Chronic Obstructive Pulmonary Disease (COPD) Finance Webinar

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Lindsay Corcoran, MHA

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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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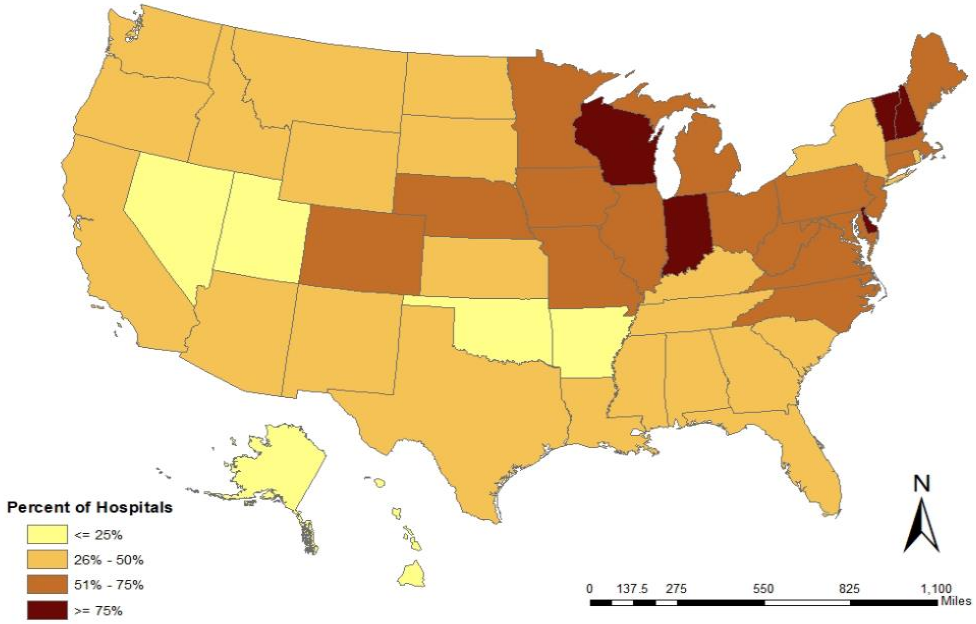
- Pulmonary rehabilitation is a supervised program that includes **exercise training, health education, and breathing techniques** for people who have certain lung conditions (COPD) or lung problems due to other conditions
- Goal is to **improve the physical and psychological condition** of people with 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 Sta 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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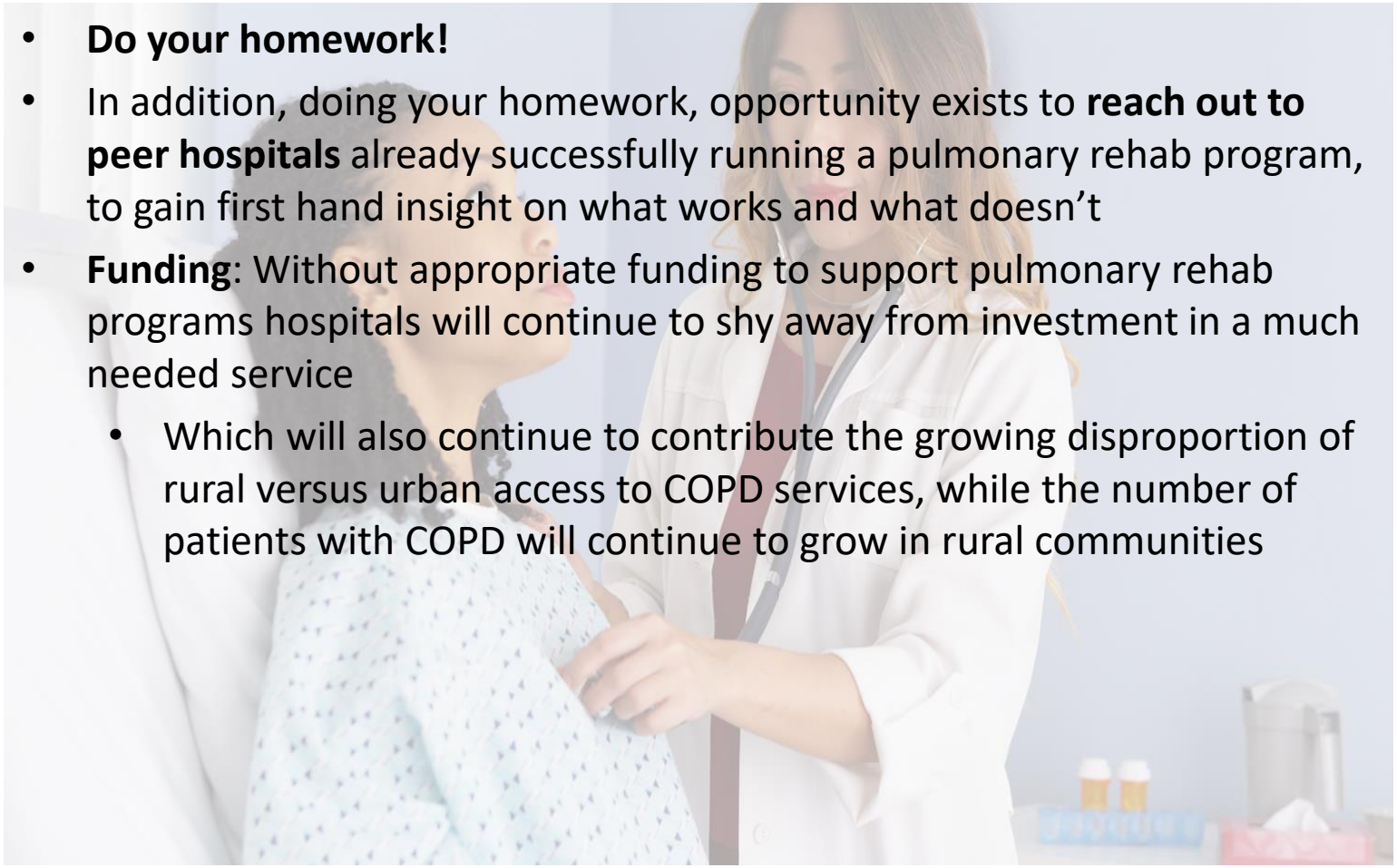
- **Up-to-date resources related to pulmonary rehab services:**
  - CMS/Medicare Administrator Contractor (MAC)
  - Professional associations
    - Evidence-based clinical best practices
    - Regulatory updates
    - Continued education
      - American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)
      - American Association of Respiratory Care (AARC)
      - American Thoracic Society
      - COPD Foundation
  - Internal expertise

Conclusion



- **Do your homework!**
- In addition, doing your homework, opportunity exists to **reach out to peer hospitals** already successfully running a pulmonary rehab program, to gain first hand insight on what works and what doesn't
- **Funding**: Without appropriate funding to support pulmonary rehab programs hospitals will continue to shy away from investment in a much needed service
  - Which will also continue to contribute the growing disproportion of rural versus urban access to COPD services, while the number of patients with COPD will continue to grow in rural communities

Questions?

Lindsay Corcoran, MHA
Senior Consultant
Stroudwater Associates

(T/F) 207-221-8262
(C) 207-939-7414
lcorcoran@stroudwater.com
www.stroudwater.com