Chronic Obstructive Pulmonary Disease (COPD) Finance Webinar

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Objectives

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Webinar attendees will be familiar with the following:

- The Problem: Current Statistics on COPD
- Treatment Options
- Value Proposition
- Pulmonary Rehabilitation Program
  - Conditions of Participation
  - Billing/Coding
- Development/Expansion of Pulmonary Rehab Program
- Care Management
- Resources

COPD in America

- **Chronic obstructive pulmonary disease (COPD):** a common, preventable and treatable disease that is characterized by persistent respiratory symptoms and airflow limitation
- COPD was the third leading cause of death in the United States in 2015, and the fourth leading cause in 2016
- In 2015, **15.5 million adults** were diagnosed with COPD in the U.S.
    - That is over 6% of the U.S. adult population in 2015 diagnosed with COPD in the span of one year!
- While 15.5M adults were diagnosed, **350K Medicare patients were hospitalized**, and approximately **150K deaths occurred** as a result of this preventable and treatable disease
- **More than $32B was spent on COPD-related patient** care in 2010, and this is projected to **increase to $49B by 2020**

Source: Croft JB, Wheaton AG, Liu Y, et al. Urban-Rural County and State Differences in Chronic Obstructive Pulmonary Disease — United States, 2015. MMWR. Vol. 67, No. 7. February 23, 2019. https://bit.ly/2GNfukb

COPD in Rural America

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- Prevalence rate for COPD is about **12% for individuals living in rural communities** compared to 7% across the U.S.
- **Age-adjusted prevalence of COPD for adult populations in rural areas is 8.2%,** almost twice the prevalence rate for adults in metropolitan areas of 4.7%
- Why such a divide?
  - Rural populations have a greater exposure to the risk factors associated with COPD
    - ✓ Tobacco exposure
    - ✓ Respiratory infections
    - ✓ Occupational and environmental exposures
    - ✓ Genetics
  - Higher proportions of lower socio-economic residents

Source: Croft JB, Wheaton AG, Liu Y, et al. Urban-Rural County and State Differences in Chronic Obstructive Pulmonary Disease — United States, 2015. MMWR. Vol. 67, No. 7. February 23, 2019. https://bit.ly/2GNfukb

COPD in Rural America, Continued

- Why such a divide? (continued)
  - Limited access to appropriate healthcare services for COPD
    - ✓ Smoking cessation programs
    - ✓ Specialty care
  - Barriers to access healthcare services
    - ✓ Transportation
    - ✓ Geographic accessibility
    - ✓ Uninsured/under-insured
    - ✓ Cultural perception

Source: Croft JB, Wheaton AG, Liu Y, et al. Urban-Rural County and State Differences in Chronic Obstructive Pulmonary Disease — United States, 2015. MMWR. Vol. 67, No. 7. February 23, 2019. https://bit.ly/2GNfukb

COPD Treatment Options

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- Smoking Cessation
- Vaccinations
- Pharmacological Therapy
- Rehabilitation, Education & Self-Management
- Oxygen Therapy and Ventilator Support
- Surgical Interventions

Source: GOLD Manual 2019

What Is Pulmonary Rehab?

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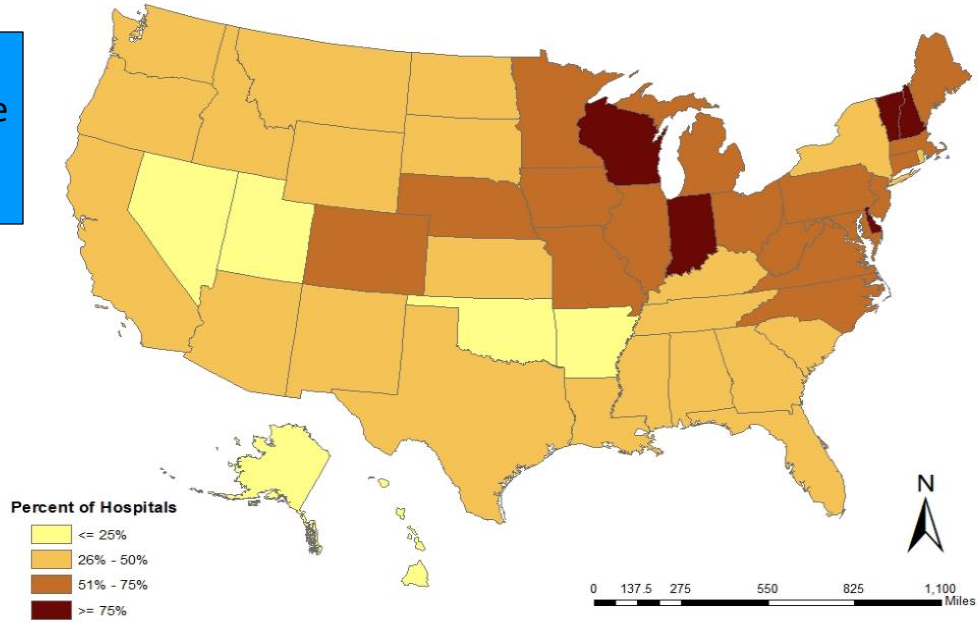
- Pulmonary rehabilitation is a supervised program that includes **exercise training, health education, and breathing techniques** for people who have certain lung conditions (COPD) or lung problems due to other conditions
- Goal is to **improve the physical and psychological condition** of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors
- Benefits include:
  - Improved survival
  - Improved exercise tolerance
  - Lessened perception of breathlessness
  - Improved quality of life
  - Reduced hospitalization time
  - Reduced hospitalizations per year
  - Decreased anxiety and depression
  - Improved arm function
  - Improved respiratory muscles

