



AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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September 17, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1751-P
Mail Stop C4-26-05
7500 Social Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1753-P: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payments and Quality reporting Programs

Dear Administrator Brooks-LaSure:

The American Association for Respiratory Care (AARC) is pleased to offer comments on the subject proposed rule. The AARC is a national professional organization with a membership of over 40,000 respiratory therapists. Respiratory Therapists are educated, trained, and licensed professionals who employ scientific principles to identify, treat and prevent acute or chronic dysfunction of the cardiopulmonary system and are key among the clinical staff that provide hospital outpatient pulmonary rehabilitation (PR) services.

We appreciate the many challenges CMS has faced during the public health emergency and commend the agency for the numerous flexibilities it implemented to allow better care and access to critical treatments for Medicare beneficiaries suffering from acute and chronic conditions. Our comments on the proposed rule focus on two issues: 1) APC placement of the new CPT codes for PR services, and 2) temporary policies to address the COVID-19 public health emergency (PHE) as they relate to virtual direct physician supervision and virtual services related to PR.

I. APC Placement of New CPT Codes for Pulmonary Rehabilitation

In the addenda to the HOPPS proposed 2022 update, CMS proposes to place the new CPT codes for pulmonary rehabilitation in APC 5733, Level 3 Minor procedures at a payment rate of \$57.17, consistent with placement and payment in previous years. By comparison, this classification group also includes services such as color vision exam, trimming nails, removing impacted ear wax, and treatment for a vaginal infection. We believe this placement should be

changed given the increased values assigned to the new codes and the lack of clinical similarity among the services within the assigned group.

RECOMMENDATION:

We recommend CMS place the new CPT codes for pulmonary rehabilitation in the same APC with cardiac and intensive cardiac rehabilitation (CR/ICR), APC 5771.

Rationale: CPT code 946X1 is described as “Physician or other qualified health care professional services for outpatient pulmonary rehabilitation, without continuous oximetry monitoring, per session. CPT code 946X2 is similar except it is with continuing oximetry monitoring, per session. The descriptors are consistent with the CPT codes established for cardiac rehabilitation which reflect physician and practitioner services with and without continuous electrocardiographic (ECG) monitoring, per session. Additionally, PR and CR/ICR programs are subject to many of the same statutory requirements. In fact, CMS is proposing to make numerous conforming changes to regulatory text and definitions in acknowledgment of the similarities between these two programs so stakeholders can more easily compare requirements.

Since the inception of the PR benefit in 2010 and the creation of HCPCS code G0424, CMS has acknowledged in rulemaking (75 FR 74224) that hospitals that did not “carefully construct the charge for a new code that represents a combination of services that were previously reported separately...under-represents the cost of providing the service.” We believe that a lack of understanding in developing accurate charges over the years has led to lower reimbursement than cardiac rehabilitation even though both programs require the same five components. This has resulted in the placement of PR in an APC that is not reflective of the actual costs that go into providing the services, the consequence of which has resulted in low utilization rates compared to cardiac rehabilitation.

In the proposed update to the physician fee schedule for CY 2022, CMS acknowledges that these new codes replace HCPCS G0424 and reflect a commensurate increase in work relative values or clinical labor time as well as refinements in equipment time, although the RUC recommendations reflected higher values. Regardless, the bottom line is the discrepancies in costs between the new CPT codes for PR and the APC payment of \$57.12, will become even greater as new labor cost data is implemented. The similarity in specialized exercise training, physiologic monitoring of various parameters, and individualized education/counseling for these patient populations with numerous monitoring that cross-over to both services is obvious. In fact, space and qualified staff are frequently shared.

For these reasons, we recommend CMS place the new PR CPT codes in the same APC with CR/ICR that more accurately reflects services that are clinically comparable in terms of resource use than the current placement of PR in APC 5733 and would not violate the 2 times greater than the lowest median cost rule.

