Priorities for Cardiac Rehabilitation Programs in 2015

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I have no disclosures.

Outline

1. Coming changes in Medicare billing & coding for cardiac rehab (CR)
2. Clarification of CMS rules
3. Current issues
4. Strategic planning for CR

1. Coming Changes for CR

- New modifier required for all services in provider-based departments (PBD)
- Modifier -59: new code in 2015 to indicate separate encounter
- CMS & CR Referral Performance Measures

What is Your Program's Role?

- Business office receives many CMS instructions
- You are your hospital's best resource for CR billing & coding compliance
- Meet regularly-be part of the team
- Share your expertise of CMS' regulations specific to CR
- Set the expectation that you need to be informed on all CR billing, coding, denial issues

New Modifier in 2015- Provider-Based Departments

- Growing trend of hospital acquisition of MD offices
- CMS needs data on type & frequency of all outpatient services furnished in off-campus provider-based departments (PBD)
- Why?
  - Payment calculations differ for hospitals vs physician offices, i.e., where and by whom service is provided
  - MD offices are becoming hospital outpatient depts

New Modifier in 2015- Off Campus PBDs

Definition of off-campus PBD setting:

- Located beyond 250 yards from main campus of hospital
- Excludes “remote location” and “satellite facility”

New Modifier in 2015- Off-Campus PBDs

- HCPCS modifier **"PO"** is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of hospital
- Reporting will be voluntary for CY 2015; required beginning January 1, 2016
  - "We welcome early reporting…"
- For analysis only-no adjustment to payments based on this data

New Modifier in 2015- Off Campus PBDs

Resources

- Federal Register, *Physician Fee Schedule*: CMS-1612-FC (10-31-14)
- 42 CFR § 413.65: definitions of campus, provider-based department, satellite facility, remote location
  - Posted on AACVPR Regulatory & Legislative Updates; Resource Links

Modifier -59: New in 2015

- Modifier -59 is required when CPT 93798 & 93797 are used on same day (not new)
  - Not needed for two 93798 codes or two 93797 codes in one day (not new)
- Effective Jan 1, 2015, a new more selective HCPCS modifier will be used to indicate a different encounter
- **XE** Separate Encounter: “distinct because it occurred during a separate encounter”

Modifier -59: New in 2015

- CMS will accept -59 or XE for now

  "…rapid migration to more selective modifiers is encouraged"

- MACs (Medicare Administrative Contractors) may require use of XE before CMS does
- Resources
  - Pub 100-20; Transmittal 1422; Change Request 8863 (8-15-14)
  - MLN Matters MM8863
  - MLN Matters SE1503
  - MLN Matters SE1418
  - Posted on AACVPR Regulatory & Legislative Updates-Resource Links

CR Referral Measures & CMS

Performance Measure #1-

CR Referral to Early Outpatient CR from an Inpatient Setting

JCRP 2007;27:260-290

- Endorsed by National Quality Forum (NQF)
- Under consideration for use in 2015 by CMS
  - EMR implications
  - Will facilitate tracking CR referral to enrollment outcome

CR Referral Measures & CMS

Performance Measure #2-

CR Referral to Early Outpatient CR from an Outpatient Setting

JCRP 2007;27:260-290

- This measure is included in CMS PQRS Program for MD offices
  - Physician Quality Reporting System
  - Make referring offices aware

2. Clarification of CMS Rules

- Procedure codes for CR
- Individualized Treatment Plan (ITP)
- Heart failure (HF) eligibility criteria
- Additional Documentation Request (ADR)
- Advance Beneficiary Notice (ABN)

Two Procedure Codes for CR

CPT Codes-AMA definition:

93797

"Physician or other health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)"

93798

"with continuous ECG monitoring (per session)"

Why Two Procedure Codes for CR?

- What constitute *"services for outpatient cardiac rehabilitation"?*
- CMS equally requires exercise ***and*** non-exercise components in a comprehensive CR program
- CMS does not require that exercise be ECG-monitored
- *That's right-CMS does not require that exercise be ECG-monitored*

Why Two Procedure Codes for CR?

Provide what each patient needs

&

do what's best for each patient.

