Setting the Record Straight

Part 1: Clarification of HR 2619

To the Editor:

As President of the American Association for Respiratory Care, I wish to set the record straight regarding a recent point/counterpoint debate appearing in *CHEST* (February 2014).1-4 Courtright and Manaker’s2,4 discussion has been clouded with errors, omissions, and misperceptions.

To be perfectly clear, the American Association of Respiratory Care has never submitted legislation to allow respiratory therapists (RTs) to practice independently and bill Medicare directly for their services, nor do we intend to. In fact, HR 2619, the Medicare Respiratory Therapist Access Act,5 does the exact opposite because it would require the physician to provide direct supervision of the RT and for the physician to bill and be paid directly by Medicare for the RT’s services.

What exactly does HR 2619 do?

- It provides coverage of pulmonary self-management education and training services in physician practices to Medicare beneficiaries with COPD, asthma, pulmonary hypertension, pulmonary fibrosis, and cystic fibrosis when furnished by registered RTs who hold either a bachelor’s or other advanced degree in a health science field.
- It improves Medicare beneficiaries’ access to RTs when they visit their physician.
- It establishes a separate benefit for pulmonary patients much like the diabetes outpatient self-management training program established by Congress many years ago.
- It requires the physician to determine whether patient self-management is needed or whether the patient has the necessary skills to self-manage.
- It takes the guesswork out of physician reimbursement and gives physicians confidence to add RTs to their team at a time when physician shortages are expected to increase.

Reducing costly hospital readmissions is a critical issue facing the Medicare program. Beginning October 1, 2014, COPD, which is one of the most costly pulmonary diseases, will be added to the list of conditions subject to the hospital readmissions reduction penalty. For patients with chronic lung disease, a key to reducing costly ED visits and hospital admissions or readmissions is to educate and train patients to recognize the symptoms and triggers of their disease to reduce or prevent the onset of acute exacerbations.

Medicare beneficiaries who work with RTs to properly self-manage their chronic lung disease can slow disease progression and improve health status. RTs can bring value to physician practices and assist in preventing short-term readmissions. That is why it is important to gain sponsorship and support for HR 2619.

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**References**


Setting the Record Straight
Part 2: Clarification of HR 2619

To the Editor:

As Executive Director of the American Association for Respiratory Care (AARC), I am writing a follow-on letter to the one presented by AARC President George Gaebler. The issue relates to a recent debate appearing in CHEST (February 2014) about whether Medicare should allow respiratory therapists (RTs) to practice independently and bill directly for COPD education.

The focus is AARC bill HR 2619, the Medicare Respiratory Therapist Act of 2013, currently before Congress. Although Mr Gaebler has clarified the provisions and intent of the bill, I want to address some of the inaccuracies of the Counterpoint Editorial because the authors appear to be confusing past AARC legislative initiatives with the present one.

The entire premise of the Counterpoint Editorial is based on inaccurate assumptions and statements. For example, the article states that (1) HR 2619 proposes RT independent billing specifically for COPD self-education, (2) the RT’s services would be furnished in the home setting as well as in physicians’ offices, (3) RTs would work under general physician supervision without physical presence of the physician, and (4) RTs can work in the home under general supervision now. None of these statements is correct.

The authors cited HR 2619 as one of their references. A close reading of the bill would show that (1) no reference to independent billing is made; (2) self-management education includes five diseases, not just COPD; (3) only physician practices would be affected; (4) general supervision is not mentioned; and (5) the bill amends Medicare’s “incident to” benefit under §1861(s)(2), which requires direct physician supervision. For services in the home, the one exception allows general supervision only to homebound patients in medically underserved areas where home health services are unavailable.

We do not intend to address the studies or conclusions drawn by the authors in their article because they are premised on erroneous hypotheses. However, regardless of the divergence of opinions in the point/counterpoint debate, we want to acknowledge and thank the American College of Chest Physicians for going on record as a supporter of HR 2619. In the spirit of fairness, we want to make sure its members have all the facts about the bill and AARC’s desire to use RT skills beyond the walls of the hospital in providing education necessary for better self-management among Medicare beneficiaries with certain chronic lung diseases.

