Continuing Care & Rehabilitation Bulletin

Issue No. 2

Notes from the Chair & Editor

by Julien M. Roy, BA, RRT

Here we are again, approaching another summer and still discussing reimbursement issues. This has been a hot topic during the past year, and it is one we need to talk even more about. In Florida, we finally made major progress with our fiscal intermediary, which prompted many of you to call me and request assistance in that area. Please continue to do so.

In Ohio, a new policy is now in effect as well, and is being covered elsewhere in this issue. Pennsylvania is also making some major changes in reimbursement, and we should hear about those in a future *Bulletin*. Louisiana is having some difficulties, but hopefully, these will be resolved soon. California is facing managed care issues in pulmonary rehabilitation reimbursement. In short, there are so many stories out there right now. Some are being successfully resolved, while others face a rough road ahead.

In early April, I was asked to help the AACVPR and AARC liaison group start working together to produce a list of intermediaries, contact personnel, and state guidelines to help other practitioners better understand the reimbursement process and develop the skills necessary to get involved in their states. At the national level, we are still in limbo as far as a federal policy is concerned, so the task is largely being left up to organizers on the state level. Again, I will say get involved.

On an other note, the AARC Program Committee is working very hard on the 44th International Respiratory Congress, to be held in Atlanta, GA, November 7-10. Thanks to all of you who helped us submit a great program for the Continuing Care & Rehabilitation Section.

Finally, I urge you to call me if you feel you can help the section in any way or want to get involved—there is always something that needs to be done, and your participation is always welcome. Stay in touch, stay well, and have a wonderful summer. ■

Ohio Medicare Update for Coverage of Services in Outpatient Pulmonary Rehabilitation

by Gretchen A. Horstman, BFA, RRT, RCP, director of pulmonary rehabilitation, Marymount Hospital, Garfield Hts, OH

Administar Federal, a Medicare fiscal intermediary, published new guidelines for coverage of outpatient pulmonary rehabilitation services in the May 1997 Medicare Provider Bulletin. This policy contained a statement which had not been previously published in the draft form of the policy that was published for review and comment back in February 1997. The local Medical Review Policy statement read: "Aphysician with either a pulmonary specialty or experience

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with pulmonary disease must provide direct supervision while sessions are in progress."

Many pulmonary rehabilitation programs in Ohio were concerned about the potential ramifications of this statement. Generally, the new Medicare policy regarding coverage of outpatient pulmonary rehabilitation was thorough and a big improvement over the old policy. However, the statement concerning physician supervision in exercise sessions raised concern among RCPs who were unsure of its intent. Several letters were written by RCPs and other health care professionals working in rehabilitation requesting clarification of this statement.

A similar statement is part of the guidelines for coverage of service in cardiac rehabilitation. Their policy states that a physician must be available in the exercise area in the event of a medical emergency while the exercise program is being conducted. It does not require that a physician be physically present in the room itself — just that he or she not be too remote from the patient's exercise area.

Most hospital based pulmonary and cardiac programs find this to be a reasonable statement, and this type of access to a physician is usually provided. But pulmonary rehabilitation programs were being told that if they continued to operate without a physician present in the exercise area, they would be guilty of committing Medicare fraud! Some hospitals in Ohio were directed by their administration to stop admitting Medicare patients into their programs and to hold billing of services until this issue could be resolved.

I contacted Cheryl West, AARC director of government affairs, concerning this situation, and provided her with copies of the correspondence between Administar Federal and myself, and information from other programs. Cheryl provided me with the following HCFA definitions regarding physician supervision, as well as incredible support and knowledge regarding Medicare. She encouraged a strong, proactive role and contacted several people within the AARC for help and support.

HCFA defines the levels of supervision as follows: "General supervision" means that a procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. "Direct supervision" does not mean that the physician must be present in the room when the procedure is being performed; however, the physician must be present in the immediate area and available to furnish assistance and direction. "Personal supervision" means a physician must be in the room during the performance of a procedure.

After reading and studying the definitions, it seemed the problem was with the intermediary's interpretation of the policy. When we questioned the intermediary regarding clarification of the supervision definitions, they stated that their interpretation was coming from Administar Federal. Many letters opposing the direct supervision statement were sent to Administar, which prompted them to publish a statement in the Medicare Provider Bulletin in September 1997. They again restated the definition of direct supervision as it was originally published and is stated in HCFA Pub, 14, Sect. 2050,1B.

Interestingly, this local policy affected the states of Indiana and Kentucky as well as Ohio but Administar heard no complaints from either of those states regarding physician supervision. Administar also stated that they were surprised that there had been no comment regarding this matter when the policy was up for review in February. The reason this was not an issue is that the statement was never part of the original draft! Administar agreed to re-open the policy for review if answers could be provided to the following questions: What level of physician supervision do we believe should exist during pulmonary rehabilitation exercise sessions? Who should be present in the room when services are rendered? How long should a patient be in a pulmonary rehabilitation program? Should patients come in and out of programs (i.e., should they be in a program for a length of time, and then six to eight months later be in the program again)?

