February 27, 2017

TO: Carol Blackford

RE: Pulmonary Rehab APC Assignment

This recommendation is a consensus of the American Association for Respiratory Care, the American Thoracic Society, CHEST/The American College of Chest Physicians and the National Association for Medical Direction of Respiratory Care.

Pulmonary rehabilitation is a covered service under the Medicare benefit, supported by a specific benefit category approved by the Congress in 2008 with formal implementation January 1, 2010. As part of that formal implementation CMS created HCPCS code G0424, a bundled code encompassing the broad set of services integral to pulmonary rehabilitation. As the chart below indicates, there has been conspicuous inconsistency in the way CMS regards pulmonary rehabilitation services in terms of APC assignment and status indicator. It had enjoyed its own APC until recently, when it was linked to a variety of other services. For 2017 it is included in APC #5733 (Level 3 Minor Procedures), along with 60+ procedures that have virtually no clinical coherence or resource utilization comparable to pulmonary rehabilitation.

SI	**Year**	**G0424**	**APC/# of codes**
S	2010	$50.46	102 (1)
S	2011	$62.98	102 (1)
S	2012	$37.43	102 (1)
S	2013	$39.31	102 (1)
S	2014	$35.35	077 (6)
Q1	2015	$52.35	0340 (50+)
Q1	2016	$55.94	5733 (50+)
S	2017	$54.53	5733 (60+)

For comparison, we point to cardiac rehabilitation services, a similar service that differs from pulmonary rehabilitation primarily by its qualifying criteria and outcome measurements. For example, to qualify for pulmonary rehabilitation the patient must have moderate, severe or very severe COPD. Cardiac rehabilitation's qualifying criteria generally focus on rehabilitation after an acute event. CMS' perspective on clinical similarities shows two policies virtually identical, as demonstrated in the table below. Despite the similarities, cardiac rehabilitation has enjoyed its own APC over the identical timeframe (2010-2017).

	CARDIAC REHAB - **42 CFR 410.49**	PULMONARY REHAB - **42 CFR 410.47**
DEFINITION	MD-supervised program that furnishes MD-prescribed exercise cardiac risk factor modification, psychosocial assessment, outcomes assessment	MD-supervised program that furnishes MD-prescribed exercise designed to optimize physical and social performance and autonomy, psychosocial assessment,

		outcomes assessment
INDIVIDUALIZED TREATMENT PLAN	Written plan tailored to each individual patient that includes description of diagnosis; type, amount, frequency, and duration of items and services furnished under the plan; established, reviewed, and signed by a physician every 30 days	Written plan tailored to each individual patient that includes individual's diagnosis; type, amount frequency, and duration of items and services under the plan; goals set for the individual under the plan; established, reviewed and signed by a physician every 30 days
OUTCOMES ASSESSMENT	Evaluation of progress as it relates to individual's rehab, including assessments from commencement and conclusion of CR, objective clinical measures of exercise performance and self-reported measures of exertion and behavior	Evaluation of patient's progress as it relates to individual's rehab, including beginning and end evaluations based on patient-centered outcomes, objective clinical measures of effectiveness of PR program including exercise performance and self-reported measures of shortness of breath and behavior
PSYCHOSOCIAL ASSESSMENT	Evaluation of individual's mental and emotional functioning as relates to individual's rehab, includes assessment of those aspects of individual's family and home situation that affects rehab treatment, and psychosocial evaluation of individual's response to and rate of progress under treatment plan	Evaluation of individual's mental and emotional functioning as relates to individual's rehab or respiratory condition; includes assessment of those aspects of individual's family and home situation that affects rehab treatment, and psychosocial evaluation of individual's response to and rate of progress under treatment plan
PHYSICIAN-PRESCRIBED EXERCISE	Aerobic exercise combined with other types of exercise (strengthening, stretching) as determined appropriate for individual patient	Aerobic exercise that improves or maintains an individual's pulmonary functional level; includes techniques such as exercise conditioning, breathing retraining, step, and strengthening exercises
DURATION	Up to 36 sessions, maximum 2 sessions per day, over period up to 36 weeks	Up to 36 sessions, maximum 2 sessions per day; an additional 36 sessions are authorized if medically necessary

The most important clinical differences between cardiac and pulmonary rehabilitation are these aspects related to pulmonary rehabilitation:

- Rehabilitation potential is much greater for heart disease than COPD.
    1. Lower intensity exercise prescription, resulting in slower progress;
    2. Pulmonary patients sicker (higher acuity) more exacerbations, more sick days;
    3. Less adherent; more absences hinder progress;

4. Higher level of supervision and staff-to-patient ratio required (oxygen tanks, slower progress, less ability to be independent;

- Psychological challenge of the chronic nature of pulmonary disease that will not improve.
- More education-counseling needed (group and 1:1)
    1. Medications, inhaler devices, etc.
    2. Less ability to achieve self efficacy.

Financial Impact on Medicare: We conducted a thorough analysis of Medicare data relevant to the two rehabilitation programs, which we summarized in the table below:

	Description	SI	Number of Singles	Geometric Mean Cost
New APC	**Cardiac & Pulm. Rehab**		**3,331,303**	**$98.37**
93797	Cardiac Rehab	S	121,962	$92.92
93798	Cardiac Rehab/monitor	S	2,769,228	$111.28
G0424	Pulmonary Rehab	S	440,113	$46.03

Given the strong similarities among these two sets of services, we recommend that CMS merge pulmonary rehabilitation services (G0424) and cardiac rehabilitation services (CPT 93797, 93798) into one unique APC.

If the Agency determines to accept our recommendation and the methodology used in 2015 (the year in which most recent data are available), there would be three critically important financial implications for the rehab community:

1. Pulmonary rehab will experience a significant increase in APC payment;
2. Cardiac rehab will experience a reduction in APC payment of approximately 10%;
3. Aggregate payment for the two services would be reduced by approximately $17M. This calculation is based on Medicare payment IF the payments were based on separate APCs using the approximate calculations above, compared to a combined payment noted in the table.

Two times rule: We fully recognize that this recommendation, if adopted, could lead to a violation of the two-times rule. As the table above indicates, the geometric mean cost (2015 data) for G0424 is $46+ while the geometric mean cost for 93798 is $111+. We strongly urge the Agency to specify a waiver to the two times rule to accommodate these services in the same, unique APC, per our recommendation.

Please feel free to contact me if you have any questions regarding this recommendation.

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