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CHEST 2009
*The Seventy-fifth Annual
International Scientific Assembly
October 31-November 5, 2009
San Diego, California*

August 31, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1414-P (July 20, 2009)
7500 Security Blvd., Mail Code C4-26-05
Baltimore, MD 21244-1850

**Re: CMS-1414-P Medicare Program; Proposed Revisions Under the
Physician Fee Schedule and Other Revisions to part B for CY 2010**

Dear Ms. Frizzera:

The American College of Chest Physicians (ACCP) welcomes the opportunity to submit comments on the proposed rules under both the Outpatient Prospective Payment System and the Medicare Physicians Fee Schedule for 2010. The ACCP's membership is comprised of over 17,500 physicians and allied health professionals whose everyday practice involves diseases of the chest in specialties of pulmonology, cardiology, thoracic and cardiovascular surgery, critical care medicine, sleep and anesthesiology. These health care professionals practice in virtually every hospital in this country, and many of the physicians head major departments in these hospitals. As a multidisciplinary society, the ACCP offers broad viewpoints on matters of public health and clinical policy in cardiopulmonary medicine and surgery.

We welcome the opportunity to comment on the proposed rule outlining coverage and payment proposals for pulmonary rehabilitation, in accordance with Section 144 of PL 110-275. Our comments focus on three primary areas related to coverage, duration, and payment. Importantly, there are numerous areas of the proposed regulation that we support and we highlight those areas as well.

Proposed Payment: CMS proposes to establish a new HCPCS code that will crosswalk to a "new technology" APC, with the new, bundled code replacing existing G codes 0237-39. The new code would only be permitted for a billable service once per day. Additional services appropriate for pulmonary rehabilitation and currently covered when

medically necessary include, for example, 94620, 94664 and 94667 are no longer billable.

Comment: While we understand the principle of proposing a single, bundled code for pulmonary rehabilitation services, the proposal is seriously flawed:

- The current G codes that will be replaced are 15 minute increment codes that pay approximately \$18-\$20/15 minutes. The new code pays \$15 for a one-hour increment of service, a full 78% payment reduction from current levels.
- The assignment of the new HCPCS code to APC 1492 New Technology – Level 1B (\$10-\$20) is also seriously flawed from both a factual and policy perspective. The HCPCS G0237-G0239 respiratory therapy codes were crosswalked to APC 970 as a “new technology” in CY 2002 at a payment rate of \$25 (per 15 minute increment), paying \$100 per hour. To reassign these services to “new technology” is neither accurate nor appropriate as CMS does have extensive experience with many of the varied components of pulmonary rehabilitation. As far back as 1981 then HCFA recognized pulmonary rehabilitation services as a legitimate covered service, so identifying a single code that replaces codes that have been in place for 8 years as “new technology” simply does not meet any reasonable level of logic. In fact, the classification of G0237-G0239 to the new technology APC in 2002 ended quickly, with the codes crosswalking to a “respiratory procedures” APC in 2004.
- The premise that the new, proposed code somehow mirrors both the estimated resources and work intensity associated with cardiac rehabilitation is not valid. In the context of equipment, we acknowledge that there are some similarities, but a comprehensive pulmonary rehabilitation program includes not only a treadmill, oximeter with printer, and one channel ECG monitor, but exercise bicycles, both upright and recumbent, arm ergometers, exercise bands, and frequently Stairmaster type equipment. Importantly, many hospitals also require the pulmonary rehabilitation department to have its own dedicated emergency cart/resuscitation equipment.
- Equally important is the fact that, if instituted, this payment system for Pulmonary Rehabilitation will cause many current programs to shut down and prevent new programs from forming. This would effectively eliminate this mandatory Medicare benefit as a treatment option for our patients sick with COPD and other pulmonary diseases such as Cystic Fibrosis, which greatly benefit from pulmonary rehabilitation.

Alternatives for consideration. We are troubled with the approach that CMS has taken. We believe there are two, more logical and appropriate pathways to consider.

1. Continue use of the current G codes G0237-G0239; continue use of the current policy that permits component billing of related services such as 94620, 94664 and 94667; and permit the physician to submit an appropriate E/M code when physician work is appropriate and medically necessary.
 - Outcomes assessment is, according to the proposed PFS rule, a physician evaluation service.
 - The intake assessment may be conducted by a physician or pulmonary rehabilitation staff, dependent upon specific patient characteristics. In the case that a physician assessment is appropriate because of patient complexity, current CMS policy does permit physician billing of an appropriate E/M code.
2. Rather than crosswalk to “new technology” APC 1492, crosswalk the codes to APC 78, Level II pulmonary treatment. This will permit CMS to bundle the services associated with pulmonary rehabilitation, exclusive of separately billable physician work. Currently, the APC 0078, Level II Pulmonary Treatment, crosswalks to three distinctly different respiratory procedures. The procedures and associated HCPCS codes are:

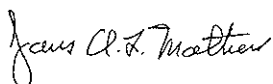
- | | |
|-------|--|
| 94060 | Bronchodilator responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration |
| 94642 | Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment of prophylaxis |
| 94660 | Continuous positive pressure ventilation (CPAP), initiation and management |

Like pulmonary rehabilitation, each of these procedures involves patient evaluation and patient instruction by specially trained professionals. When performing pre- and post-bronchodilator spirometry, the patient is instructed how to perform the test, and the results are evaluated by trained staff for effort and reproducibility. Aerosol inhalation also requires a component of patient education and trained staff is available to assess for adverse reactions. In the case of CPAP initiation and management, modifications are instituted in the mode of therapy depending on the individual patient’s response.

Pulmonary rehabilitation encompasses all of these activities: patient instruction, evaluation, and on-going program modification to meet the individualized needs of the patient.

ACCP appreciates the opportunity to comment on the proposed rules under the Medicare Physician Fee Schedule. Should you or your staff have any questions, please do not hesitate to contact me, or Lynne Marcus, Vice President of Health Affairs, at lmarcus@chestnet.org. Her telephone number is 847-498-8331.

Sincerely,



James A.L. Mathers, Jr., MD, FCCP
President, American College of Chest Physicians

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<http://edocket.access.gpo.gov/2009/pdf/E9-15882.pdf>