Source: GOLD Manual 2019
Source: National Health, Lung and Blood Institute. https://www.nhlbi.nih.gov/health-topics/pulmonary-rehabilitation
Source: https://www.verywellhealth.com/pulmonary-rehabilitation-914701

Pulmonary Rehab in Rural

- 1,366 US counties or county equivalents have at least one hospital outpatient pulmonary rehab program, while **1,776 counties do not have a pulmonary rehab program, including 697 counties that do not have a hospital**
- **36.3% of CAHs and 46.7% of rural PPS hospitals have an outpatient PR program**, along with 53.2% of urban PPS hospitals

Percent of Hospitals With Outpatient Pulmonary Rehab by State 2018



Source: Moscovice IS, Casey MM, Wu Z, Disparities in Geographic Access to Hospital Outpatient Pulmonary Rehabilitation Programs in the U.S., CHEST (2019), doi: https://doi.org/10.1016/j.chest.2019.03.031

Value Proposition

- Overall improvement health and education
- Decreased admission/readmissions – profitability, quality
- Decreased ED visits
- Outmigration
- Additional service offering to support patient needs
- Value-based healthcare
  - Provide high-quality, low cost patient care

Pulmonary Rehabilitation

- High-Level Overview of Medicare Conditions of Coverage: **42 CFR 410.47**
- **Mandatory Components of Pulmonary Rehab Program**
  - Physician-prescribed exercise: Physical activity includes techniques such as exercise conditioning, breathing retraining, step and strengthening exercises. **Some aerobic exercise must be included in each PR session**. Physical activity **must be prescribed by a physician**.
  - Education or training: must be closely and clearly related to the individual's care and treatment which is tailored to the individual's needs. Education includes **information on respiratory problem management and, if appropriate, smoking cessation counseling.** Any education or training prescribed must be documented in the individuals treatment plan.

Source: CMS Medicare Policy: 42 CFR 410.47

Pulmonary Rehabilitation, Continued

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- **Mandatory Components of Pulmonary Rehab Program (continued)**
  - Psychosocial assessment: requires a written evaluation of an individual's **mental and emotional function** as it relates to the individual's rehabilitation or respiratory condition
    - Periodic reevaluation is necessary
    - A recognized assessment tool can be utilized, i.e., depression screening, but must include physician's plan of action based on the results
  - Outcomes assessment: requires a written **evaluation of the patient's progress** as it relates to the individual's rehabilitation
    - Show what interventions/services worked and what did not for the patient
    - If goal not met, what modifications were made to address the failure

Source: CMS Medicare Policy: 42 CFR 410.47

Pulmonary Rehabilitation, Further More

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- **Mandatory Components of Pulmonary Rehab Program (continued)**
  - Individualized treatment plan (ITP): The ITP must be **established, reviewed, and signed by a physician**, who is involved in the patient's care and has knowledge related to his or her condition, **every 30 days**
    - Whether the initial pulmonary rehab ITP is developed by the referring physician or the PR medical director, **the medical director and or supervising physician must review and sign the plan prior to subsequent treatment** in the pulmonary rehab program
    - ITP must include the following:
      - ✓ Description of patient diagnosis
      - ✓ Exercise prescription (type, amount, frequency, duration)
      - ✓ Goals set for the patient under the plan
      - ✓ Mental and emotional functioning
      - ✓ Outcomes assessment

Source: CMS Medicare Policy: 42 CFR 410.47

Pulmonary Rehabilitation, Again

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Billing, Coding and Reimbursement

- Pulmonary rehabilitation services are bundled into a single HCPCS code: **G0424** - Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day
  - A maximum of two 1-hour sessions per day
  - One session of pulmonary rehabilitation services in a day must be at least 31 minutes
  - Two sessions of pulmonary rehabilitation services may only be reported in the same day if the duration of treatment is at least 91 minutes
- Limitations on Coverage
  - Medicare Part B pays for a pulmonary rehabilitation exercise program for up to **2 one-hour sessions per day, for up to 36 lifetime sessions (72 sessions)**
  - Commercial Coverage: There are varying limitations on pulmonary rehab services (BCBS Kansas – 18 sessions in a single 6 week period), while some commercial insurers follow Medicare limitations

