March 28, 2019

CTS INSPIRATIONS

CTS NEWS

President's Message

March is Pulmonary Rehabilitation Month! As a lung transplant pulmonologist, participation in pulmonary rehabilitation is required for all of my patients, and I have witnessed personally how much benefit these programs provide to people suffering from lung disease. Most of us in the pulmonary community recognize how important Pulmonary Rehabilitation is for our patients – but did you know that its very existence is threatened? Pulmonary Rehabilitation programs around the state have been forced to close and access to programs can be quite limited. We dedicate this installment of CTS Inspirations to Pulmonary Rehabilitation. Please take a moment to learn what you can do to help at this critical time for our Pulmonary Rehabilitation programs. And please join me in saying thank you to all of the health care professionals who make the pulmonary rehabilitation programs possible.

With thanks,

Lorriana Leard, MD
President, California Thoracic Society

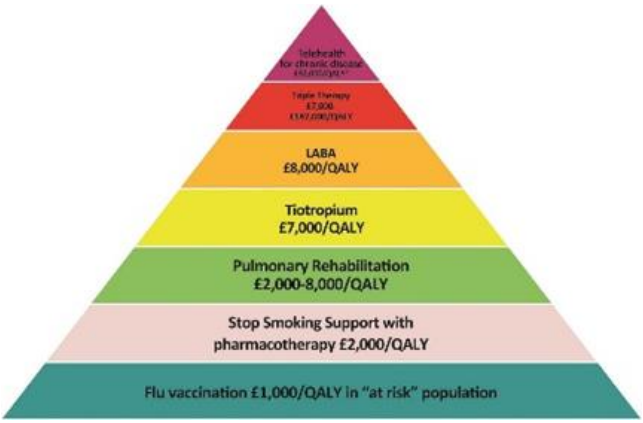
EDITOR'S NOTE

Awareness – Pulmonary Rehabilitation Works Yet Reimbursement and Awareness are Poor

Despite being a major recommendation of nearly every leading guideline for COPD and IPF, and covered by Medicare and many insurance plans, poor reimbursement and awareness limits patient PR referral, utilization and availability. ATS has embarked on a campaign to improve national reimbursement and awareness of pulmonary rehabilitation (PR) under the leadership of Judy Corn, Senior Director, Patient Education and Documents at ATS and PR Assembly Leadership and former CTS presidents Richard Casaburi and Chris Garvey as well as Carolyn Rochester, Dick ZuWallack, and others. This initiative has been made possible by a generous grant from the Gawlicki Family Foundation. ATS recognizes that poor awareness and equally poor reimbursement significantly limit both utilization and availability of PR. Below are brief articles that focus on understanding and improving PR reimbursement and awareness, a pulmonologist's perspective on PR referrals as well as resources for PR. ***We are asking that CTS members join the ATS Call to Action for PR reimbursement and help promote and share key resources and recommendations*.**

Pulmonary Rehabilitation – California as a Leader in Improving Reimbursement and Awareness

by Chris Garvey NP, Richard Casaburi PhD, MD and Phil Porte



Reimbursement – What Isn't Working, Why it Matters and How to Fix It

- Pulmonary rehabilitation (PR) is clinically effective, safe, and cost effective (1,2), and results in improvement in exercise capacity, dyspnea and quality of life better than other therapies (3) as well as shorter hospitalization length of stay in COPD (4).

- Despite the high prevalence of symptomatic lung disease and the benefits of PR, inadequate reimbursement threatens PR availability, with only about 3% of Medicare beneficiaries with COPD receiving PR (5)

- Decline and stagnation of payment for PR is complex. Rigorous analysis has found that hospitals are undercharging for PR, which has at least in part led to inadequate reimbursement that does not cover the cost of providing PR services.

- ATS, CTS and other scientific and professional societies have taken the lead in addressing PR reimbursement and awareness inequities.

- A priority to address poor coverage is for pulmonologists to both partner with PR clinicians and *meet with hospital financial leads to educate them of the need for PR, its value, and that availability of this effective intervention requires adequate hospital charges to survive.*

The evidence of clinical effectiveness of pulmonary rehabilitation (PR) is strong and continues to grow, yet inadequate reimbursement and limited availability challenge effective PR delivery in the United States (1). Only about 3% of Medicare-eligible COPD patients in the US have received PR (5). Low reimbursement has the potential to influence availability of what is widely acknowledged as the standard of care in chronic lung disease.