Since physicians had made the policy, they wanted the majority of comments to come from physicians. They also requested a copy of the

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new pulmonary rehabilitation program guidelines (unpublished as of November 1997) from the AACVPR, and requested that Dr. John Hodgkins, Dr. Brian Carlin, AACVPR vice president, and physicians from one of the three states the policy affected write letters of support.

The following actions were taken to answer these questions and to provide the information for Administar Federal. Cheryl West put together a packet of materials and sent it to Administar along with a letter signed by 1997 AARC President Kerry George. The AARC letter requested that clinical evidence be provided to support the premise that a physician needs to be present in an exercise session to supervise RCPs and other health care professionals. The packet contained the original draft of the policy, HCFA's definitions of supervision, and AARC-recommended guidelines for pulmonary rehabilitation programs.

Copies of the NBRC entry level CRTT exam content outline and written registry exam content were included as well, to provide "background on the complexity and depth of respiratory care educational requirements." Kerry George also stated in his letter to Administar that "RCPs are highly educated, trained, and tested in all aspects of pulmonary disease and respiratory therapy."

Copies of the policy in draft and final form, along with letters of correspondence from Administar and a letter explaining the situation in Ohio, were given to Drs. Hodgkins and Carlin at the AACVPR National Conference in Dallas, TX, in November 1997. These physicians agreed to draft a letter, as well as send copies of the new AACVPR Guidelines for Pulmonary Rehabilitation to Administar Federal for consideration.

The Ohio Society for Respiratory Care's (OSRC) liaison to the Ohio Thoracic Society (OTS), Mike Schwartz, was contacted regarding this issue. Dr. Robert Denton, the OTS Executive Committee representative, sent a letter referring to the cardiac guidelines and asking for clarification of the current policy.

All this hard work and effort on the part of Ohio RCPs, the AARC, the AACVPR, the OTS, and the OSRC paid off. Administar Federal released a special notice on December 29, 1997, stating that because they had received further clarification of the definitions of supervision from HCFA indicating that physician supervision is not required in the hospital outpatient setting, a physician is NOT required to be present in the service area during the time that the pulmonary rehab session is in progress. We had won!

This is an excellent example of what we can accomplish by taking the initiative to get involved in issues that effect our practice of respiratory care. It also demonstrates the value and importance of belonging to our professional organizations and the support and expertise they provide. Finally, and most importantly of all, we will be able to continue to provide our patients with quality pulmonary rehabilitation programs and improve their quality of life! ■

Practitioner of the Quarter: Request for Nominations

Don't forget to make your nominations for the Continuing Care & Rehabilitation Practitioner of the Quarter. This honor is given to an outstanding practitioner from this section each quarter. Our Specialty Practitioner of the Year will be selected from these winners. 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 your nominee's qualifications for the award to the section chair at the address/number listed on page 2 of this issue. Be sure to include your name, address, and phone number, along with that of your nominee. ■

Resource Directory Sign-Up Form

An updated version of our *Resource Directory* will soon be released, and we are seeking new individuals to add to the list. If you have experience in any of the following areas and would be willing to have your name, address, and phone number listed as a resource for your colleagues, please fill out the following form and send it to Julien Roy at the addresses/numbers listed on page 2 of this issue. Also, feel free to suggest other areas of expertise in the space provided. (If you are already listed in the directory but have a change of address/phone, or would otherwise like to update your entry, please send your changes to Julien as well.)

Name _____

Address_____

Phone_____ FAX _____

e-mail _____

Areas of Expertise: (Check all that apply)

❑ Pediatric Cardiopulmonary Rehab ❑ Smoking Cessation ❑ Patient Education/Compliance

❑ Pulmonary Development/Organization ❑ Documentation/Reimbursement ❑ Home Care/Home Ventilation

❑ Discharge Planning ❑ Travel Consultants ❑ Pre-and Post-Lung Reduction Surgery

❑ Other Area(s) of Expertise _____

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Submission Guidelines for Articles Written for the Bulletin

Article length: *Bulletin* articles should be between 500 and 1,000 words (about 1-3 typed, double-spaced pages).

Format: In addition to a paper copy, all articles should be submitted on a 3-inch floppy disk saved in a Microsoft Word for Windows, TEXT ONLY, or ASCII format, or e-mailed to the editor in one of those formats.

Deadlines: The remaining deadlines for this year are: June 1, August 1, October 1, and December 1.

Article Review: All authors are welcome to review a copy of their article before it goes to press. If you would like to review a copy of your article, please include a FAX number when you submit it to the editor. It is the responsibility of the author to contact the editor if any changes need to be made before the article goes to press. ■