We’re certainly not telling you anything new with the statement that healthcare is changing. Recently, one physician leader shared his perspective that this past year has been “the most tumultuous year” he’d ever experienced, and he’s set to continue with that as his new normal for the foreseeable future.

You may be asking: What’s with all the upheaval? And, more importantly, what does it have to do with me? Well the answers are “lots” and “lots.” In response to the Affordable Care Act, healthcare organizations, leaders and providers are challenged with shifting payment mechanisms and evolving organizational structures to be able to provide the highest quality of care both effectively and efficiently. In a nutshell, the old system of fee for service (FFS) and payment for quantity is shifting quickly to one of shared savings and payment for quality and value. Nobody knows exactly what the details will look like once the dust settles, but one thing we know for sure is that there is, and will continue to be, a strong focus on rewarding health, improving health status of populations and decreasing the staggering cost of managing the highest risk populations — those living with chronic illness.

An axiom to which we closely adhere at our workplace is what is known as the 80-80-80 rule: 80% of healthcare dollars (many studies show higher rates) are spent on chronic illness, 80% of those dollars are spent on expensive care, i.e., emergency visits hospitalizations and rehospitalizations, and lastly, 80% of care (again, a low estimate) happens outside the four walls of the hospital and/or provider office and/or of the cardiopulmonary rehabilitation center. Simply stated, most care is self-care and the better able we are to equip individuals living with chronic illness — and their families — with the tools they need for effective self-management becomes job one. This clearly opens up opportunities for those of us who have been working for years in evidence-based care of people living with chronic illness. Both cardiac and pulmonary rehabilitation programs traditionally have worked well to empower individuals with the tools and skills that they need for effective self-management.

While there is much more to tell you, be aware that AACVPR has recently launched a Health Care Reform Task Force (HCRTF). Commissioned by President Anne Gavic, the HCRTF is to serve as scouts surveying the horizon, first to gather information, followed by structured recommendations back to the AACVPR Board of Directors for moving the organization, the profession, our programs and professionals into the new world unfolding before us. For more information on this new world, I highly recommend reading (and re-reading) Dr. Marjorie King’s article on “Affordability, Accountability, and Accessibility in Health Care Reform” in the most recent May/June 2013 issue of the Journal of Cardiopulmonary Rehabilitation and Prevention (JCRP). The article, a call to action for each one of us, captures Dr. King’s thought-provoking Award of Excellence Presentation from the 2012 AACVPR 27th Annual Meeting in Orlando. In it, she captures the implications of healthcare reform for cardiovascular and...
pulmonary rehabilitation and prevention. The article explores emerging healthcare delivery and payment models, including expanded access to care related to the Affordable Care Act of 2010, patient-centered medical homes (PCMHs) and medical neighborhoods, accountable and coordinated care organizations, and value-based purchasing and insurance design, with an emphasis on implications for cardiovascular and pulmonary rehabilitation. If you haven't yet read this seminal article, read it now, absorb it, make your plans, implement those plans and share it all, ad lib.

The opportunities are great and the time to move is now. Read through examples in this very issue of N&V on how some have transformed their practices into behavior change and health management. The challenge to each of us is to craft a new way of being and a new way of doing to remain relevant, visible, viable, successful, and most importantly, of greatest value to the lives of the patients and families that we serve. Thanks to the scientists who have armed us with significant and substantial evidence to bring to the table. Be on the lookout for more information coming from this forward-thinking group. We will be inviting and welcoming your ideas, input and experience as we tap into the collective wisdom of the whole that is our membership. Stay tuned, better yet, get involved, as we put health and care into healthcare.

“Carpe Diem, Seize the Day!”
— Horace.