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References

Board of Medical Advisors Supports HR 2619

To the Editor:

The Board of Medical Advisors to the American Association for Respiratory Care is compelled to comment on the point/counterpoint debate “Should Medicare Allow Respiratory Therapists to Independently Practice and Bill for Education Activities Related to COPD?” in a recent issue of CHEST (February 2014). As noted by Fuhrman and Aranson, the American Association for Respiratory Care does not advocate independent practice for respiratory therapists (RTs). The bill before Congress, HR 2619, would modify Medicare Part B, allowing provision for education in self-management and training provided by qualified RTs (bachelors or an advanced degree) employed by a public or private health care setting as well as in physicians’ offices.

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physician. Medicare would reimburse physicians employing RTs who provide services to qualifying patients with chronic lung disease under direct physician supervision.

In their counterpoint side of the debate, Courtright and Manaker\(^1\) cited studies illustrating benefits of specific pulmonary disease programs:

At least three RCTs [randomized controlled trials] evaluated COPD-specific education and action plans for outpatients. An educational intervention in Canada significantly reduced both COPD hospitalizations and exacerbations among patients with COPD. A more recent study observed a 41% reduction in the composite end point of COPD hospitalization or emergency service following an educational intervention in US veterans.

From their perspective, these programs were not perfect. However, our analysis is that the programs were not perfected, which is a subtle, but very important distinction. We recommend focusing on what worked and implementing studies striving to improve clinical and financial outcomes. Courtright and Manaker\(^1\) repeatedly expressed concern about possible redundant billing driving increased costs. The physician responsible for both direct supervision of RT employee services and related billing would be unlikely (and ill-advised) to provide identical services as the RT and bill for both.

Also not fully explored in the debate is the impending physician shortage (including pulmonary physicians) coupled with the underuse of trained health-care professionals in pulmonary medicine, that is, RTs. If there are insufficient numbers of pulmonary physicians to care for patients with chronic lung diseases, how will physicians and hospitals reduce hospital readmissions? In 2012, the Centers for Medicare & Medicaid Services reported that almost 98% of readmissions were patients with two or more chronic conditions, which included asthma and COPD.\(^3\) In October 2014, COPD will be included as one of the diagnoses subject to the hospital readmissions reduction penalty. Expanding the role of RTs in patient care, including patient education, should probably be wisely and widely instituted rather than debated.

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**REFERENCES:**


**Response**

To the Editor:

We thank Mr Gaebler for his comments on our point/counterpoint debate.\(^1\)\(^-\)\(^4\) Perhaps said best by Representative Brady in the same issue, “disagreement on a piece of legislation is the rule, not the exception.”\(^5\)

Differences aside, we are delighted with the interest sparked by this debate.

Critically, this debate focused on the hypothetical title question posed, not the specifics of bill HR 2619.\(^6\)

Narrowing the focus to solely COPD still allowed spirited examination of many issues. Furthermore, as noted by Brady,\(^2\) the long journey from advocacy to law includes drafting many versions of legislation to meet the challenges of opposition and the demands from competing regulations before ultimate implementation. Indeed, HR 2619\(^6\) is the most recent of iterative legislative initiatives by the American Association of Respiratory Care in partnership with the physician community.

We strove to frame the debate posed in the context of the real world in which we live, practice, and pay taxes. The debate posed independent practice, which does not preclude rendering services in the office, hospital, nursing facility, or home. For example, despite statutes mandating coverage, Medicare provides very narrowly defined G codes with limited reimbursement for pulmonary rehabilitation services in various settings.\(^2\) A similar fate would undermine the noble intent of
HR 2619. As we emphasized, some COPD self-management education (SME) services provided by respiratory therapists are currently reimbursed as “incident to” services. Depending on the final steps of regulation, enormous costs could ensue from the implementation of pulmonary disease SME provided by respiratory therapists without empirical, favorable, cost-benefit evidence.