CMS' Expectations for ITP

Directly from **42 CFR 410.49**-Medicare provision for CR:

- Individualized treatment plan means a written plan tailored to *each individual patient*
- goals *set for the individual* under the plan
- outcomes assessment means an evaluation of progress *as it relates to the individual's rehab*
- exercise…as determined to be *appropriate for individual patients*
- Emotional functioning *as it relates to the individual's rehab*
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, *tailored to the patients' individual needs*
- ITP detailing *how components are utilized for each patient*

Individualized Treatment Plan

- Is your patient involved in the development and monthly review of progress & re-assessment of *his/her* behavior goals?
- Is your ITP a *functional* tool for on-going communication between staff and patient?
- Are you measuring meaningful outcomes?
  - AACVPR Cardiac Rehabilitation Registry
- Are your patients achieving significant outcomes?
  - AACVPR CR Registry provides benchmarking capability

Heart Failure Eligibility Criteria

"…beneficiaries with stable, chronic heart failure, defined as patients with

- left ventricular ejection fraction of 35% or less and,
- New York Heart Association (NYHA) class II-IV symptoms despite being on optimal heart failure therapy for at least 6 weeks."

NCD 20.10.1

HF Eligibility Criteria

"Stable patients are defined as patients who have not had recent (≤ 6 weeks) or planned (≤ 6 months) major cardiovascular hospitalizations or procedures."

NCD 20.10.1

CMS Terms of Eligibility

Stable

- HF symptoms are not worsening such that prompt evaluation for hospitalization is needed

Optimal therapy

- Guideline-based heart failure therapy
  - Generally includes guidelines-recommended meds
- Optimal treatment requires on-going re-assessment & medication adjustment, based on each patient's response and most effective control of his/her symptoms

What Does That Mean?

"When I see a new HF patient in CR, I make a point of stating in my assessment that the patient is clinically stable and on a regimen of guideline-supported HF medications…"

Dr. Phil Ades

HF Eligibility Criteria

Planned (≤ 6 months)

- "Scheduled" is planned
- "Consideration of…" &"Future evaluation for…" is not planned
- CR may be appropriate treatment to aid in future therapy decisions

What Constitutes "Major"

- Not typically considered major cv events:
  - ICD, PPM, PCI, HF Clinic or ER for diuresis/meds
- Major hospitalization during CR course for:
  - LVAD placement
  - HF exacerbation
    - 6 week waiting period would be required
    - "…major cardiovascular hospitalizations…"
- Major or not:
  - Non-cardiac dx
    - 6-week waiting period may not apply, depending on dx and patient's clinical status

HF Eligibility Criteria

- The CR Medical Director serves an essential role in HF eligibility decisions.
- Medical necessity, dept policies, Medical Director communication with referring MD, and collaborative clinical judgment should guide referral appropriateness.

Ejection Fraction Eligibility Criteria

- Patient referred to CR meeting criteria (EF $\leq$ 35%), but now has LVAD, so EF has improved to 40%-still eligible?
- Is a new echo or other means of evaluating EF required post-hospital DC prior to CR entry?
- Is EF measurement required upon CR completion?

Heart Failure–Billing

- Diagnosis/ICD-9 code: 428.22
  - "Chronic systolic heart failure"
- Other ICD-9 codes may better describe patient's diagnosis that would also be acceptable for CR claims

Related CR FAQs

- Valve repair/replacement *by any technique* is covered by Medicare
- Use of ICD-10 (diagnosis) codes begins October 1, 2015
- There are no Medicare reimbursement codes for inpatient cardiac rehabilitation

Additional Documentation Request (ADR)

- ADR comes from MAC when considering payment
- Providers currently have 30 days to send more information to support claim before payment or denial decision by MAC
- Effective 4-6-2015:
  - Providers will have **45 days** to respond to an ADR
  - Can request extension of 15 calendar days if needed
- **Bottom Line**-be sure you know about all denials in time to respond

Advance Beneficiary Notice (ABN)

- ABN is a “waiver of liability” indicating to CMS that patient has been informed that service will or may not be covered by Medicare and patient is financially responsible
- If no ABN is obtained, patient may not be billed for denied service
- ABN applies only to traditional Medicare, not to Medicare Advantage plans

Advance Beneficiary Notice (ABN)

Examples:

