Medicare Policy and Reimbursement in 2018

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I chose to focus my portion of the Medicare Policy and Reimbursement presentation on frequently asked questions and areas of confusion about the Medicare rules. I will only address in this summary, information not already summarized in the article, Designing a Comprehensive Pulmonary Rehabilitation Program.

A logical place to begin is to differentiate between "pulmonary rehabilitation", as defined by Medicare, and "respiratory services". A **PR** program is typically a *multidisciplinary* program, *individually tailored* and *designed to optimize physical and social performance and autonomy* of care for patients with chronic respiratory impairment. PR provides services to Medicare beneficiaries with moderate to very severe ***chronic obstructive pulmonary disease (COPD).*** PR is a comprehensive service, therefore ***all*** services provided are bundled into one CPT code, G0424.

Respiratory services (RS) are individualized services that are reasonable and necessary for improving respiratory function. The lack of specific guidelines for RS requires program staff to use good clinical judgment in determining who should enroll in RS. The patient must, of course, have a diagnosis of chronic respiratory disease other than COPD; but there must also be medical necessity for the service. For example, persistent symptoms despite medical therapy, functional limitations, impaired quality of life, and/or increased health care utilization, e.g. ED visits, hospitalizations, or frequent unscheduled physician visits. Although RS provides individual services or interventions, there are some CPT codes bundled into the RS codes, such as pulmonary function testing, chest physical therapy and the six minute walk test (6MWT). The bundling of these services are described in the National Correct Coding Initiative edits (NCCI) published in October of 2010.

The rules for PR, and lack of rules related to RS, creates confusion. This is particularly true when Medicare Administrative Contractors (MACs) are allowed some degree of interpretation of the rules, and also have a choice of whether or not to develop a Local Coverage Decision (LCD) related to RS. The Jurisdiction 5 MAC, Wisconsin Physician Services (WPS) has chosen to NOT provide a LCD on RS; therefore we lack clear guidelines to follow for enrolling patients with chronic respiratory disease other than COPD into RS. Recognizing the confusion this creates, the AACVPR created the MAC Liaison Task Force (TF). The TF includes volunteer AACVPR members from each MAC jurisdiction to serve as the experts, providing 2-way communication between the MAC Medical Directors and the AACVPR membership. All questions regarding reimbursement should go to the MAC Liaison in each MAC jurisdiction. At this time, the MAC Liaison for J5 (Iowa, Kansas, Missouri and Nebraska) and J8 (Indiana and Michigan) is Janie Knipper.

I believe clarification is warranted in regards to supervising physician and medical director in pulmonary rehabilitation. While Medicare defines the role of a PR medical director, the rules focus mostly on the "supervising physician". The Social Security Act, outlined in the Code of Federal Regulations, 42.CFR 410.47, defines PR as a physician supervised program. This means a physician must be **physically immediately** available and accessible for medical emergencies at all times the program is being furnished. The supervising physician does not have to be the medical director, or they can be one in the same. In my opinion, I think it is prudent to outline in a PR policy, how you have implemented physician supervision. For example, do you have a medical director as well as supervising physicians, or does the

medical director serve both roles? If you have both, can the supervising physician serve as the medical director when the medical director is unavailable? The MAC Medical Director for jurisdiction 5 has stated that the supervising physician must be documented in the patient's medical record for each day of service. If you keep a log of the supervising physician, the log can be submitted with the patient's medical records if Medicare requests documentation; however, the name of the supervising physician must also be documented in the medical record. This would most likely be done on the daily progress note.

CMS outlines the standards for the medical director as including substantial involvement, "***in consultation with staff***, in directing the progress of the individual in the program including ***direct patient contact*** related to the periodic review of his or her treatment plan". Because Medicare law, the Social Security Act, identifies PR as a physician supervised service, this is not something that can easily be changed. We have to find a means within our programs to meet this requirement, which includes finding a medical director that is aware of and willing to fulfill this role. WPS, the J5 MAC, has provided further clarification of the role of the physician in regards to the periodic review of the treatment plan: *"If the plan is developed by the referring physician or the PR physician…PR physician must also review and sign the plan prior to initiation of the PR program."* Meeting this requirement continues to be a significant challenge for PR programs. Keep in mind, this rule is for Medicare beneficiaries with COPD enrolled in "pulmonary rehabilitation". While it would certainly be beneficial for all PR/RS patients, I encourage all programs to first meet the requirement for those patients where reimbursement depends on meeting the requirement.

In summary, PR programs must be aware of existing regulations guiding the practice of providing comprehensive pulmonary rehabilitation; and staff must use good clinical judgment when providing respiratory services. While the rules can be challenging and demanding of staff time and physician time, we must find a way to meet the requirements. Networking with other PR program staff can be useful when looking for ideas on how to meet these requirements.