



Dear Pulmonary Rehabilitation Colleague:

As you know, starting in 2012, the Medicare reimbursement for hospital-based pulmonary rehabilitation programs dropped dramatically, from \$63/hour in 2011 to \$37/hour in 2012. This cut was both unexpected and definitely unwelcomed.

Why did the reimbursement drop?

The short answer is that we, the pulmonary rehabilitation community, did not charge appropriately for the service in our hospital charge-based reporting. The longer answer is that pulmonary rehabilitation programs across the country, have been underreporting the charges associated with providing pulmonary rehabilitation services in the UB-04 hospital cost report. In reviewing the available cost report data from 2010, Centers for Medicare & Medicaid Services (CMS) noted that the median cost for providing pulmonary rehabilitation services was about \$150/hour, far less than the estimate CMS used as the base for the initial reimbursement of \$63/hour.

Medicare reimbursement for physician office based pulmonary rehabilitation is not impacted by this policy.

The good news is that each of us can do something about this. The ATS, in close collaboration with our sister pulmonary rehabilitation societies, has created a pulmonary rehabilitation tool kit that will walk you through all the likely inputs associated with providing hospital-based pulmonary rehabilitation services. This tool kit will help you better understand—and report to CMS—the costs associated with your program.

However, this will probably require some extra work on your part. For most pulmonary rehabilitation providers, we are not the ones responsible for filling out and submitting the UB-04 cost report to CMS. After reading and understanding the information in the tool kit, you will have to find out who at your facility is responsible for the UB-04 cost report form and educate them. This education process will probably take some time, but I strongly believe it will be worth the effort.

The bad news is that even if we do everything right and accurately report charges related to pulmonary rehabilitation, the reimbursement won't reflect this until 2014 at the earliest. Because of the time delay in CMS's ability to collect and review charge data, it will take some time for the improved cost reporting data to change reimbursement rates.

Many of you probably have received similar information from our sister societies. If you have already acted on it, thank you. The next thing you can do is contact your colleagues at the pulmonary rehabilitation program across town (or across the country) and encourage them to act, too.

I hope you will take the time to read, understand, and act on the information in the tool kit. Please feel free to contact me if you have questions or need additional information.

Sincerely
Richard ZuWallack, MD
Chair, ATS Assembly on Pulmonary Rehabilitation

PULMONARY REHABILITATION TOOLKIT

Guidance to Calculating
Appropriate Charges for G0424

Developed by and in Cooperation With

The American Association of Cardiovascular & Pulmonary
Rehabilitation

The American Association for Respiratory Care

The American College of Chest Physicians

The American Thoracic Society

The National Association for Medical Direction of

Respiratory Care

Introduction

This toolkit has been developed by a broad based coalition that includes several key pulmonary societies, including the American Association for Respiratory Care (AARC), the American Association of Cardiovascular & Pulmonary Rehabilitation (AACVPR), the American Thoracic Society (ATS) and the National Association for Medical Direction of Respiratory Care (NAMDRRC). It is designed to give hospital based pulmonary rehabilitation programs detailed information regarding payment for pulmonary rehabilitation services under the fee-for-service program of Medicare.

In 2010 Medicare began using HCPCS code G0424 as the billing mechanism for pulmonary rehabilitation services for patients with moderate, severe and very severe COPD. For two years Medicare relied on proxy data to develop payment rates because no data existed for G0424. Now that data are available, Medicare has established a payment rate of approximately \$37 ***based on two sources of information provided to CMS by hospitals submitting bills for G0424:***

1. First, based on claims data, the median hospital **charge** for G0424 was \$150.
2. Secondly, based on information from hospital cost reports, the cost to charge ratio applied to the median charge has resulted in a payment rate of \$37 per session.

This toolkit is designed to focus on #1, above, the hospital charge for G0424. In its final rule announcing 2012 payment rates, CMS highlights G0424 as a primary example of hospitals' failure to develop appropriate charges for new "bundled" codes that reflect a broad base of services that had been separately billable (see p. 8 of this toolkit). The information provided here is designed to ensure that hospitals carefully consider all the services, supplies and equipment that are integral to the provision of pulmonary rehabilitation services encompassed in G0424 and establish appropriate charges reflective of that scope of services.