President's Message

We are the World: AACVPR joins Global Partners in Prevention of CVD

Anne M Gavic, MPA, FAACVPR

Non-communicable diseases (NCDs) are currently the leading global cause of death. In 2008, of the 57 million deaths the occurred globally, 36 million – almost two thirds – were due to NCDs, comprising mainly cardiovascular disease, cancers, diabetes and chronic lung diseases. (WHO 2012)

In 2012, members of the World Health Organization (WHO) met to finalize work on a framework for prevention and control of NCDs. Included in the final plan are nine target goals to be voluntarily pursued by members.

These goals include a decrease in inactivity, sodium intake, blood pressure, diabetes, obesity and tobacco use — all toward the ultimate goal of decreasing premature mortality from NCD 25% by the year 2025.

To this end, AACVPR, as an organization dedicated to prevention and rehabilitation of cardiovascular and pulmonary diseases, has been invited to join as a global partner in pursuing these goals.

- Last year, AACVPR was invited to join the newly formed International Council on CVD Prevention and Rehabilitation (ICCPR) along with 11 other cardiac rehabilitation organizations from across the globe. As a member of ICCPR, AACVPR fully endorsed the International Charter on Cardiovascular Prevention and Rehabilitation.
that calls for CVD prevention and rehabilitation to be obligatory, not optional services. In addition, the charter calls for countries with well-established preventive and rehabilitative services to support low and middle income countries in the development of those services.

- This spring, Europrevent, the annual conference of the European Association for Cardiovascular Prevention and Rehabilitation (EACPR), focused on the potential for developing a Global Alliance for CVD prevention in Clinical Practice. I was honored to represent AACVPR with 22 leaders from CVD prevention and rehabilitation organizations around the globe. The discussion centered on the opportunities and challenges of creating such a global alliance with the express purpose of sharing guidelines and standards, as well as education, training and research. The end goal of this shared communication is to develop leadership for primary and secondary prevention services and provide evidence necessary to improve accessibility and efficacy of primary and secondary preventive services.

As part of these discussions, it becomes clear how much we share with our international neighbors in seeking ways to manage the significant economic and societal burden of CVD. However, it is also apparent how complex the solutions are considering the diversity of cultures, economics and healthcare delivery models. Still, this is essential work, and AACVPR is pleased to be included in the circle of discussion, and looks forward to this growing partnership.

_The world has shrunk. Increasingly peoples and nations have grown dependent on one another. No one can any longer act entirely in his own interest._ — Ghandi

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**Executive Director's Corner**

*Megan Cohen, MPA, CAE*

Every spring, AACVPR holds a Capitol Hill event called Day on the Hill or as we like to refer to it in the office, DOTH. While the thought of flying to Washington to meet with your legislators may seem scary or intimidating to some of you, it's really a wonderful experience. I've asked some folks who visited with their Members of Congress this year to share their experience with me so that I, in turn, can share it with you. And this is what they told me.

Ivy Hollinrake traveled all the way from Fairbanks, Alaska, for her first Day on the Hill. It was an amazing experience. To start, it was my first time to Washington D.C., so that, in itself, was awe-inspiring! As I grew up in Fairbanks, Alaska, history always seemed so remote to me; so, walking the streets and visiting the buildings of our forefathers, was a lesson in humility as well as a surge in pride in our country at the courage and foresight of our Founding Fathers as they established our early government. Seeing the Lincoln Memorial, above all, was the most emotional experience, although the Vietnam memorial and the Arlington Cemetery were right there as well. I felt blessed at the opportunity to see the Capital, the White House, the Library of Congress, and the Supreme Court as well as Memorials to the many soldiers and wars they fought to defend our country and our right to be free. The statuary everywhere was so majestic.

My official reason for travel was to lobby our lawmakers for support of an upcoming bill S. 382. The bill would provide a “technical correction” to amend P.L. 110-275 to allow non-
physician providers to provide physician supervision of cardiac and pulmonary rehab programs, as allowed by other hospital outpatient services that fall under direct physician supervision regulation.

When I got my invite to attend from NWCVPR, I was so excited and honored. I followed the guidelines placed on the AACVPR website and contacted my senators and representatives to make appointments. I gave them two day options (to improve my chances of being seen) and they all picked Wednesday, the 6th, my first day on the Hill. I researched the topic and practiced my presentation.

