Continuing Care & Rehabilitation Bulletin

Mar./Apr. '00

American Association for Respiratory Care

Notes from the Chair

by Trina M. Limberg, BS, RRT, FAACVPR

By the time this issue of the Bulletin reaches you in early April, you may have already heard the details of a new policy proposal from the Health Care Financing Administration (HCFA) that was discussed at the annual section business meeting in Las Vegas. The proposal is being drafted by a Committee of Regional Medical Directors, and the committee chair is the medical director from California Blue Cross who worked on the new policy that went into effect there in November of 1999.

It appears that the recommendations in the HCFA policy will be similar to those in the new California Blue Cross policy, except for the FEV1 criteria. The new policy draft puts forth a lower FEV1 of 50% predicted. This would potentially restrict coverage of patients with higher abnormal FEV1 values. As of this writing in early February, Dr. John Hodgkin, Dr. Paul Selecky, the American Association for Cardiovascular and Pulmonary Rehabilitation, and the AARC were working on a response to the draft. We will keep you updated on this issue as developments arise.

The other reimbursement item discussed at the annual business meeting — and also posted to the section listserve — was on the use/billing of CPT codes for oximetry 94760 and 94761. HCFA has apparently bundled the code with physician visits. It appears that physicians will not be permitted to bill separately for these services. In follow-up correspondence with the AARC's director of government affairs, Cheryl West, we have learned that if rehab programs/hospitals are billing under Medicare Part A, there shouldn't be any problems. HCFA has generated a Carrier Program Memorandum to clarify the inconsistencies in the 2000 Medicare Physician Fee Schedule which is retroactive to January 1 of this year. Admittedly, I would feel better if these documents (i.e., the language in the Federal Register) were specific about what you could and could not bill for, but unfortunately, they are not that straight forward. We have checked this out with our carrier in Southern California and have been told that we can continue to bill as long as there is medical justification for performing oximetry.

In other news . . .

I have received word from the Program Committee that our section can expect to be supported for a post-graduate "How To" pulmonary rehab pre-conference at the 2000 Respiratory Congress in Cincinnati, OH. Don't forget to include this meeting in your budget requests.

Kelli Hagen, our AARC liaison, is working to update the section Resource Directory. If you are on the list or would like to be included, please drop us a line with your name, contact information, and the areas of rehab in which you hold expertise.

We are still looking for an Internet coordinator to visit the chat room, monitor activity, and respond and/or route questions to appropriate resource people. In addition, we need more of you to contribute articles of interest to this Bulletin. The latter is a particular-

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ly painless way to make a contribution to the section. If you have any ideas for articles or case studies, please contact me and I'll help you get started!

Lastly, we are in the process of collecting nominations for our 2000 Specialty Practitioner of the Year. Please take the time to nominate a colleague who you feel goes above and beyond the call of duty to support his or her profession and patients. For your convenience, a Specialty Practitioner of the Year form appears in this issue.

As always, if you have comments about the Bulletin or would like to contribute to it, please contact me. My addresses and phone numbers are listed on this page. ■

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Specialty Practitioner of the Year: *Julien M. Roy, BA, RRT*

We all know that pulmonary rehabilitation improves the lives and health of people with COPD and other chronic lung illnesses, but reimbursement has traditionally lagged behind the science. Today that's changing, and our 1999 Specialty Practitioner of the Year, Julien Roy, is a big part of the reason why.

Among his many other achievements over the past few years — including a stint as section chair in 1996-98 — Roy has worked tirelessly with leaders from the AARC and American Association for Cardiovascular and Pulmonary Rehabilitation to promote a national reimbursement policy for pulmonary rehab at the Health Care Financing Administration. He has also played a key role in establishing a policy with the local intermediary in his home state of Florida, where he currently serves as pulmonary rehab director at Halifax Medical Center in Daytona Beach. Because of their efforts, patients in Florida are now able to receive adequate reimbursement for the pulmonary rehab services they need to stay out of the hospital and in step with life.

Says friend and colleague Kris Hara, RRT, from Kaukini Medical Center in Honolulu, HI, "Julien's energy and enthusiasm for the profession and the field of pulmonary rehab have blazed political paths. His activities on behalf of patients are a constant reminder of why we do what we do and encourage all of us to 'take the bull by the horns.'"

Roy believes membership in the AARC and the section has helped him accomplish these goals and others. But he says the greatest benefit afforded those who join the Association and the section is the sense of belonging to a special group of practitioners in respiratory care. "Membership allows you to stay in touch with the latest developments in the treatment of respiratory disease, support the AARC at your level of expertise, and share ideas with other specialists in the area of continuing care and rehabilitation for better delivery of patient care and services."