Action preceding evidence can have enormous and potentially unjustified costs as demonstrated by the ongoing debate over critical care bed supply in the United States. The rapid increase in US critical care beds from 2000 to 2005 in response to perceived demand was followed by an exorbitant increase in intensive care expenditures without significant evidence of a concomitant increase in quality of care. Furthermore, newer data support the notion that critical care services could actually be reduced without harming patients, and controversy about critical care bed supply rages on.

We agree with Dr Papadakos that further studies are warranted to refine an optimal approach to the delivery of COPD SME, but we believe that evidence of improved clinical and financial outcomes should precede law mandating expanded payment for such services. At a minimum, a study to confirm the safety of COPD SME is merited based on the most recent randomized controlled trial that was stopped early due to excess mortality in patients receiving this intervention.

Again, we thank our colleagues for their thoughtful letters. From this lively debate, we hope that readers consider all the issues of reform as health care perpetually evolves through advocacy, legislation, and regulation.

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FINANCIAL/NONFINANCIAL DISCLOSURES: The authors have reported to CHEST the following conflicts of interest: From 2010 to 2013, Dr Courtright’s spouse worked for Connolly, LLC, a Centers for Medicare & Medicaid Services Recovery Audit Contractor. Dr Manaker has received fees as a Grand Rounds speaker, lecturer, consultant, and expert witness on documentation, coding, billing, and reimbursement from hospitals, physicians, departments, practice groups, professional societies, insurers, and various attorneys. In March 2011, he received funding from Aetna Inc for consultation on diagnosis coding. Dr Manaker serves on the Hospital Outpatient Panel, a federal advisory commission to the Centers for Medicare & Medicaid Services. Dr Manaker also serves on the Board of Directors of CHEST Enterprises, Inc, a wholly owned, for-profit subsidiary of the American College of Chest Physicians.

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Response

To the Editor:

We thank Messrs Kallstrom and Gaebler and Dr Papadakos for their thoughtful letters about our point/counterpoint debate on whether Medicare should allow respiratory therapists (RTs) to independently practice and bill for educational activities related to COPD.

We appreciate the poignant comments by Messrs Kallstrom and Gaebler, dispelling the myths and clarifying the facts of HR 2619, the Medicare Respiratory Therapist Act of 2013.

We agree with Dr Papadakos’ illuminating statement that the ability to reduce hospital readmissions for patients with chronic lung disease will be challenging in the face of reduced physician numbers. However, contrary to Dr Papadakos’ claim that the “impending physician shortage (including pulmonary physicians)” was “not fully explored in the debate,” we, indeed,
stated the dire forecast of physician shortages in our side of the debate, including those in pulmonary and critical care medicine. We also mentioned the ever-enlarging caseload of increasingly complex patients with chronic lung disease, whose care is laborious and time intensive, not to mention the added burdensome regulations imposed by the Affordable Care Act (ACA).

As noted by Messrs Kallstrom and Gaebler, HR 2619 proposes a logical and appropriate use of RTs in physicians’ offices, who would render patient care and education only as determined by the physician. Readers would be well served to remember this debate, and Messrs Kallstrom’s and Gaebler’s concise description of HR 2619, on October 1, 2014, when the ACA’s hospital readmission penalty is implemented.

Under the ethics of transparency, we are obligated to disclose that we are both active members of the Board of Medical Advisors (BOMA) to the American Association for Respiratory Care: Dr Fuhrman as an American Society of Anesthesiologists representative and Dr Aranson as a CHEST representative. Before and during the writing of the point/counterpoint debate articles, we informed our fellow BOMA members what we had been asked to discuss, but did not seek or receive their input. Nor did any member of the BOMA review the article before its submission.

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