Unfortunately, on my first day on the Hill, we experienced a snow storm that closed many of the offices and facilities, but my cohort and wonderful mentor, Joyce Kratz-Klatt, and I were able to visit 22 offices of senators and representatives from our Northwest Region by the end of that day. Nothing could stop us hardy North-westerners! Our pictures were even posted on Facebook and Twitter when we visited the office of Senator Murkowski (R-AK). I felt quite intimidated at first, as I wandered the House and Senate buildings, approaching the offices of our esteemed legislators, and I admit to feeling a tad inadequate in my humbleness from “Podunk” Alaska. To add to that, the first health aid I spoke with did not introduce herself and was somewhat condescending and aloof toward my first presentation, and my confidence level plummeted. The rest of the day, however, our receptions were very warm, our listeners very attentive and I felt positive about our cause and that our message was being heard.

That evening at the dinner and preparatory workshop (the one I probably should have attended before my visits), I listened to the other experienced DOTH attendees and became extremely motivated. I had more ideas of what to say and how to say it, and the most important thing I was reminded of, was that THEY WORK FOR US! We can demand (nicely) for our time to be listened to and respected. I reminded myself that I have been a nurse for 30 years and have managed my cardiac rehab for 15 years. Not only am I a valued person in the workforce, but I am also a constituent. I WILL be following up with the one office I mentioned, and I WILL make sure my message is received by my senator. I will also follow up with the rest of my Alaska offices, and others, to keep the message active and keep seeking support.

I also heard from Ruth Akers, a Pennsylvania representative from the Tristate Society for Cardiovascular Pulmonary Rehab (TSSCVPR). She and several of her colleagues “Stormed the Hill” in April because they couldn’t make it through the March snow storm for DOTH. Rather than snowflakes, the Pennsylvania team welcomed the cherry blossoms and armed with packets of information attended meetings with health legislative staff from offices of Pennsylvania Senators Pat Toomey and Robert Casey.

Good dialogue and exchange of information resulted in positive meetings with hopes that both
senators would support and sign support for S.382. Next, the PA group broke off into teams visiting every Pennsylvania Representative and dropping off information packets. Most of our team met with their congressional Representatives. The team felt these meetings were vital in the event that a House companion bill might become necessary to push this legislation through. At the end of the day, the PA team felt hopeful that our senators would give support to our Senate bill and will continue to follow up with email letters and phone calls and encourage all our PA TSSCVPR members to join forces to make this bill a success.

(Left to Right) Jill Fox (Somerset, PA), Mary Matalon (Lancaster, PA) Ruth Akers (Downingtown, PA) Kathy Thumma, President of TSSCVPR, (Camp Hill, PA), David Martens (Doylestown, PA), Nadine Greco (Scranton, PA)

As of the date of publication, S382 introduced by Senator Schumer from NY has 12 co-sponsors (listed below). But more are needed to make this important change for cardiac and pulmonary rehabilitation centers. We need your help. Please visit the Advocacy/Day on the Hill for more information on S382 and contact your legislators today.

**SPONSOR:** Sen Schumer, Charles E. [NY] (introduced 2/26/2013)

**COSPONSORS (12)**

- Sen Baldwin, Tammy [WI] - 6/11/2013
- Sen Boxer, Barbara [CA] - 5/22/2013
- Sen Crapo, Mike [ID] - 2/26/2013
- Sen Durbin, Richard [IL] - 4/16/2013
- Sen Franken, Al [MN] - 5/14/2013
- Sen Grassley, Chuck [IA] - 3/12/2013
- Sen Harkin, Tom [IA] - 5/7/2013
- Sen Risch, James E. [ID] - 3/12/2013
- Sen Schumer, Charles E. [NY] (introduced 2/26/2013)
- Sen Thune, John [SD] - 5/14/2013