Reasons for the decline in PR reimbursement are complex. It is at least in part tied to a Medicare change in PR reimbursement in 2010, when a new "bundled" payment code "G0424" for COPD was introduced. The code pays for one hour of PR including all costs of staff, medical director, gym, etc. In 2010, Medicare arbitrarily established a payment rate of $50 for one unit of G0424. Medicare acknowledged in 2011 that *failure to carefully construct the charge for G0424 that reports a combination of services previously reported separately under-represents the cost of providing the service described by G0424 and can have significant adverse impact on future payments* (6).

Historically, PR had been paid for in 15-minute increments for most services. A recent review of charges for PR for COPD patients submitted to Medicare in 2015 from claims billed by 1350 U.S. hospitals found that the majority of PR providers and hospitals never adequately modified PR charges to reflect the nearly fourfold increase in time and resources used for the "bundled" G0424 billing code. Medicare's use of PR charges (as well as information from the hospital cost report) to calculate PR payment. One consequence of this is that cardiac rehabilitation reimbursement is now double that of PR (table 1).

CMS Final CY 2017 Outpatient Services Payment Rates

HCPCS Code (APC)	Short Descriptor	Amount paid for service
93798 (5771)	Monitored Cardiac rehabilitation	$110.18
G0424 (5733)	Pulmonary rehab with exercise	$54.53

A critical concept when calculating appropriate charges is that the amount paid for services is typically a small fraction of the amount charged by health care systems. Below is an example of amount charged for services versus the amount paid.

Examples of Medicare Outpatient Prospective Payment System Hospitals for 2015

Ambulatory Payment Classifications (APC) / Description	Average Estimated Submitted Charges	Average Total Payments
0269 - Level I Echocardiogram Without Contrast	$2,386.36	$409.22
0369 - Level II Pulmonary Function	$1,354.23	$229.25

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Outpatient2015.html accessed 10/1/18

PR needs your help. Hospital administrators set charge rates for all hospital services, including PR. They need to be aware of the concerns regarding G0424 billing and the impact of undervalued charges on Medicare payment. A *Pulmonary Rehabilitation Toolkit* that details resources for PR billing is available.

It is time for the pulmonary medicine and scientific community to bring these concerns to their hospital administration. It is also time for pulmonologists to partner with PR clinicians and administrators to determine if charges for PR services reasonably represent the complexity of the intervention, the acuity of the target population and the value of this evidence-based intervention.

References

1. Rochester CL, Vogiatzis I, Holland AE, Lareau SC, Marciniuk DD, et al. An Official American Thoracic Society/European Respiratory Society statement Policy Statement: Enhancing Implementation, Use, and Delivery of Pulmonary Rehabilitation. Am J Respir Crit Care Med. 2015;192(11):1373-86. doi: 10.1164/rccm.201510-1966ST. PubMed PMID: 26623686.

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3. Casaburi R, ZuWallack R. Pulmonary rehabilitation for management of chronic obstructive pulmonary disease. N Engl J Med 2009;360:1329-35.

4. Griffiths TL, Burr ML, Campbell IA, Lewis-Jenkins V, Mullins J, Shiels K, Turner-Lawlor PJ, Payne N, Newcombe RG, Ionescu AA, Thomas J, Tunbridge J. Results at 1 year of outpatient multidisciplinary pulmonary rehabilitation: a randomised controlled trial. Lancet. 2000;355(9201):362-8. PubMed PMID: 10665556.

5. Nishi SP, Zhang W, Kuo YF, Sharma G. Pulmonary Rehabilitation Utilization in Older Adults With Chronic Obstructive Pulmonary Disease, 2003 to 2012. J Cardiopulm Rehabil Prev. 2016. doi: 10.1097/HCR.0000000000000194. PubMed PMID: 27428819.

6. Medicare and Medicaid Hospital Outpatient Prospective Payment. Federal Register, Department of Health and Human Services, Centers for Medicare and Medicaid Services. CFR parts 410, 411, 416, 419, 489 and 495. November 30, 2011. 76;230:74224.

