

# How to Survive and Grow Your Rehabilitation Program Through 2013

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# Points to Consider Today

- Current policy and political issues effecting Cardiac and Pulmonary Rehabilitation Services
- Options to enhance program survival and growth

# Current policy and political issues effecting Cardiac and Pulmonary Rehabilitation Programs

Federal Health Care Law (Obamacare) and Health Care and Education Reconciliation Act: Passed in March, 2010 and upheld in the Supreme Court in June, 2012



Patient Protection and Affordable Care Act (PPACA)

# Federal Health Care Law Mandates

1. Decrease the number of uninsured Americans
2. Reduce overall costs of health care
3. Improve health care outcomes
4. Streamline delivery of health care services

# Patient Protection and Affordable Care Act (PPACA)

- Items enacted at various time intervals between 2010 and 2020
- PPACA required insurance companies to:
  1. Cover all applicants for insurance
  2. Offer same insurance rates regardless of pre-existing conditions or gender

# Highlighted Federal Health Care Law Enactments to Date

1. Reimburse purchase of generic drugs
2. Create task forces on “Preventative Services and Community Prevention Services” to develop, update, and disseminate evidence-based recommendations on the use of clinical and community preventive services
3. Chain restaurants and food vendors required to display caloric content of foods as well as saturated fat, carbohydrates, and sodium contents (i.e. McDonalds)
4. Department of Health and Human Services (HHS) has developed the “National Prevention, Health Promotion and Public Health Council” to develop a national prevention and health promotion strategy... Chaired by the Surgeon General

# Federal Health Care Law Enactments to Date

5. Children may stay on parents health care policy until age 26
6. Insurance will pay for preventative care and medical screenings, especially women's screening, i.e. mammograms, colonoscopies
7. Cannot drop insurance when insurer is sick
8. Insurance must cover childhood immunizations and adult vaccinations
9. Flexible spending accounts cannot be used for OTC drugs
10. Hospitals will incur fines for 30 day readmissions for 3 diagnoses (acute MI, heart failure, pneumonia) on progressive scale of 1%, 2%, 3% over a period of time

# Federal Health Care Law Enactments in the Future

- Oct. 2013: Providers will be paid based on quality of care rather than amount of care (assessed by patient satisfaction instruments)
- 2014: No discrimination of insurance coverage based on gender or pre-existing medical conditions
- 2014: Eliminate lifetime and annual dollar limits on benefits
- Limit age rating: an older individual can only pay 3 times as much as a younger person (currently pay 5 – 7 times higher) [AARP.org](http://AARP.org)
- Health insurance not necessarily less costly \*



# Federal Health Care Law Enactments in the Future

- Health Insurance operated by state exchanges: offering more competition and transparency \*
- ACA will supposedly provide subsidies and payment supports to lower-income citizens \*
- 2015: Medicare payments will increase for Physicians who provide a high quality of care compared to cost
- 2018: All insurance plans must cover preventive care and check-ups without co-pays
- 2020: Medicare Part D (medication donut hole) will be completely phased out

\* USA Today 12/28/12

# United States Congressional Budget Office

- Patient Protection and Affordable Care Act (PPACA) will:
  - Decrease the overall budget deficit
  - Decrease medicare spending

# Clinical Trends on the Local Level

- AACVPR Health Policy and Reimbursement Update
  - Medicare Cardiac Rehab Payment—Hospital Setting
    - CPT 93797 and 93798: \$79.91 (effective Jan. 2013)
    - National average, will vary by geographic location
    - Co-payment for secondary insurance or out-of-pocket: \$15.99
    - Must use KX modifier for > 36 sessions

# Clinical Trends on the Local Level

- AACVPR Health Policy and Reimbursement Update
  - Medicare Pulmonary Rehab Payment for COPD—  
Hospital Setting
    - G0424: \$39.31
    - Co-Payment: \$7.02
  - MD supervision required: payment varies
  - 36 sessions, 72 sessions/lifetime with kx modifier

# Medicare Respiratory Therapy Codes

- May be used for non-COPD respiratory disease medicare billing
  - Timed codes G0237, G0238: \$35.09 per 15 minutes
  - Un-timed group therapy code G0239: \$35.09 (1x/session)
  - Co-Pay: \$7.02
- MD supervision not required: no cost

# Medicare Physical Therapy Codes

- May be used for non-COPD respiratory disease medicare billing
  - Timed CPT codes: Depends on geographical region of USA
- MD supervision not required: no cost