**Breaking News**

**CMS Announces Formal Consideration for Coverage of Cardiac Rehabilitation for Chronic Heart Failure**

*See Megan Cohen’s Executive Director’s message above to learn more about the progress of AACVPR’s Day on the Hill to address this issue.*
CMS (Centers for Medicare & Medicaid Services) has received a formal request submitted by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), American College of Cardiology (ACC), American Heart Association (AHA), and Heart Failure Society of America (HFSA) for a national coverage determination (NCD) to add the diagnosis of chronic heart failure (CHF) to the list of approved indications for coverage for cardiac rehabilitation (CR). The addition of any cardiac indication for coverage of CR must be done through the NCD process. Therefore, CMS has posted its intent to conduct a national coverage analysis (NCA) to complete a thorough review of the evidence to determine if Medicare beneficiaries would benefit from this additional qualifying diagnosis to current coverage policy.

There is a 30-day public comment period from 6-4-13 through 7-4-13. CMS is requesting public comment on the clinical evidence of health benefit outcomes, both short and long term, provided by this service to Medicare beneficiaries with the diagnosis of CHF. CMS is particularly interested in comments that include published clinical studies and other scientific information that provides evidence for improvement in short and long term outcomes related to this service for the diagnosis of CHF.

Click here for the National Coverage Analysis (NCA) Tracking Sheet for Cardiac Rehabilitation (CR) Programs - Chronic Heart Failure (CAG-00089R3).

AACVPR does not discourage individuals from submitting comments. More importantly, we anticipate that comments are consistent with those submitted by AACVPR, ACC, AHA, and HFSA in the formal request, posted on the above web page. After the 30-day public comment period, the typical time frame would be for CMS to then follow with a proposed Decision Memo (late 2013) and a final coverage regulation by early 2014.

**Senate Bill S.382 - Have You Sent Your TWO Letters?**

AACVPR has been advised by CMS (The Centers for Medicare and Medicaid Services) that a technical correction by Congress is necessary in order for Medicare to allow CR and PR to utilize qualified nonphysician practitioners (NPPs, i.e., Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants) to meet the direct physician supervision requirement for hospital outpatient services. This flexibility was extended to all other hospital outpatient services requiring direct physician supervision in 2010, but CMS was unable to include CR and PR solely due to its interpretation of Public Law 110-275.

In 2011, members of the Senate Finance Committee sent a letter to CMS explaining that the intent of the legislation was not to create a roadblock to these programs, but to enhance access to these important services. CMS' response was that due to the statutory definition of physician, Congress needs to revise terminology in the statute before CMS can allow NPPs to provide such supervision for CR and PR. (This is totally unrelated to the medical director physician role in CR and PR programs.)

Your state affiliate is ready to take action. Please become involved by contacting your affiliate leadership and offer to send your two letters. Your voice made a difference once in securing the future of cardiac and pulmonary rehab programs. No one is too busy to care about our patients’ future opportunities to receive CR and PR services.
Innovative Programs & Best Practices

Tracy Herrewig, MS, RCEP, FAACVPR

The Innovative Programs and Best Practices section is dedicated to providing our readership an introduction to people and programs that are being innovative in their thinking and in the way they provide services. The end goal of which is to improve patient care, outcomes, and of course the patient experience.

The contributor for this issue’s column is Terresa Bubbers.

Innovation

Terresa Bubbers, MS, RCEP, CES, Certified Wellness Coach
Supervisor of Exercise Physiology, Gundersen Lutheran Medical Center, La Crosse, WI

We cannot solve a problem by using the same kind of thinking we used when we created them. — Albert Einstein

It’s tough when markets change and your people within the company don’t. — Harvard Business Review

The staff in the Exercise Physiology Department at the Gundersen Lutheran Medical Center in La Crosse, Wisconsin is the most innovative, open to change people I have ever worked with. Innovation is a strong part of our culture. At times, we all wish we could just keep things as they are because change is crazy, busy and messy. We also realize that for our patients to receive the best that we have to offer, we have to keep reaching for excellence and we cannot achieve excellence by doing what we have always done. The healthcare market and the climate change and excellence become an evolving target. Our department is involved in more than 13 different programs and they all started because a staff person had an idea and our organization values what we do and our clinical expertise.