Make the Referral: A Majority of Our Patients Will Benefit from Pulmonary Rehabilitation

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Key Summary Points:

- Pulmonary rehabilitation (PR) should be an integral part of the treatment plan for patients with chronic respiratory disease.
- Although the benefits of pulmonary rehabilitation in patients with COPD are widely accepted, we need to increase awareness that others with chronic respiratory disease are likely to benefit.
- We must push for better reimbursement for PR to stimulate growth of existing programs and foster development of new programs in order to improve patient access.

The American Thoracic Society and the European Respiratory Society have defined pulmonary rehabilitation as a "comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors."[1] Today the benefits of pulmonary rehabilitation (PR) are widely accepted amongst clinicians and scientists for patients with chronic obstructive pulmonary disease (COPD). We must now increase awareness of the growing literature that all patients with symptoms of dyspnea from chronic respiratory conditions with reduced functional capacity or quality of life can gain a great deal from this multimodal program.

Patients with chronic lung disease mainly complain of shortness of breath and fatigue. In those with COPD, studies also demonstrate an increased risk of depression and anxiety. Pulmonary rehabilitation consists of an exercise program and an educational curriculum covering topics on oxygen use, medications, nutrition and breathing techniques. Education focuses on long term behavioral change including maintenance of exercise and physical activity. In addition, PR provides a social support system that helps recognize and address psychological stressors. This forum allows for peer interaction and an open communication with the health care team.

In patients with COPD, PR has shown to improve exercise performance, reduce symptoms of dyspnea and improve health related quality of life (HRQL). Data demonstrates that patients with interstitial lung disease (ILD), bronchiectasis, cystic fibrosis, asthma, pulmonary arterial hypertension, lung cancer and lung transplantation also benefit. For instance, those with ILD may learn techniques to conserve energy and use equipment to assist with activities of daily living. Patients with bronchiectasis may acquire knowledge for secretion clearance with nebulizer education and oscillating positive expiratory pressure device teaching. Despite its broadening scope, PR may not be appropriate for everyone. Those with significant orthopedic, cardiac, psychiatric or neurologic conditions that limit mobility may not be able to participate. Furthermore, pulmonary rehabilitation has been shown to reduce utilization of health care resources. Patients with COPD who undergo PR have a lower number of unscheduled clinic visits, emergency department visits and hospital admissions.

Pulmonary rehabilitation should be an integral part of the treatment plan for patients with chronic respiratory disease. In addition to smoking cessation, oxygen therapy and inhaler medications, we need to consider this intervention early in the disease course.

With increased awareness of its many benefits, we hope for better PR reimbursement to allow for program development and improved patient access.

References

1. Spruit MA, Singh SJ, Garvey C, et al. An official American Thoracic Society/European Respiratory Society statement: key concepts and advances in pulmonary rehabilitation. Am J Respir Crit Care Med 2013; 188:e13.

2. Troosters T, Casaburi R, Gosselink R, Decramer M. Pulmonary rehabilitation in chronic obstructive pulmonary disease. Am J Respir Crit Care Med 2005; 172:19.

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4. Ryerson C, Cayou C, Topp F, et al. Pulmonary rehabilitation improves long-term outcomes in interstitial lung disease: A prospective cohort study. Respiratory Medicine 2014; 108.

Pulmonary Rehabilitation Resources in California

1. ATS recently published two editorials highlighting poor PR utilization and reimbursement as significant barriers to PR availability and ultimately improved patient outcomes.

https://www.atsjournals.org/doi/abs/10.1164/rccm.201809-1711ED

https://www.atsjournals.org/doi/abs/10.1513/AnnalsATS.201809-641ED

2. http://www.livebetter.org/

ATS and the *Gawlicki Family Foundation* are working together to increase awareness of pulmonary rehabilitation

3. https://www.aacvpr.org

American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

CTS member *Trina Limberg* at UCSD is a member of the AACVPR BOD. *Karen Lui* is a former President as are *Brian Carlin* and *John Hodgkin*. *Rich Casaburi, Chris Garvey* and *Andy Ries* are among current AACVPR Fellows hailing from California.

4. https://www.cspr.org.