Expectations and timelines: There are no easy or quick fixes to this payment issue. CMS will use Medicare claims data from 2011 to develop its proposed payment rate for 2013 when that announcement appears in July, 2012. Therefore, it is likely that the pulmonary rehabilitation community will not see a substantive adjustment to payment rates as a result of this nationwide educational effort until 2014 payment rates are announced in July, 2013. But it is imperative that hospitals act as swiftly as possible to review and adjust their charges for G0424 so that claims data submitted to Medicare, which includes a specific column for identification of hospital charges on the UB-04, is accurate. Without such an adjustment to charges, the payment rate will remain problematic.

TABLE OF CONTENTS

Section I: Reduction in Payment for Pulmonary Rehabilitation Services

Delivered to COPD Patients..... 4

Executive Summary 4

Section II: Pulmonary Rehabilitation – Strategies to Address

Medicare Payment Reductions 4

Background 4

How CMS Derived the PR Payment Rate 5

Options That Were Considered 5

What the Future Holds 6

Section III: Strategic Plan to Address Medicare Reductions

Overview 6

Checklist 7

Multi-society Contacts 8

Section IV: Variables in Determining an Appropriate Charge for HCPCS

Code G0424 9

Services 9

Variation in Services for Patients with Differing Diagnoses.... 11

Exercise Equipment 15

Department Equipment and Supplies 15

Software 16

Written supplies 16

Books 16

Department Furniture, Accessories 16

Uncompensated services 18

**Section I: Reduction in Payment for Pulmonary Rehabilitation Services
Delivered to COPD Patients**

Executive Summary

Outpatient pulmonary rehabilitation (PR) has recently faced a significant funding challenge. Effective 1/1/2012, CMS has dramatically reduced reimbursement by Medicare for PR services delivered to COPD patients. Five leading national pulmonary societies have worked aggressively to understand and address this change. Extensive analysis has revealed that the reduction in reimbursement appears to be from inadequate detail and appropriateness of PR charges submitted by many hospitals on their Medicare claims for the billing code G0424 (PR for moderate to severe COPD, GOLD II – IV). AARC, AACVPR, ACCP, ATS, and NAMDRRC have developed resources and strategies for improving the accuracy of the charges that are reported to Medicare so that the charges accurately reflect the complexity and depth of PR services.

This PR reimbursement toolkit offers PR providers:

1. The detail and resources to understand and calculate all that is entailed in an appropriate charge for PR services integral to bundled code G0424, and
2. The guidance to accurately communicate these important aspects of PR to hospital financial personnel.

The ultimate goal is that the charges submitted for PR by hospitals on Medicare claims truly reflect all the important elements (services, supplies and equipment) that occur in PR and that this accuracy is subsequently reflected in appropriate reimbursement of PR services by CMS.

For more in-depth information including detailed background and a glossary of terms on this important issue, see pages 19-20. Resources for this important facet of care and services are also available at www.AACVPR.org and www.AARC.org.

This toolkit is a resource that has been developed by experienced PR clinicians from multiple pulmonary organizations and societies. It is designed to assist you and your hospital administrative staff in calculating a fair and accurate charge for G0424 that reflects the complexity of providing PR services.

Section II: Pulmonary Rehabilitation – Strategies to Address Medicare Payment Reductions

Background

In July, 2011 the Centers for Medicare and Medicaid Services (CMS) proposed in its rules for hospital outpatient payment to reduce payment for G0424, the HCPCS code for payment of

pulmonary rehabilitation provided by hospital outpatient services, from approximately \$63 to \$37. A multi society response (AARC, AACVPR, ACCP, ATS, NAMDRRC) focused on several aspects of the proposal, ultimately focusing on our belief that the data CMS used was aberrant. That approach was unsuccessful, and effective January 1, 2012, the payment rate has been reduced as proposed.

In order to address this important issue in a coherent and coordinated manner, all of the societies noted above are planning to participate in a nationwide effort to address this payment issue, at the individual hospital level. Please review this information very carefully, and also note we have added a very short glossary as the terms we use, and the context in which we use them, are very important with very specific payment implications.

How CMS Derived the PR Payment Rate

CMS uses **hospital charge data** that is submitted with Medicare claims via the UB-04 to calculate payment rates for hospital outpatient services, then applying a “cost-to-charge ratio” to establish actual payment rates. When G0424 went live in 2010, CMS admittedly had no data on which to base payment and determined that it would use “proxy data” from codes G0237, 38 and 39, resulting in a payment rate of \$50 for 2010 and \$63 for 2011. Now that data are available from 2010 claims, CMS calculated the \$37 payment rate based on the **charges** hospitals identified on their **claims** submitted to Medicare.

