed during a single patient encounter.

**G0424** is also time sensitive, tied to a one hour session of rehabilitation (minimum 31 minutes), with a cap of no more than two billable sessions per day.

- **G0237-39** are identified as “respiratory services” with specific coverage rules outlined in various LCDs promulgated by CMS contractors. Generally speaking, the ICD-9 diagnosis codes include a wide range of chronic pulmonary diseases, *exclusive of chronic obstructive pulmonary disease*.

**G0424** is designated for coverage of pulmonary rehabilitation **only** for chronic obstructive pulmonary disease – COPD (limited to moderate, severe and very severe classifications).

**Comments:** Given the strong similarity between the work associated with G0237-38 + ancillaries on the one hand and G0424 on the other, it makes no sense that CMS would propose a payment rate for the former at \$29+ **for fifteen minutes** and \$38 for the latter for up to **one hour**. Because the strong historical base for claims for G0237-39 covering approximately 10 years, we cannot help but surmise that there are flaws somewhere in the determination of the \$38 rate.

We believe that the hospital claims data are flawed because they clearly do not include accurate charge data, the data CMS uses to determine costs i.e. APC payment rates. We believe this is the case for several reasons:

1. The newness of the code in 2010 makes it easy to realize hospitals simply do not fully understand the nature of this code, especially compared to the charge data that is used for the basis of payment rates for G0237-39:
  - a. With 10 years of experience with G0237-38 as 15 minute codes, we believe that hospitals presumed that a single code for very similar services correlated to a different diagnosis would also be a 15 minute code.
  - b. CMS' own data signal that hospitals are not reporting charges associated with the corollary services that are bundled into G0424.
  - c. The role of the physician must not be understated. Not only is there a requirement for direct patient contact once every 30 days, but the physician must also certify and, as appropriate, modify the beneficiary plan of care every 30 days as well. This physician work, bundled into G0424, can be separately billable E&M codes when used in conjunction with G0237-39.
2. For a notable portion of 2010, CMS contractors provided incomplete, inconsistent, and inaccurate information to hospitals/pulmonary rehabilitation programs. For example:
  - a. CMS Change Requests did not appear until May 2010 and some MACs would not permit billing of G0424 until October, 2010
  - b. Some MACs would instruct hospitals to use G0237-39 for COPD patients, directly contrary to CMS central office transmittals.

Given this environment, it is understandable that hospitals have struggled with developing charges for a one hour code for COPD patients receiving pulmonary rehab when charges are already in place for very similar services for patients with differing chronic pulmonary diseases.

## **Recommendations & Justifications**

1. For 2012 continue to use G0237-39 data for determining payment rates for APC 0102.

We believe this is a viable recommendation for several reasons as noted above and summarized here:

- a. Given the strong historical data base for G0237-39, the weak data base for G0424 and the clear clinical similarities between the G0237-39 and G0424, using 10 years of data tracking is wiser than using one year of artifact data.
- b. At \$38 for a bundled payment for G0424, the service is simply not sustainable. The proposed payment amount for one hour is 35% lower

than the payment rate for 30 minutes of G0237-38 for very similar services and a 40% reduction from current payment rates.

- c. The overall cost of pulmonary rehabilitation must be taken into consideration along with the growing body of Class A peer reviewed studies documenting health care cost savings directly correlated to pulmonary rehabilitation. CMS will ironically lose an important tool for reductions in readmission to the hospital and decreasing length of stay for those who are readmitted if it creates this payment barrier to pulmonary rehabilitation. **(Seymour JM, et al. Outpatient pulmonary rehabilitation following acute exacerbations of COPD. Thorax 2010; 65:423-428; Nici L et al. Pulmonary rehabilitation in the treatment of chronic obstructive pulmonary disease. Amer Fam Phys 2010; 82:655-660)**
  - d. We fully acknowledge that G0237 and G0238 are codes for one-on-one services while G0424 is generally recognized more as a group code. It is important to recognize that patient acuity for the COPD population is an important consideration. Our collective professional estimate is that 1 of every 3-4 patients enrolled in a formal pulmonary rehabilitation program necessitates substantial one-on-one contact with a health professional. Given the standard of care of a ratio no greater than 4:1 for group related services for stable patients, it is misleading to presume that G0424 is solely and singularly a group oriented therapeutic service; it is not.
  - e. Until such time as a more robust and accurate G0424 data set is available, we recommend CMS continue to use the G0237-39 data set as a proxy to establish reimbursement rates for G0424.
2. For hospital cost reports filed January 1, 2012 and thereafter, pulmonary rehabilitation should be reported as a non standard cost center rather than as a standard cost center.

We believe that the RTI (Research Triangle Institute) recommendation to shift cardiac rehabilitation services (and a few others) is also applicable to pulmonary rehabilitation for several reasons.

- a. The authorizing legislation for cardiac and pulmonary rehabilitation services is virtually identical.
- b. CMS has recognized the similarity between the two services and initially used cardiac rehab as a proxy model for pulmonary rehab under PFS.
- c. It is clear that hospitals are struggling with the framework of G0424 as a bundled code; such a shift should, over time, hopefully contribute to a resolution of this matter and develop more accurate charge data, cost reports, etc.

Respectfully submitted,



David Gutterman, MD, FCCP  
President  
American College of Chest Physicians



Lynn Tanoue, MD  
President  
National Association for Medical Direction  
Of Respiratory Care



Karen J. Stewart, MSc, RRT, FAARC  
President  
American Association of Respiratory Care



Nicholas Hill, MD  
President  
American Thoracic Society



Bonnie K. Sanderson, PhD  
President  
American Association of Cardiovascular and Pulmonary Rehabilitation