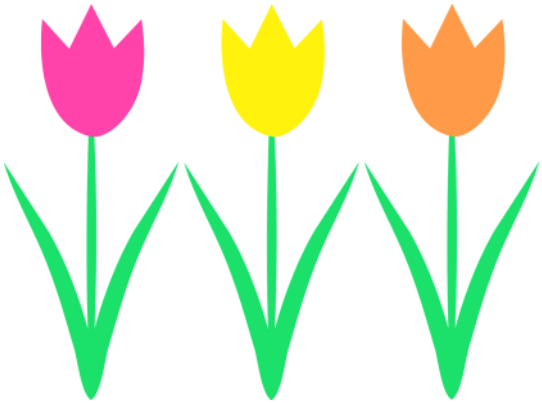
The **California Society for Pulmonary Rehabilitation (CSPR)** is led by Aimee Kizziar, UC Davis, Lynn McCabe, Carlsbad, CA and Missy Von Luehrte, El Camino Hospital.

CSPR's annual meeting is being held **May 3-4, 2019** in Sacramento and features an outstanding lineup of speakers from throughout the state including Josh Mooney (Stanford) and Justin Oldham (UC Davis) .

https://www.cspr.org/register-2019.html

Access: https://www.cspr.org/find-a-program.html

5.https://www.copdfoundation.org/Learn-More/I-am-a-Person-with-COPD/Pulmonary-Rehabilitation.aspx



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ANNOUNCEMENTS

Join us for the LUNG FORCE Expo!

This special one-day educational event brings together patients, caregivers, family members, guests, health care professionals and advocates.

LUNG FORCE Expo - San Francisco
Wednesday, April 10, 2019

UCSF Mission Bay Conference Center
1675 Owens Street | Suite 251
San Francisco, CA 94158

See details: http://action.lung.org/sfexpo

At the LUNG FORCE Expo, you'll find:

- Educational programs for patients and professionals
- Inspirational speakers
- Exhibitors and supporters
- Materials and resources
- This course meets the requirements for CEU for RCPs and Nurses in California

Patients, caregivers, friends, family and healthcare providers are invited to join the American Lung Association to learn about the latest treatments, resources and research to help those living with lung disease lead healthier, active lives! Includes light breakfast, lunch, and snacks.

- **Patient, Friends, Family, Public Registration fees:**
  Early bird: $10 (before 4/1/19), $15 (after 4/1/19)
  Registration: 9:00 a.m. (Light breakfast available)
  Program: 10:00 am to 3:00 p.m.

- **Professionals fee: Six CEUs available**
  Early bird $75 (before 4/1/19), $100 (after 4/1/19)
  Registration: 8:00 a.m. (Light breakfast available)
  Program: 9:00am to 5:00pm

For more information and to register, click on the following links:

http://action.lung.org/site/DocServer/16924_agenda.pdf?docID=42363
https://action.lung.org/site/TR?pg=informational&fr_id=18101&type=fr_informational&sid=7050

Volume 18, Issue 2 & 3 of the SWJPCC Journal

Volume 18, Issues 2 & 3							
Title (Click on title to open the manuscript, **CME in Bold**)	**Journal Section**	**First Author**	**Year**	**Vol**	**Issue**	**Pages**	**Date Posted**
FDA Commissioner Gottlieb Resigns	News	Robbins RA	2019	18	3	65-6	3/7/19
Ultrasound for Critical Care Physicians: An Unexpected Target Lesion	Critical Care	Smith J	2019	18	3	63-4	3/5/19
Physicians Generate an Average $2.4 Million a Year Per Hospital	News	Robbins RA	2019	18	3	61-2	3/4/19
Medical Image of the Month: Incarcerated Morgagni Hernia	Imaging	Hothi S	2019	18	3	59-60	3/2/19
March 2019 Pulmonary Case of the Month: A 59-Year-Old Woman with Fatigue	**Pulmonary**	**Wesselius LJ**	**2019**	**18**	**3**	**52-8**	**3/1/19**
Medical Image of the Month: Pectus Excavatum	Imaging	Insel M	2019	18	2	50-1	2/2/19
February 2019 Imaging Case of the Month: Recurrent Bronchitis and Pneumonia in a 66-Year-Old Woman	**Imaging**	**Gotway MB**	**2019**	**18**	**2**	**31-49**	**2/1/19**