We do not believe the CMS data are flawed. Rather, we believe that many hospitals did not establish appropriate charges for pulmonary rehabilitation, as CMS identified an approximate median charge of \$150 for G0424 claims submitted to Medicare. We suspect that hospital charges for G0424 were correlated by the hospitals to the charges for G0237-39, with one huge flaw in their premise. Codes G0237-38 are **one-on-one** 15 minute codes, while G0424 is, for all practical purposes, a **group one hour** code. We further believe that when hospitals saw a unique bundled code appear for 2010 and that CMS would use proxy data from G0237-39 to establish payment rates, many hospitals simply identified the charges as similar, unaware of the HUGE time and staffing differences in the code definitions.

Options That Were Considered

The societies considered several options to address this matter, and none of the options offered quick solutions with any reasonable chance of success. The solution we have agreed to implement is –

Educate hospitals to the errors of their ways, convincing them to adjust their “charge masters” to more accurately reflect the provision of pulmonary rehabilitation.

The benefit of this approach is hopefully obvious. Once charges are appropriately established and identified on Medicare claims data, the methodology CMS uses to establish payment rates will realign the payment rates for G0424 accordingly.

We fully recognize the challenges associated with this approach. They include:

1. It is a huge undertaking to convince each hospital to review its charges for pulmonary rehabilitation. First, one has to identify the actual person(s) within the hospital responsible for the “charge master.” Secondly you need to convince them of the need for more accurate charges for a service at the low end of the billable spectrum.
2. And perhaps most importantly, if this initiative IS SUCCESSFUL, it would take at least 6-18 months of incredibly diligent work, likely resulting in accurate charges on claims data appearing in time for 2013 at the earliest, 2014 as a more likely target date.
3. If we are unsuccessful in this massive educational program, payment rates will remain low for the foreseeable future.

What the Future Holds

As noted above, the pulmonary medicine community submitted joint comments to CMS strongly protesting the 2012 proposed rate, emphasizing that the charge data are flawed, that the proxy data are accurate (and have been in place since 2001), and that for all practical purposes, COPD patients who receive pulmonary rehab side by side (billed thru G0424) with non-COPD patients (billed thru G0237-39) receive the same services and are paid through two different codes.

Additionally, we have every reason to believe that the charge data appearing on **2011 claims** which are already in the Medicare claims data base and will be the basis for 2013 payment rates, would likely mirror the 2010 charge data, resulting, once again, in a payment rate calculation for 2013 at approximately \$38.

Section III: Strategic Plan to Address Medicare Payment Reduction for Pulmonary Rehabilitation Provided by Hospital Outpatient Services

Overview

As previously stated, CMS uses **hospital charge data** that is submitted with Medicare claims to calculate payment rates for hospital outpatient services, then applying a “cost-to-charge ratio” to establish actual payment rates. When G0424 went live in 2010, CMS admittedly had no data on which to base payment and determined that it would use “proxy data” from codes G0237,

38 and 39, resulting in a payment rate of \$50 for 2010 and \$63 for 2011. Now that data are available from 2010 claims, CMS calculated the \$37 payment rate based on the **charges** hospitals identified on their **claims** submitted to Medicare.

Therefore, it is imperative that hospitals review their charges for pulmonary rehabilitation and adjust them accordingly. You will find an attachment to this overview that specifically identifies all the professional services, equipment and supplies that are integral to pulmonary rehabilitation, all of which a hospital should consider when it sets charges for G0424. Remember, the charges identified on the Medicare claims form (UB 04, a copy of which is attached and highlighted), has virtually nothing to do with what Medicare might pay for a particular service being billed. In fact, CMS specifically cites G0424 and pulmonary rehabilitation as a good example of hospitals' failure to adjust their charges accordingly. The November 30th 2011 **Federal Register** announcing outpatient payment rates for 2012 includes the following statement on p. 74224:

In recent years, the CMS and the AMA's CPT Editorial Panel have increasingly created new codes that use a single HCPCS code to report combinations of services that were previously reported by multiple HCPCS codes or multiple units of a single HCPCS code. **For example, effective January 1, 2010, CMS created HCPCS code G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session) to represent a comprehensive program of pulmonary therapy** and the CPT Editorial Panel created CPT code 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) to report all devices furnished under a single IMRT treatment plan. As we have stated before, we expect hospitals to carefully review each new HCPCS code when setting charges for the forthcoming year. However, in particular, **hospitals should be especially careful to thoughtfully establish charges for new codes that use a single code to report multiple services that were previously reported by multiple codes. It is vital in these cases that hospitals carefully establish charges that fully include all of the charges for all of the predecessor services that are reported by the new code. To fail to carefully construct the charge for a new code that reports a combination of services that were previously reported separately, particularly in the first year of the new code, under-represents the cost of providing the service describing by the new code and can have significant adverse impact on future payments under the OPPS for the individual service described by the new code.**