Editor's Note: *1999 was, indeed, a year of major significance for Julien Roy, and not just because he won our annual Specialty Practitioner of the Year award. See his article in this issue for more on what the past year had in store for him and the courageous way he not only dealt with it, but learned from it.* ■

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Arizona Secures Medicare Policy for Pulmonary Rehabilitation Reimbursement

by Bonnie Fahy, RN, MN, FAACVPR

After ten months of negotiation, representatives from Medicare intermediary Blue Cross/Blue Shield of Arizona (BCBSAZ) and pulmonary rehabilitation professionals in Arizona have developed a policy for the reimbursement of pulmonary rehabilitation services in the state. The pulmonary professionals involved in this effort included members of the Arizona Society of Cardiovascular and Pulmonary Rehabilitation (the state society of the American Association of Cardiovascular and Pulmonary Rehabilitation), the American Thoracic Society, and the AARC.

The policy, which went into effect on October 1, 1999, excludes coverage for the diagnosis of asthma and requires patients with an approved obstructive lung disease to have an FEV_1 of <65%. Those with an approved restrictive lung disease must have a TLC of <70%. In addition, the pulmonary function testing must be completed within 90 days of referral, and all patients are required to have had an ECG and chest X-ray within the past six months. BCBSAZ now approves an initial evaluation, an exercise tolerance test, and if medical necessity is documented, 18 rehabilitation sessions over a nine-week period. For each of the 18 education/training sessions, one CPT code (94799) is to be charged, regardless of services provided. Although this policy is not as lenient as policies in other states, having a policy in Arizona is a significant improvement over having no policy at all.

Everyone involved in the development of this policy agrees that the negotiation process was a learning experience. Arizona Medicare representatives were presented with the current research supporting pulmonary rehabilitation as a standard of care, and the rehabilitation professionals became versed in Medicare protocol. However, the most important outcome of this process is the availability of Medicare reimbursement for rehabilitation services to pulmonary patients covered by BCBSAZ. ■

A View from the Other Side

by Julien M. Roy, BA, RRT, FAACVPR, director of pulmonary rehabilitation services at Halifax Community Health Center in Daytona Beach, FL

Have you ever imagined your patient's view of pulmonary rehabilitation? Have you ever experienced shortness of breath and a difficult exercise regimen?

None of us would wish to be on the patient side of things, but I am living proof that experiencing rehab from their perspective can give you a new appreciation of what life is like with a chronic or acute problem. I hope this article on my experiences will instill some knowledge of how we all perceive our patients on the "other side of the fence."

I am the director of a very large pulmonary rehab program in East Central Florida. I have been involved with pulmonary rehab for the past 16 years and respiratory care for the past 28. But what I experienced over the past year has given me a different outlook on patient care, especially when it comes to pulmonary rehabilitation — or any rehab program.

On April 4, 1999, I experienced a massive myocardial infarction. During the course of the MI, I required cardiac massage and defibrillation several times. As a result, I lost a great deal of my myocardial functions. Several months later, with deteriorating health, a re-evaluation diagnosed the worst: a large left ventricular aneurysm and several blockages on the left side of my heart. After a quadruple bypass and placation of the left ventricular aneurysm, followed by several weeks of recovery, I started cardiac rehabilitation.

The initial visit was an education in humility, since I started cardiac rehab next door to my own pulmonary rehab department. All the familiar faces helped the situation a bit, but now I was on the other side of the counter — a patient with a monitor and O_2 sat device on my finger, lots of discomfort, and associated pain. I was started on a few minutes of exercise. Dealing with SOB and angina pain made me realize how difficult it is to be a patient faced with learning how to crawl all over again — especially at age 48 and totally disabled.

I adjusted after several sessions. Now, looking out from the treadmill, I realized how every move we make as practitioners is viewed by our patients. What else you are going to do when you face the rehab staff? Every patient, including myself, delicately analyzes the attitude, friendliness, tone of voice, and professionalism of the health care professionals taking care of him. Several setbacks and readjustments in my treatment plan and exercise regimen made me appreciate the quality and required knowledge of the personnel caring for such a population. Looking back at my involvement in pulmonary rehab made me proud to be such a professional. It gave me a deeper understanding of how to listen to patients and their perceived symptoms.