Many years ago we positioned ourselves to become the experts in tobacco consults on the inpatient side. Because tobacco use is a common issue among our cardiac and pulmonary populations, we determined that this was a topic we needed to become familiar with. We started by seeing the patients on the cardiac floors and have evolved to seeing every patient who reports using tobacco within the last year upon admission. The creation of a standing order that includes a tobacco consult, if applicable, has increased our numbers from 730 consults per year to 2,108 consults last year. We also recognized that tobacco consults were being missed on the weekend and, therefore, started staffing half-day Saturdays, Sundays and holidays to meet the demand of patients. As you can imagine, adding holidays and weekends to the schedule was a not a popular idea, but once we determined patients were being missed and we were not meeting quality measures, the decision became easier. It was the right decision for our patients. Even though tobacco consults are a challenging part of our work because it requires staff to use their coaching skills more than their expertise skills, the rewards are many. Staff develops compassion for patients with this serious addiction and empathy to the many challenges patients face to become nicotine-free. The reward comes from watching a patient who is scared to even think about living without their “friend” tobacco who has been part of their life for up to 40 years, to believing that it is possible and that their health is worth the effort.

The staff stays engaged in program innovation by leading and driving the goals of all of our programs. They monitor the outcomes and progress of the goals and report out at monthly staff meetings, helping keep all staff on the same page and moving in the same direction. Innovation and change are embraced as opportunities to serve our patients and each other better. Staff operates with the premise that excellence is not a goal but an expectation of each one of us every day.

Update on AACVPR Liaison Activity

New Website Resources from AACVPR Liaisons
The Professional Liaison Committee uses two simple principles for interaction with our liaison organizations: (1) that whatever we do should provide benefits to our members and (2) that whatever we share with liaison organizations should help spread positive messages about cardiovascular and pulmonary rehabilitation and AACVPR. One of the most obvious and simple ways to do this is by sharing resources on our websites to provide reciprocal member benefits. We have been working with the Preventive Cardiovascular Nurses Association (PCNA) for many years to share useful resources, and more recently have added resources from the American Academy of Physical Medicine and Rehabilitation (AAPM&R), the American Association of Diabetic Educators (AADE), and WomenHeart on the AACVPR website. These organizations, among many others, also shared AACVPR resources for patients and professionals with their members to promote cardiovascular and pulmonary rehabilitation.

Check out the links that were recently added to Resources for Professionals in the Members Only section of the AACVPR website, including Guidelines for the Practice of Diabetes Education, WomenHeart Resources for Professionals and Patients, the PCNA Resource Center for Health Care Professionals and Their Patients, and PM&R Knowledge Now. Find these links here.

Like many other things that happen in AACVPR, these new resources are available to us due to the efforts of not only AACVPR staff like Jessica Eustice, but also because volunteers from both the Website Committee and Professional Liaison Committee made it happen. Many thanks to Val Kramer, Leah Lenz and Tracy Herrewig for finding and organizing these for us!

Join Us in Nashville for the AACVPR Annual Meeting
October 3–5, 2013
Pre-meeting Events: October 2, 2013

Registration is now open for the premier event of the year for the cardiovascular and pulmonary rehabilitation team: the AACVPR 29th Annual Meeting.

AACVPR is proud to once again introduce an exceptional educational program featuring leaders in the field. Please join us in examining current and future trends and proven strategies as speakers address research and clinical practice topics ranging from resistive exercise training and testing in pulmonary rehabilitation to tackling obesity in cardiac rehabilitation, anxiety treatment in patients to integrating nutrition into ITPs, harnessing mobile-health technologies to improving program efficiency.