[EMPHASIS ADDED]

Checklist

Given the background CMS has provided in establishing charges for a single bundled code, following is a checklist of what every pulmonary rehabilitation program MUST do:

- ☐ Determine what your hospital is “charging” for pulmonary rehabilitation services (HCPCS code G0424) AND how the hospital determined that charge. Please be familiar with ALL the components that go into this bundled code, including professional services, supplies and equipment. The best way to verify the actual charge your hospital is submitting to Medicare is to see a copy of the claim submitted to Medicare on a UB-04.
- ☐ If you believe that the “charge” for pulmonary rehabilitation is not reflective of what it should be (according to CMS, the median charge on 2010 claims data was \$150, resulting in a payment rate of \$37), you must be prepared to challenge the hospital’s calculations. We know this can be frightening and perhaps threatening, but the singular goal is to ensure that Medicare is paying hospitals appropriately. CMS itself has signaled it believes hospitals are not charging for G0424/pulmonary rehabilitation appropriately.

In order to address this, you will need to take several important steps:

- ☐ Determine who is responsible for computing the charges for pulmonary rehab and identifying those charges on the hospital’s “charge master.” This could be the chief financial officer or it could be a compliance officer, or some other administrative position within the hospital.
- ☐ Schedule an appointment with this person. Perhaps you want to include your medical director for additional support. Be prepared to document the following:
- CMS’s statement that it believes hospitals need to adjust charges for pulmonary rehabilitation.
 - All the components that should be considered by a hospital in developing its charges. That includes services, supplies and equipment. This is all enumerated as part of this strategic plan, with the support of all five professional pulmonary societies.
 - Be aware that some institutions, dependent upon State law, might be able to change their “charge master” on specific schedules, with approval of the State.
 - Once it is clear that the hospital is open to adjusting its charges, let the professionals who address these matters do what they do best – adjust the charges!
 - The best way to confirm that charges have been adjusted is to see a copy of the UB-04 which MUST identify charges for all services billed to Medicare.
- ☐ For assistance in any capacity on this matter, here is a list of resources for you:
- Gerilynn Connors Gerilynn.Connors@inova.org
Bonnie Fahy Fahy.bonnie@gmail.com

Anne Gavic	agavic@NCH.ORG
Chris Garvey	chrisgarvey@dochs.org
Lana Hilling	lane.hilling@johnmuirhealth.com
Debbie Koehl	Dkoehl@iuhealth.org
Trina Limberg	tlimberg@ucsd.edu
Phil Porte	phil@namdrc.org

Section IV: Variables in Determining an Appropriate Charge for G0424

There are several things you need to consider when determining the appropriate charge for G0424. These are outlined below. **[NOTE: Physician's Current Procedural Terminology (CPT®) codes, descriptions, and numeric modifiers are © 2011 by the American Medical Association. All rights reserved].**

- 1. Consider what services the hospital is providing that it would charge for separately (unbundled) if allowed? Examples include the following:**

G0237: Therapeutic procedures to increase strength or endurance of respiratory muscles (i.e. breathing retraining), face to face, one- on-one, each 15 minutes (includes monitoring)

G0238: Therapeutics procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring). This involves a variety of activities, including teaching patients strategies for performing tasks with less respiratory effort including ADLs, stair climbing, ongoing physical activity and exercise needs. Used in the PR setting, this includes pre- and post-activity vital signs, dyspnea measurement and management.

G0239: Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring). This involves a variety of activities, including teaching patients strategies for performing tasks with less respiratory effort including ADLs, stair climbing, ongoing physical activity and exercise needs. Used in the PR setting, this includes pre- and post-activity vital signs, dyspnea measurement and management.

G0436: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes. This includes assessing readiness to quit, working collaboratively with the patient using techniques such as motivational interviewing to build confidence in successful cessation, referral to community support, addressing problem solving to prevent relapse, and collaboratively working with the medical team to manage pharmacological needs to enhance successful long term cessation.