- Medicare doesn't cover the diagnosis but patient's secondary insurance does-2ndary needs to have documentation of Medicare denial before it will pay
- For use with services covered by Medicare up to a certain number of times ("frequency limited") within a specified amount of time, such as pulmonary rehab beyond lifetime 72 session limits, some laboratory tests, some preventive screening tests and vaccinations

Advance Beneficiary Notice (ABN)

Examples (cont)

- In case where patient completes a 36-session CR course, but (patient, MD, other) wants/needs more sessions for same course/same diagnosis, ABN would be appropriate in case MAC denies >36, based on review of medical necessity documentation for that diagnosis
- New CR diagnosis = new course without need for ABN

3. Current Issues

- Supervision by non-physician practitioners and U.S. Senate Bill # 488
- Medicare Advantage plans and high co-payments
- What professional certification means for CR

Direct Physician Supervision

- Thank-you, Stacey Greenway!
- Do NOT confuse this physician role with role of medical director in CR-not related
- Passage of S.488 would offer flexibility to existing capacity limitations (location, hours of operation, etc) and remove financial burden of paying MDs for supervision, a non-billable, non-reimbursable CMS requirement

Excessive Medicare Co-Payments

Two Medicare program options:

1. Fee-for-service (“traditional”)

   Set reimbursement & co-pay amounts

2. Managed Care (“Medicare Advantage”)

   MA plan has leeway in setting co-pay amount

Excessive Medicare Co-Payments

- Some MA plans have set exceedingly high co-pays for CR & PR

  ≥ twice FFS co-pays (CR=$20, PR=$10)

- AACVPR & AHA met with CMS (12/14) to bring this patient barrier to their attention
- We look forward to CMS' analysis of MA plan data and consequent actions

Certified Cardiac Rehabilitation Professional CCRP

AACVPR CR Program Guidelines, 5th edition, **2013**, cha 10, pg 209

Preferred Qualifications for following program staff:

- Program Director (Master's degree preferred)
- RN
- Exercise Specialist -Bachelor's in exercise science (CES preferred)
- Exercise Physiologist-Master's in exercise physiology (RCEP preferred)
- PT (ABPTS CV & Pulmonary Specialist certification preferred)
- RT
- ***And preferred for all disciplines-***

Certified Cardiac Rehabilitation Professional CCRP

"Advanced knowledge of exercise physiology, nutrition, risk factor modification strategies, counseling techniques, and uses of behavioral change programs and technologies as applied to CR/SP services and defined in the AACVPR Core Competencies position statement"

- i.,e., today's CCRP certification

Why Professional Certification?

Certification is:

- A standard within health care
- Frequently profession-wide to allow for:
  - Application of professional standards
  - Improve the quality of practice
  - Protect the public

Why CCRP?

- Provides opportunity to review and expand professional knowledge & skills
- Emphasizes your ability to provide quality care in a specialized area
- Indicator of your level of professionalism & dedication to the field
- It’s personal & portable

Professional Certification for Cardiac Rehabilitation

- *Profession*: *A calling requiring specialized knowledge and often long academic preparation.*

  Merriam-Webster Dictionary

- *Excellence is the gradual result of always striving to do better.*

  Pat Riley

4. Strategic Planning for CR

Cardiac Rehabilitation

The provision of comprehensive long-term services involving medical evaluation, prescriptive exercise, cardiac risk factor modification, and education, counseling, and behavioral interventions.

CR Clinical Guidelines; Agency for Healthcare Policy & Research (AHCPR), HHS, 1995

Strategic Question #1

Is your program ready to move from volume to value in Medicare payments?

Value Based Purchasing

From Health & Human Services (1-26-15)

- 2016: 85% of fee-for-service payments tied to quality & value
  - –2018=90%
- 2016: 30% of all Medicare provider payments will be under *alternative care payment model*
  - –2018=50%

Value Based Purchasing-VBP

"Alternative care payment model" = payments based on **quality** of care, not **quantity**

- Accountable Care Organization (ACO)
  - Doctors, hospitals, & health care providers coordinate care with goal of *right care at the right time*, avoiding unnecessary duplication of services and preventing medical errors

Value Based Purchasing-VBP

- Patient Centered Medical Home
  - Partnering with community resources
- Bundled payment for “Episode of Care”
  - CR ready to be part of bundle?