II. Temporary Policies to Address the COVID-19 Public Health Emergency (PHE)

CMS is seeking input from stakeholders regarding the feasibility to make permanent various flexibilities CMS instituted through PHE waivers that will expire at its conclusion. The AARC

extends its thanks to CMS on its numerous policy revisions, especially allowing hospital outpatient PR services furnished by respiratory therapists and others to be furnished in a patient's home under the direct "virtual" supervision of the physician. This has enabled our most vulnerable patients in rural areas to continue to receive the care they need without traveling long distances and putting themselves in danger of potential exposure to COVID-19. In response to CMS' request for input around these policies, we offer the following recommendations.

RECOMMENDATIONS:

- **Current enhanced access to PR via virtual delivery should be extended into 2022 as health care in the US moves increasingly to effective telehealth models.**
- **We strongly recommend that CMS continue to allow direct supervision to be met via virtual presence beyond the PHE and ultimately on a permanent basis.**
- **CMS should use a service-level modifier when direct physician supervision is being met via real-time audio/video communications technology to enhance data collection.**

Rationale: Some PR programs were forced to move out of the hospital to make room for COVID patients. This virtual option of direct supervision has allowed hospitals to provide PR at hospital outpatient off-campus locations where a physician is not physically and immediately available. It has particularly provided improved access to PR services in rural and critical access hospitals (CAH) through expanded hours that, under the temporary waiver, are not restricted to the provision of services only when a physician is immediately and physically available. Furthermore, the safety of pulmonary rehabilitation is well-substantiated and anecdotal evidence to date that suggests there have been no medical emergencies with direct supervision delivered via virtual audio-visual telecommunication technology.

Recognizing that the large majority PR programs are in the hospital outpatient setting, it will be critical that virtual direct supervision be an option for *both* the outpatient and physician office setting on a permanent basis. This is especially important because these valuable programs have proven not only to improve health outcomes and quality of life, but a recent study [Lindenaur, et al JAMA. 2020 May 12;323(18):1813-1823] shows a 37% drop in mortality in those who received pulmonary rehabilitation within three months of hospital discharge. We believe it will be evident that the quality and safety of pulmonary rehabilitation services are not negatively affected and, in fact, access to these services is improved with a virtual option for direct supervision requirements.

With waivers adopted during the pandemic, the flexibility to deliver PR sessions via virtual real-time communications technology has benefitted PR beneficiaries throughout the U.S. Anecdotal information and early research suggests beneficiaries have exhibited improved adherence due to removal of previously identified barriers such as travel, time, restricted PR space, expenses, and other deterrents to utilization and continued use is essential in meeting the incredible clinical challenges posed by patients with COVID as well as continuing to safely care for our patients with other non-COVID respiratory conditions.

Real-time (synchronous) virtual delivery of PR requires the flexibility to meet the direct supervision requirement via virtual presence using real-time audio-visual technology. Because

many PR programs have not had the bandwidth to expand to virtual delivery during the PHE, data on outcomes in comparison to center-based rehabilitation are in the early stages of assessment. Given the current rise in COVID-19 cases due to the delta variant, it is critical that the virtual delivery of pulmonary rehabilitation continue, especially as safety has not been an issue and there is strong evidence that the virtual delivery of services is an important aspect in improving patient outcomes.

The current situation of having little data on utilization illustrates the usefulness of a modifier to better understand the extent to which virtual direct supervision is being used for CR/ICR/PR services. Use of the temporary PR telehealth code (physician office setting) and remote delivery of rehabilitation sessions under the Hospitals without Walls waiver do not adequately track current utilization of remote rehabilitation sessions. The degree of virtual direct supervision and remote delivery will be an estimate at best. This will be critical data to have going forward to address new virtual models of care.

The AARC appreciates the opportunity to provide these comments and look forward to CMS' consideration of our recommendations in the final rule.

Sincerely,

A handwritten signature in cursive script that reads "Sheri Tooley".

Sheri Tooley BSRT, RRT, RRT-NPS, AE-C, CPFT, FAARC
President and CEO 2021-2022