G0437: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes. This includes assessing readiness to quit, working collaboratively with the patient using techniques such as motivational interviewing to build confidence in successful cessation, referral to community support, addressing problem solving to prevent relapse, and collaboratively working with the medical team to manage pharmacological needs to enhance successful long term cessation.

82962: Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use. This includes training (and possibly procurement) of BG testing equipment, timing of testing, signs and symptoms and hyper / hypoglycemia, impact and management in the context of exercise training and physician notification of abnormalities.

94620: Pulmonary Stress Test/Simple (Six minute walk) with analysis including data conversion to MET level. May include oxygen titration with exercise.

94664: Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered-dose inhaler with/without holding chamber, dry powder inhaler or IPPB device. Includes providing a holding chamber, in depth training, demonstration, return demonstration, follow-up, cleaning of equipment and medication adherence strategies.

94640: MDI or Nebulizer treatments. Includes appropriate timing for medications based on patient's symptoms as part of an action plan to reduce and control symptoms and exacerbations.

94667: Manipulation chest wall, such as chest PT, e.g. percussion and vibration to facilitate lung function, initial demonstration and or evaluation, use of positive expiratory pressure device (Acapella, TheraPEP, Flutter), Vest or other device to promote secretion clearance

94760, 94761: Pulse Oximetry with appropriate documentation, including determination of oxygen needs at rest and with activity, needs and use of portable systems, strategies to manage severe hypoxemia, e.g. high flow cannulae, oxymizer, travel needs, etc.

96152: Health and behavior intervention, each 15 minutes, face-to-face; individual.

96153: Health and behavior intervention, each 15 minutes, face-to-face; group.

99211-99215: E & M codes previously used for initial evaluation and development of individualized treatment program (ITP). Includes patient evaluation, individualized goal, ongoing reassessment, discharge instruction and exercise prescription.

97001: Physical Therapy evaluation includes assessment and treatment planning.

97003: Occupational Therapy for evaluation includes assessment and treatment planning.

97802: Medical nutrition therapy, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes including management of cachexia, obesity, follow-up with medical team.

97803: Medical nutrition therapy, reassessment and intervention, individual, face-to-face with the patient, each 15 minutes including management of cachexia, obesity, follow-up with medical team.

97804: Medical nutrition therapy, reassessment and intervention, group (2 or more individuals), each 30 minutes including management of cachexia, obesity, follow-up with medical team.

98960: Education and training for patient self-management, face-to-face with the patient, each 30 minutes, including prevention and management of exacerbations, action plan, disease self management strategies, management of panic, anxiety and depression, end of life planning, control of airway irritants and allergens.

98961: Education and training for patient self-management, 2-4 patients, each 30 minutes, including prevention and management of exacerbations, action plan, disease self-management strategies, management of panic, anxiety and depression, end of life planning, control of airway irritants and allergens.

98962: Education and training for patient self-management 5-8 patients, each 30 minutes, including prevention and management of exacerbations, action plan, disease self-management strategies, management of panic, anxiety and depression, end of life planning, control of airway irritants and allergens.

2. One of the challenges facing institutions when determining appropriate charges for G0424 is the recognition that this bundled code covers a broad cross section of Medicare beneficiaries with COPD. At one end of the scale is the patient with moderate COPD, whose utilization of services, supplies and equipment is understandably at one end of the spectrum; the very severe COPD patient enrolled in pulmonary rehab invariably utilizes notably more intensive services, yet both are reimbursed at the same rate by Medicare. Here are some examples that illustrate this dichotomy.

Moderate COPD : GOLD Stage II (simple with absent of co-morbid conditions)

Initial Assessment including: history, focused physical exam, informed consent, review of outcome measurement, explanation of PR program and development of

individualized treatment plan (ITP) and exercise prescription in collaboration with medical director.

60 y.o. female with a sedentary lifestyle and a chief complaint of dyspnea on exertion (DOE). Exercise tolerance of one flight of stairs. No O2 Rx indicated by 6 minute walk test (MWT). 75 pkyr smoking history, quitting 2 months ago. BMI of 30. On short term disability due to a recent exacerbation. Poor understanding of self-management skills including MDI/DPI medication use and symptom awareness. Respiratory symptoms reported to health care provider 6 days following onset of productive cough and increased shortness of breath. Social support from spouse.