Reimbursement Based on Value

- All-cause readmission penalties in effect
  - AMI, HF, COPD
  - CABG coming in 2017
- Meaningful outcomes will define “value”
- AACVPR CR Registry and payers will define “meaningful”
- Ability to benchmark with other programs within Registry

Strategic Question # 2

Is your program delivery model ready to:

- Foster self-management skills?
- Individualize the service you provide?
- Meet growing demand?

Teaching Self Management Skills?

How do we modify the Cardiac Rehab model to promote self efficacy for multiple behavior changes, long term adherence to those behavior changes and avoid programmed failure?

Self Efficacy

Self Efficacy – Behavior Change

– Bandura A. 1994

- The self knowledge that our participants have that they can change their own behaviors
- Empower participants to change their own behavior - Coaching!
- “Self-care confidence”

Self Efficacy

Aren't we in the business of fostering self-change?

- Exercise
- Lipid Management
- Dietary Fat
- Weight Loss
- Blood Sugar Control
- Stress Management
- Relaxation Techniques
- Smoking Cessation
- Medication Adherence

Why Now?

- What we've been doing isn't working
- Focus is increasingly on long-term outcomes
- Behavior change leads to reduced hospital re-admissions
  - 80% of HF re-admissions are due to behavior non-adherence

Individualized Services

- ITP
- Appropriate use of ECG monitoring
  - Conclusion: “Programs that emphasize highly supervised exercise including longer term use of continuous ECG monitoring may impair self-efficacy for independent exercise.”
    - Carlson JJ, Norman GJ, Feltz DL, et al. Self-efficacy, psychosocial factors, and exercise behavior in traditional versus modified CR. *JCR*. 2001;21:363-373.
  - “We are ECG-addicted.”
    - Nashville, 2013-Mark Vitcenda, UW-Madison

Individualized Services

- 1x/wk to 5x/wk-open access
- Up to 9 months for phase II to long-term maintenance
  - Conclusion: “21% of CR participants failed to improve peak VO2 primarily due to exercise training performed at lower relative intensity despite similar RPE. …alternative training protocols should be considered.”
    - Savage PD, Antkowiak M, Ades PA. Failure to improve cardiovascular fitness in CR. *JCRP*. 2009;29:284-291.

Individualized Services

CPT 93797 is intended for group or 1:1-

- Integrated psychosocial consultation-treatment
- Nutritional counseling

Time for New Phase II Model?

Does your Phase II contribute to:

- programmed failure

or

- Smooth transition and long-term success in maintenance (Phase III/IV) and home exercise

Strategic Question # 3

Is your program cost-efficient enough to operate in the black?

- Serve other pt populations
  - Self-pay “safe-start” phase III
  - PAD
  - Pre & post gastric bypass
  - Diabetes management

Strategic Question # 3

Traditional CR programs are “loss leaders”

- Cost $100/session to deliver
- Study found the lowest costs/pt by matching capacity to demand
  - Can we afford a 4-5 week waiting list for phase II?
    - Lee AJ, Shepard DS. Costs of CR & enhanced lifestyle modification programs. *JCRP*. 2009;29:348-357.

Strategic Question # 3

Is your program staff-efficient?

- Lots of unnecessary repetitive documentation and paperwork in 2015
- Unnecessary ECG-monitoring
- Down time in facility
- Is capacity meeting demand?

Strategic Question # 4

Has your program incorporated the latest science & current regulations?

- HIIT
  - Keteyian SJ, Hibner BA, Bronsteen K, et al. Greater improvement in cardiorespiratory fitness using higher-intensity interval training in standard CR setting. *JCRP*. 2014;34:98-105.
- Inverse relationship between CR participation and adverse cv events
  - Hammill, BG, Curtis LH, Schulman KA, Whellan DJ. Relationship between CR and long-term risks of death and MI among elderly Medicare beneficiaries. *Circ*. 2010;121:63-70.

In Conclusion

"It is time to rebrand and reinvigorate. CR of the future must be a patient-centered, comprehensive secondary prevention program delivered through a variety of easily accessible care models that emphasize the value of CR in healthcare outcomes and cost effectiveness."

Sandesara PB, Lambert CT, Gordon NF, et al. Cardiac Rehabilitation and Risk Reduction. *JACC*. 2015;65: 389-95.