The educational program is headlined by two nationally renowned keynote speakers: Kenneth Thorpe, PhD, of the Rollins School of Public Health at Emory University and Robert Cooper, PhD, Founder and CEO of Cooper Strategic LLC. Read more about these exceptional speakers below.

To review the complete educational line-up for the AACVPR 29th Annual Meeting, please visit www.aacvpr.org/nashville2013.

Quality Healthcare for Chronic Disease: Partnering with Our Patients and the Public for Optimal Outcomes
Kenneth E. Thorpe, PhD

From 1993 to 1995, Dr. Thorpe was Deputy Assistant Secretary for...
Health Policy in the U.S. Department of Health and Human Services. In this capacity, he coordinated all financial estimates and program impacts of President Clinton’s healthcare reform proposals for the White House. He also directed the administration’s estimation efforts in dealing with Congressional healthcare reform proposals during the 103rd and 104th sessions of Congress.

Dr. Thorpe regularly testifies before committees in the U.S. Congress and in front of governments around the world on healthcare reform, including disease prevention, wellness, and coordination of care. Now, he brings his expertise and knowledge to AACVPR with a specially tailored keynote address.

**Leading in a Changing World: What’s Different Today, and Why It Matters**

*Robert K. Cooper, PhD*

As fast as the world is changing, it has never been more important for leaders, professionals, and teams in healthcare to be strategic about change. We are being asked to deliver exceptional results in more effective new ways. Pressures and distractions are everywhere, and rising. Interactions are briefer than ever. Goals and expectations are higher than ever. Are there simple, learnable new skills that enable leaders and professionals to quickly discover where the smallest changes – in attitude, energy, engagement, focus, teamwork, and ingenuity – can make the biggest difference? The answer is yes.

For 20 years, Robert Cooper, PhD, has studied how exceptional leaders and teams achieve what everyone else thinks they can’t. Join us to benefit from his counterintuitive wisdom, inspirational speaking skills, and disciplined metrics that have enabled leaders and teams in many industries and fields to produce breakthroughs.

**Inside the Industry**

**Health & Public Policy FAQs**

**Cardiac FAQs: Cardiopulmonary Services Promotes “Smokeless and Ready for Surgery”**

*Ana Mola, MA, RN, ANP-C, FAACVPR*

Accountable Care Act (ACA) legislation, enacted March 2010, provides an economic landscape to test healthcare payment reform models with the goal of advancing value-based healthcare and improved health outcomes through quality care that is accessible and affordable (Korda & Eldridge, Winter 2011/2012). The preoperative period is a unique and synergistic opportunity to align providers to engage in a surgical teachable moment addressing patient’s unhealthy lifestyle behaviors that may complicate the patients’ surgery, trigger a readmission and delay their recovery. Health compromising lifestyle behaviors, such as smoking, produces post-operative complications and fosters an economic drain on the...
Lifestyle behavior changes, such as tobacco cessation, provided by cardiac rehabilitation (CR) and pulmonary rehabilitation (PR) professionals can bend the cost curve in the right direction.

Approximately 10 million smokers undergo surgery every year (Shi & Warner, 2010). Smoking substantially increases a patient’s risk of surgical complications and studies have shown that smoking has a strong tendency to be an independent risk factor for surgery (Khullar & Maa, 2012). In the review of the literature, more than 300 studies have examined the association between smoking and surgical outcomes (Tonnesen, 2011). Active smoking is associated with an increase of perioperative cardiovascular, pulmonary and wound healing complications, including infections, anastomotic dehiscence, re-intubation and respiratory failure (Warner, 2006; Theadom, A., Cropley, M., 2006). There is a significant financial cost associated with these surgical complications, as one study estimated that the pulmonary complications associated with perioperative smoking resulted in an additional cost of $52,000 per surgical episode (Dimick, Chen & Taheri, 2004).