- Assess knowledge re: COPD, train in dyspnea control techniques, need for ongoing medical follow-up and collaboration with medical team to optimize health, manage symptoms, and prevent further complications.
- Prevention and management of acute exacerbation of COPD (AECOPD) including Action Plan: skills to activate Action Plan, hand hygiene, vaccination, prevention of exposure to irritants / allergens.
- Assess use of MDI/DPI.
- Review ADL performance and limitations, including ROM.
- Assess physical performance, symptoms and oxygenation with 6 MWT.
- Assess physical demands /work requirements – goals to return to work, full time or part time.
- Discuss time management – working and committing to an exercise program.
- Assess nutritional status. Establish weight loss goals.
- Psychosocial Assessment – response to recent acute exacerbation of COPD, fear, anxiety, social support status.
- Assess smoking relapse risks.
- Develop supervised exercise prescription with supervising physician, including home exercise program.

Severe COPD: GOLD Stage III (moderately complex, co-morbid conditions include hypertension, CAD, osteoarthritis, obesity)

Initial Assessment including: history, focused physical exam, informed consent, review of outcome measurement, explanation of PR program and development of individualized treatment plan (ITP) and exercise prescription in collaboration with medical director.

68 y.o. male, hospitalized 3 months ago for exacerbation. Has 12 month history of progressive dyspnea and fatigue which are moderate with walking and severe with stairs and inclines. Has 15 stairs at home. Chief complaint is DOE. Exercise tolerance of 50 feet ambulating on flat surface, uses cane, yet fell 3 months ago. Has O2

concentrator and E cylinders at home but not currently using. SpO2 92% on room air at rest, 86% with 6 MWT. O2 Rx indicated for ambulation. 50 pkyr smoking history, quitting 6 years ago. BMI is 36. Poor understanding of MDI/DPI/nebulizer and medication use. Cough productive for small amount thin tan mucus. Bilateral coarse rhonchi in upper lobes. Retired unmarried flight attendant; no caregiver or support available. Feels anxious and moderately depressed due to social isolation. Moderate insomnia for 6 months.

- Assess knowledge re: COPD, train in dyspnea control techniques, need for ongoing medical follow-up and collaboration with medical team to optimize health, manage symptoms, and prevent further complications.
- Prevention and management of AECOPD including Action Plan: skills to activate Action Plan, hand hygiene, vaccination, prevention of exposure to irritants / allergens.
- Assess use of MDI/DPI/nebulizer/prednisone: train in schedule, actions, side effects, techniques, prevention of weight gain due to prednisone.
- Assess and train in secretion clearance techniques, cough technique.
- Review ADL performance and limitations, including ROM.
- Assess physical performance, symptoms and oxygenation with 6 MWT as well as titration of oxygen with increasing exercise duration and intensity.
- Assess physical demands: Train in ADL management, pacing, assistive devices, and stair climbing. Evaluate balance, train in fall prevention, enhancing balance.
- Assess nutrition status - establish weight loss goals, meet with dietitian x 2 for focused training and follow-up.
- Assess oxygen needs; determine needs and train re: oxygen Rx, rationale, safety, travel, role during sleep, assist with obtaining portable system.
- Psychosocial Assessment – stress management, strategies to control anxiety, manage depression, intimacy issues, advance directives, and community resources for support, problem solving.
- Assess smoking relapse risks.
- Develop supervised exercise prescription with supervising physician, including home exercise program.

Very Severe COPD : GOLD Stage IV (complex, co-morbid conditions include obstructive sleep apnea, uncontrolled Type II diabetes, hypertension, CAD, osteoarthritis, obesity)

Initial Assessment including: history, focused physical exam, informed consent, review of outcome measurement, explanation of PR program and development of individualized treatment plan (ITP) and exercise prescription in collaboration with medical director.

66 y.o. male, hospitalized 3 times during the last year for AECOPD, last discharged 3 weeks ago. Has difficulty walking across a room and bathing due to DOE and

fatigue. History of falls. Uses no assistive devices for balance. Has O2 concentrator and E cylinders at home. Using 1½ lpm with exercise and sleep, PRN at rest. SpO2 90% on room air at rest, 88% after walking 570 feet using O2 at 1½ lpm. Increased O2 Rx indicated for ambulation. Current smoker with 100+ pkyr smoking history. Uncontrolled diabetes. BMI is 40. Poor understanding of MDI/DPI/nebulizer and medication use. Daily cough productive for 30 cc, clear, thick sputum. Obstructive Sleep Apnea, sleep study confirmed and CPAP ordered but has not started therapy. Lives alone with grown children nearby who assist with transportation and meal preparation. Not sure how/if pulmonary rehabilitation can help him.