# CPT Code Reimbursement by Region

CPT Code	NC	AZ	San Francisco	Los Angeles	MA
PT Eval (1x/episode) 97001	\$70.74	\$72.87	\$86.79	\$79.15	\$78.35
Ther Ex (per 15 min) 97110	\$29.44	\$30.31	\$36.96	\$33.37	\$33.01
Group (1x/session) 97150	\$18.89	\$19.52	\$23.91	\$21.52	\$21.32
Ther Act (per 15 min) 97530	\$32.25	\$33.30	\$41.23	\$36.95	\$36.57
Phys Perf Test (per 15 min) 97750	\$30.86	\$32.00	\$38.70	\$34.99	\$34.72

# What about Medicaid?

- Cardiac Rehabilitation (93797 and 93798) is allowed 6-36 sessions in N.C. following approval
- For use of 97000 CPT and G237,G238, G239 codes: Requires approval of sessions and # of sessions
- **“Optional benefits”** for Medicaid recipients: Physical Therapy, Occupational Therapy, Respiratory Care, Speech/hearing/language disorders, Preventive and Rehabilitative Services
- Varies state by state
- [www.medicaid.gov](http://www.medicaid.gov)



# Difficulties for Patients Attending Cardiac and Pulmonary Rehab Insured by Medicare and/or Private Insurance

- Large co-pays required by private insurance companies
- Limited sessions for each episode or per year
- Cap on \$ reimbursement
- Not understanding benefits
- Unaware of right to appeal insurance denials
- Low premiums usually mean high co-pays, large deductibles

# Difficulties for Providers of Cardiac and Pulmonary Rehab

- Lack of knowledge of medicare/medicaid and the multitude of private insurance policies and benefits
- Time to learn these benefits and communicate with providers and policy holders
- Understanding the maze of insurance language, treatment requirements/exceptions, and appeals processes
- Understanding the complexities of billing codes, modifiers, and reimbursement
- Keeping up with the ever-changing health care policies

# Difficulties for Providers of Cardiac and Pulmonary Rehab

- Patients not knowing about rehabilitative services
- Patients not knowing that their insurance pays for rehabilitative services
- Unwillingness or inability of patients to pay out of pocket for services
- Lack of referral to rehabilitation by primary care providers
- Family or home-based deterrents to attending rehabilitation

# What can Rehabilitation Providers Do?

- Within your rehabilitation program:
  - Educate yourselves on the vocabulary----and realities--  
--of insurance coverage
  - Study patient's insurance policies with them---- tell  
them what good coverage looks like
  - Initiate the conversation about costs
  - Assemble an interdisciplinary team to be able to take  
advantage of various billing options and program  
models
  - Build relationships with local coverage determination  
(LCD) medical directors to explain services and initiate  
dialogue around payer's policies

# What can Rehabilitation Providers Do?

- Work with local hospital discharge planning committees to encourage automatic referrals to cardiac and pulmonary rehabilitation programs
- Work with local hospitals to flag admissions/discharges with cardiac and pulmonary diagnoses eligible for rehabilitative services
- Make regular visits to the hospital to speak with patients about out-patient rehabilitation services and provide written information
- Open dialogue with local hospital administrators about readmissions and outline services and rehabilitation personnel available to deliver post-discharge rehabilitative services to target populations
- Provide in-services and brochures to in-patient therapy groups (Respiratory Care and Physical Therapy), discharge planners (RNs), and out-patient Physician and clinic groups

# What can Rehabilitation Providers Do?

- Offer smoking cessation classes to participants and community members (Smoking Cessation educator on staff)
- Get involved in support groups, Better Breathers Clubs
- Offer community screenings and educational sessions
- Offer individualized Physical Therapy services following hospital discharge or acute exacerbations for those patients too weak or too debilitated to attend group rehabilitation
- Offer individualized Physical Therapy services to cardiac or pulmonary patients with neuromuscular impairments unable to attend group
- Transition those patients into group rehabilitation when stronger
- Offer interdisciplinary services (which include physical Therapy) using 97000 billing codes to provide rehabilitation to the Heart Failure population

# What can Rehabilitation Providers Do?

- Offer optional hours for Cardiac/Pulmonary rehabilitation that are participant friendly: early morning, nights, weekends
- Coordinate MD coverage (cost): Medicare Cardiac and Pulmonary participants exercise at the same time using the same Physician
- Provide short-term Asthma programming at night and/or weekends (Asthma educator on staff)
- Provide out-of-pocket payment programs for Stage I COPD
- Provide out-of-pocket payment graduate/maintenance rehabilitation programs
- Network with others through health care professional organizations (AACVPR, APTA, AARC, ACCP, ATS, etc.)
- Keep up-to-date by reading websites
  - [www.cms.gov](http://www.cms.gov)

# References

- [www.medicare.gov](http://www.medicare.gov)
- [www.medicaid.gov](http://www.medicaid.gov)
- [www.aacvpr.org](http://www.aacvpr.org)
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