After several months of recuperation and rehab, I returned to my director position in the pulmonary rehab department. I felt I had gained a much deeper knowledge of patient care and much more empathy for our patients'

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complaints and capabilities. Sharing all this information with my staff made them realize the importance of their choice of career in rehabilitation.

At the end of last year, following another catherization and several cardiac tests, the bad news was that I had an ejection fraction of only 26%. My physical capabilities are very diminished and now interfere with my continued work in pulmonary rehabilitation. But my understanding of how precious life is and what the gift of good health really means has increased immeasurably. The struggle of our COPD patients and their persistence in pulmonary rehab has a greater significance. It is difficult to plan your life and exercises around breathing and discomfort. I salute all the patients I have cared for over the past 16 years, not only for their continued faith in us rehab professionals, but also for their smallest accomplishments.

I will be retiring from my position sometime within the next several months so that I can enjoy my precious life with my wife and children. But I will continue to be involved through other activities with pulmonary patients, my greatest love outside of my family. My message to all of my fellow practitioners is, listen to your patients and continue to encourage and help them achieve their goals. ■

FYI . . .

Last year of life improving

Not only are people living longer than they used to, the last year of life has improved for many of those over age 85, say investigators from Loyola University Stritch School of Medicine in Maywood, IL, who compared data from the 1986 and 1993 National Mortality Followback Surveys conducted by the National Center for Health Statistics. Death certificates were drawn from a national random sampling of death certificates, and next of kin were contacted for information about activities of daily living (ADLs), lifestyle, and other health information in the last year of the life of the person who died.

The study found that women had significantly shorter or fewer hospital stays in the last year of life in 1993 than in 1986 (an average reduction of 3.3 nights for the 65 to 84 year-old age group and the over 85 age group). There was a reduction of 18.4 nights on average for nursing home stays for women aged 65 to 84 and 42.3 nights for women over age 85. Men had no significant change in hospital stays over time. However, men over the age of 85 showed an average reduction in nursing home stays of 32.6 nights.

When questioned about the individual's ability to walk, bathe, dress, use the toilet, and eat, surveys showed the proportion of women over age 85 who had a restriction of at least two ADLs decreased from 62.5 percent in 1986 to 52.1 percent in 1993.

The rates of individuals with no reported cognitive impairment increased in both sexes from 1986 to 1993, but were not statistically significant among older men.

The overall sickness score decreased, and the quality of life score increased for women over 85. It varied for the other groups studied.

Summarizing the results, the authors write that overall, statistics for men between the age of 65 and 84 didn't change significantly. For women aged 65 through 84, there were some significant changes. But men and women at least 85 years old "experienced a better overall quality of life in the last year of life in 1993 than those in 1986."

Say the authors, "Our study demonstrates that the burden of disability in the last year of life was reduced from 1986 to 1993 in the oldest men and in all women. This finding indicates that the decline in hospital and nursing home use is partly due to better health." (JAMA, 1/26/00)

Disease management resource

The disease management (DM) field has grown rapidly over the past few years, resulting in a wider range of products, services, and programs. Now a new guidebook published by the Healthcare Intelligence Network (HIN) provides an overview of the area, complete with case studies of successful DM programs for Alzheimer's disease, arthritis, asthma, back pain, behavioral health, diabetes, end-stage renal disease, frail elderly care, heart disease, joint replacement, organ transplant, respiratory illnesses, women's health, and wound care. The 2000 Disease Management Directory & Guidebook is available from HIN for $349 and may be ordered at the online bookstore at www.hin.com or via email at info@hin.com. For information by phone call (888) 446-3530 or (732) 528-4468. (Healthcare Intelligence Network) ■

Save These Dates!

AARC Summer Forum
Vail, Co.
June 2-4, 2000

46th International Respiratory Congress
Cincinatti, OH
October 7-10, 2000

AARC Asthma Disease Management Courses

Vail, CO
June 4-5, 2000

Atlanta, GA
Nov. 17-18, 2000

Specialty Practitioner of the Year

Don't forget to make your nominations for the 2000 Continuing Care and Rehabilitation *Specialty Practitioner of the Year*. This honor is given to an outstanding practitioner from this section each year at the AARC's Annual Convention.

The recipient of this award will be determined by the section chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the section.

Use the following form to send in your nominations for this important award:

I would like to nominate _____ for Continuing Care and Rehabilitation *Specialty Practitioner of the Year* because

_____

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_____

_____

Nominee	Your Name
Hospital	Hospital
Address	Address
City State, Zip	City State, Zip
Phone	Phone

Mail or FAX your completed form to the section chair at the address/number listed on page 2 of this issue.

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