- Assess knowledge re: COPD, train in dyspnea control techniques, need for ongoing medical follow-up and collaboration with medical team to optimize health, manage symptoms, prevent further complications.
- Smoking cessation counseling with on-going support.
- Prevention and management of AECOPD including Action Plan: skills to activate Action Plan, hand hygiene, vaccination, prevention of exposure to irritants / allergens.
- Assess use of MDI/DPI/nebulizer/prednisone: train in schedule, actions, side effects, techniques, prevention of weight gain due to prednisone.
- Assess and train in secretion clearance techniques including cough technique, percussion, vibration and postural drainage.
- Review ADL performance and limitations, including ROM and need for assistive devices (shower chair).
- Assess physical performance, symptoms and oxygenation with 6 MWT as well as titration of oxygen with increasing exercise duration and intensity.
- Assess physical demands: Train in ADL management, pacing, assistive devices, and stair climbing. Evaluate balance, train in fall prevention, enhancing balance with the use of a rollator.
- Assess nutrition status - establish weight loss goals, meet with dietitian x 4 for focused training and follow-up for weight loss and diabetic management.
- Monitor blood sugar before and after exercise.

Services are only one component that a hospital should consider in developing its charges for pulmonary rehabilitation. The supplies and equipment that are integral to the provision of pulmonary rehabilitation should be part of any thorough computation of charges for PR services.

3. While it is difficult to attribute all the supplies and equipment associated with the provision of pulmonary rehab services, neglecting to include the expense associated with the supplies and equipment directly associated with pulmonary rehab will shortchange the hospital if it does not include calculations addressing these legitimate expenses. The lists provided below are meant to provide examples for your consideration.

Exercise equipment

- NuSteps
- Treadmills
- Air Dyne bikes
- Stationary Bikes
- Recumbent Bike
- Elliptical trainer
- Recumbent elliptical trainer, e.g. REX
- Rowing machine
- Stepper
- Arm ergometer
- Free weights
- Elastic bands or tubing, e.g., Theraband
- Wall pulleys
- Resistance equipment such as Bow Flex, Hydrofit, etc.
- Universal Weights
- Shoulder wheel
- Mats, knee pads (for assist in getting up and down)
- Balls for resistance exercises on mats

Department Equipment and Supplies

- Blood pressure cuffs
- Stethoscope
- Oximeters (stationary, hand held and finger oximeters, probes and replacement oximeter sensors for fingers, earlobe, forehead)
- Timers
- Oxygen (Piped in oxygen, portable liquid and / or gas, system for storage and refill, strollers and holders, delivery of refills)
- Cannula including high flow cannula, Oxymizer pendant and cannula, OxyArm
- Oxy mask, non-rebreather mask
- System for storage of cannula

- EKG monitoring capacity (defibrillator with oscilloscope or telemetry)
- Crash cart with defibrillator or AED
- Accu check blood glucose monitor and quality assurance system
- Scale with calibration capability
- Rollator, quad cane, 4 point walker, cane
- Wheelchair
- Accapella high frequency oscillation / PEP valves/ Vest device
- Peak Flow Meters
- Hand Sanitizers mounted on wall
- Equipment Sani-wipes
- Gloves mounted on wall
- First-aid supplies
- Audiosystem

Software

- Krames on demand
- Epocrates

Written Supplies

- Pulmonary Rehabilitation manuals such as Krames
- Krames or other manual for interstitial lung disease

Books

- AACVPR PR Guidelines 4th edition
- ACSM Guidelines for Exercise Testing and Prescription

Department Furniture, Accessories

- Notebooks for class
- Files for patient charts
- File Cabinets
- Computers
- Office for clinicians
- Chairs and table for education room
- Chairs for waiting room
- Dry erase boards for education room and exercise room
- DVD and TV for education room

- TVs for exercise room
- Benches/chairs for exercise room
- Files for patient's exercise cards in exercise room
- Desk for charting in exercise room
- Phones for each person and one for exercise room
- Printer
- Copier/fax
- Secretary and reception desk
- Coffee maker and cabinet
- Sink for patients and staff to wash their hands
- Bottled water
- Clocks with second hands
- Refrigerator

4. Refer to your facility's current charge master and note the charge for each code per day on your list. If the code is provided more than once, multiply the charge for that code times the number of times the code was provided.

5. Add up all of the charges. Divide the totaled charges by the average number of sessions per a PR course in your pulmonary rehabilitation program.