Source: CMS Medicare Policy: 42 CFR 410.47

Pulmonary Rehabilitation, Once More

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Billing, Coding and Reimbursement (continued)

- Medicare requires that a patient meet the COPD GOLD stages II-IV criteria to be eligible for Medicare coverage of pulmonary rehabilitation (use of G0424)

Stage	FEV_1/FVC	FEV_1
I – Mild	< 0.70	$FEV_1 \geq 80\%$ predicted
II – Moderate	< 0.70	FEV_1 50-79% predicted
III – Severe	< 0.70	FEV_1 30-49% predicted
IV– Very Severe	< 0.70	$FEV_1 < 30\%$ predicted

- COPD Diagnoses with ICD-10 Codes:
  - Bronchitis, not specified as acute or chronic: J40
  - Simple chronic bronchitis: J41.0
  - Mucopurulent chronic bronchitis: J41.1
  - Mixed simple and mucopurulent chronic bronchitis: J41.8
  - Unspecified chronic bronchitis: J42
  - Chronic obstructive pulmonary disease, unspecified: J44.9
  - Unilateral pulmonary emphysema: J43.0
  - Panlobular emphysema: J43.1
  - Centrilobular emphysema: J43.2
  - Other emphysema: J43.8
  - Emphysema, unspecified: J43.9

Source: GOLD Manual 2019

Pulmonary Rehabilitation, Final

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Billing, Coding and Reimbursement (continued)

- If a patient does not meet the COPD criteria, their services can be covered as individual **respiratory care services** (not pulmonary rehabilitation)
  - G0237 – Therapeutic procedures to **increase strength or endurance or respiratory muscles**, face to face, one on one, each 15 minutes (includes monitoring)

    Example: Breathing retraining or inspiratory muscle training on select patients who would benefit.
  - G0238 – Therapeutic procedures to **improve respiratory function**, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)

    Example: Teaching patients strategies for performing tasks with less respiratory effort including ADLs, airway clearance strategies, stair climbing, or other activities to improve functional capacity.
  - G0239 – Therapeutic procedures to improve respiratory function or increase strength or endurance or respiratory muscles, two or more individuals (includes monitoring)

    Example: Group exercise. Not a timed code; it is billed once per day only.

Source: CMS Medicare Policy: 42 CFR 410.47

Program Development / Expansion

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Considering the development of a pulmonary rehab program?	Expansion / growth of current pulmonary rehab program?
• Identify current and future need • Investment/resource needs • Clinical and regulatory requirements • Partnership opportunities • Pricing strategy • Value of reducing readmission	• Marketing/promotion of services • Education • Expand the role of respiratory therapists • Patient support groups • Maintenance programs • Care management

Care Management

Patients hospitalized after acute exacerbation of COPD have a 30-day readmission rate of 19.2%

- Transitional Care Management (TCM):
  - TCM services are designed to prevent hospital readmissions by providing seamless care when a patient is discharged from an inpatient facility (hospital) to community-based care (clinic)
  - Providers may conduct the following TCM components beginning at the day of discharge up to 30 days:
    - Interactive contact within 2 business days of discharge
    - Certain non face-to-face services
    - Face-to-face visit within either 7-14 calendar days of discharge

99495: $170.67	99496: $240.71

Source: David M. Jacobs et al., Annals of the American Thoracic Society. Early Hospital Readmissions after an Acute Exacerbation of Chronic Obstructive Pulmonary Disease in the Nationwide Readmissions Database. 2018. https://doi.org/10.1513/AnnalsATS.201712-913OC
Source: Medicare Learning Network: Transitional Care Management

Care Management, Continued

Patients hospitalized after acute exacerbation of COPD have a 30-day readmission rate of 19.2%

- Chronic Care Management (CCM):
  - CCM services are designed to address the complex needs of Medicare beneficiaries suffering from multiple chronic conditions
  - At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional is required in order to bill Medicare for the service **(CPT 99490).** Moderate or complex medical care, up to 60 minutes of clinical staff time must be recorded for billing purposes **(CPT 99487).**
  - Services include:
    - Utilizing EHR to record patient health information
    - Development of a comprehensive care plan
    - Access to care and care continuity (24/7)
    - Comprehensive care management
    - Transitional care management

99490: $43.13	99487: $95.51

Source: Medicare Learning Network: Chronic Care Management

Resources

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- **Up-to-date resources related to pulmonary rehab services:**
  - CMS/Medicare Administrator Contractor (MAC)
  - Professional associations
    - Evidence-based clinical best practices
    - Regulatory updates
    - Continued education
      - American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)
      - American Association of Respiratory Care (AARC)
      - American Thoracic Society
      - COPD Foundation
  - Internal expertise