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
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 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 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. 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. Perhaps said best by Representative Brady in the same issue, “disagreement on a piece of legislation is the rule, not the exception.” 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. Narrowing the focus to solely COPD still allowed spirited examination of many issues. Furthermore, as noted by Brady, 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 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. A similar such fate would undermine the noble intent of