EXAMPLE: Methodology to Calculate a Fair and Reasonable Charge for G0424

We will go through each of these steps individually. Here is a summary of the process:

a. Think about what services you are providing that you would charge for separately (unbundled).

b. Make a list of the services and number of times that you would perform that service in a typical pulmonary rehab program. Example: If the patient would attend 36 group exercise sessions, list 36 charges of G0239.

c. Refer to your current charge master and note the charge for each code on your list. Example: If the charge for G0239 is "X", multiply "X" times 36.

d. Add up all of the charges. Divide by the number of sessions in your program and this is your proposed charge for one G0424.

The number that you have calculated represents one charge of G0424

If you think that the charge that you have calculated is too high, think of all of the services you provide and receive no reimbursement.

Examples of Uncompensated Services

- Procurement of prescription and medical records
- Insurance verification including available number of visits from Medicare, co-pays, co-insurance, etc.
- Development of Individualized Treatment Plan (ITP)
- Psychosocial assessment and questionnaires
- On-going assessment of nicotine dependence
- Patient-centered outcome measurement, pre- and post-program
- Evaluation of current exercise prescription, including hypoxemia and oxygen needs, with updating each session
- Procurement of educational materials and purchasing/copying costs
- Documentation of education sessions
- Physician supervision with oversight of development and approval of initial ITP with review and direct patient contact every 30-days, immediate availability of the physician
- Team conference, related care planning and documentation
- Discharge planning and long term exercise prescription, including discharge instructions and summary to patient and provider
- Purchasing and upkeep of exercise equipment
- Cost of physical space and utilities
- Patient support including support group, linkage to community resources
- Staff salaries

It is probably very helpful to compare your hospital's charge for G0237, a 15 minute unbundled code for one-on-one service with G0424, a bundled code for one hour of group service. While not directly correlated to a 1:4 ratio because of the 15 minute versus 60 minute factor and the staffing requirements, the comparison should be justifiable when charges for each service are examined in an objective manner.

Section V: Glossary of Terms

HCPCS codes: These are codes established by CMS to address procedures, services, devices etc that are not addressed by the CPT coding system owned and operated by the American Medical Association.

Code G0424 was created by CMS for billing of pulmonary rehabilitation for COPD patients, effective January 1, 2010.

Ambulatory Patient Classifications (APCs): Payment for hospital outpatient services are tied to APCs with payment rates developed prospectively.

CMS uses two key pieces of data to determine payment rates. First, they examine Medicare claims data to collect information regarding “charges.” Once the median charges are determined by a review of claims data from a given year, CMS applies a “cost to charge ratio” to determine final payment rates. The source of data for CMS calculations of the “cost to charge ratio” is the hospital cost report.

Hospital Cost Report: This is a very complex report, filed once a year by a hospital, correlated to the hospital’s fiscal year. Therefore, unlike other reports, these are **once-a-year** reports are submitted to CMS throughout the year, dependent upon the end of a hospital’s fiscal year.

Frequently hospitals will use outside consultants to assist and coordinate submission of the hospital cost report. Importantly, this is NOT a request by a hospital to get paid by Medicare – it is a reporting requirement tied to participation in the Medicare program.

Charges: The “charge” for a specific service is a reflection of all the component pieces included in the delineated service. For pulmonary rehabilitation, a bundled service (code G0424) that precludes hospitals from billing Medicare for the component services embedded within pulmonary rehabilitation services as defined by G0424, this should include calculations tied to all the professional services, supplies and equipment that are part of the services identified as part of G0424.

It is very common to use terms like hospital charges and hospital costs interchangeably. In the context of CMS data collection, they are very different terms with critically different meanings. Hospital charges are NOT directly tied to what Medicare pays a hospital but all the charges from all hospitals across the country are used to determine APC payment rates. Hospitals are required to identify “charges” on the claims forms submitted for CMS for hospital outpatient

services, but this is **not** the amount the hospital expects to receive from Medicare; nor is it the amount Medicare plans to pay.

Charge Master: This is, in effect, a list of all the services that a hospital offers and the charges associated with those services. Medicare requires that these charges be identified on the claims data submitted for payment for **outpatient services**.

UB – 04: This is the standard form used by Medicare (and some private payers) to process claims for hospital outpatient services. A specific field on this form requires the hospital to identify the charge associated with the service.

Contributors to this toolkit came from key pulmonary societies, including the American Association of Cardiovascular & Pulmonary Rehabilitation, the American Association for Respiratory Care, the American Thoracic Society and the National Association for Medical Direction of Respiratory Care.

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