At a time when the nation is bending the cost curve in healthcare reform, the ACA has created a brave new world for patients, providers and hospital systems to embrace cost utility, re-engineering clinical care to improve the quality of care, incorporating best practices into clinical care delivery models, and enhancing patient and caregiver experience. Cardiac and pulmonary rehabilitation professionals have an opportunity to highlight the lifestyle behavior programs they have been successfully delivering and educate their leadership that CR/PR services can bend the cost curve in the preoperative surgical patients that are smokers. Cardiopulmonary rehabilitation services can be performed at any point of the patient’s trajectory of surgery with outcomes that can enhance the patients’ preoperative, hospitalization and recovery phases. This is just another example of how cardiopulmonary services can be highlighted as a public health intervention with cost savings for all.

**References**


**Pulmonary FAQs: Pulmonary Rehabilitation MAC Audits and Results**
Documentation Problems Uncovered in Medicare Audits

Gerilynn Connors, RCP, RRT, BS, MAACVPR, FAARC

Q: Pulmonary Rehabilitation programs in MAC 11 and MAC 15 have experienced audits, sent in records and the table below shows the results. There is a high percentage of denials. Why?

A:

<table>
<thead>
<tr>
<th>Report Date</th>
<th>State</th>
<th>MAC</th>
<th>Claims Audited</th>
<th>Claims Denied</th>
<th>Charge Denial Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr. 24, 2013</td>
<td>Kentucky</td>
<td>J15</td>
<td>139</td>
<td>116</td>
<td>83.8%</td>
</tr>
<tr>
<td>Mar. 28, 2013</td>
<td>Ohio</td>
<td>J15</td>
<td>363</td>
<td>290</td>
<td>77.7%</td>
</tr>
<tr>
<td>Feb 2013</td>
<td>North Carolina</td>
<td>J11</td>
<td>151</td>
<td>131</td>
<td>88%</td>
</tr>
<tr>
<td>Feb 2013</td>
<td>South Carolina</td>
<td>J11</td>
<td>120</td>
<td>104</td>
<td>87%</td>
</tr>
<tr>
<td>Feb 2013</td>
<td>Virginia</td>
<td>J11</td>
<td>129</td>
<td>96</td>
<td>63%</td>
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Documentation, Documentation, Documentation. MAC 11 published an article on the TOP DENIAL Rates for all Outpatient Service claims. This includes pulmonary rehabilitation, cardiac rehabilitation and “other” outpatient services audited such as physical medicine. The number one denial rate was for medical records not submitted for the audit. You may think, how could this occur? When and if your program is audited are you notified, do you copy and send the records to medical records that sends them to Medicare, do you include information about physician supervision? If you are depending on the Medical Records department to send the records, DON’T. How do they know all the required documentation Medicare expects, such as your supporting evidence with PFTs for the diagnosis, the ITP, the name of the physician supervising your pulmonary rehabilitation sessions?

The table below shows the TOP 10 REASONS for payment denials in MAC 11.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>56900</td>
<td>Auto Deny - Requested Record Not Submitted</td>
</tr>
<tr>
<td>2</td>
<td>5T009</td>
<td>Claim Level Denial for Multiple Line Denials</td>
</tr>
<tr>
<td>3</td>
<td>5D900/5H900</td>
<td>Beneficiary Signature Requirements Not Met</td>
</tr>
<tr>
<td>4</td>
<td>5H261</td>
<td>Sessions Did Not Include the Required Services</td>
</tr>
<tr>
<td>5</td>
<td>5D169/5H169</td>
<td>Services Not Documented</td>
</tr>
<tr>
<td>6</td>
<td>5D301/5H301</td>
<td>MD Must Be Readily Available</td>
</tr>
<tr>
<td>7</td>
<td>5D901/5H901</td>
<td>Pulmonary Rehab Not Warranted for Diagnosis</td>
</tr>
<tr>
<td>8</td>
<td>5D261</td>
<td>Sessions Did Not Include the Required Services</td>
</tr>
<tr>
<td>9</td>
<td>5H241</td>
<td>Cardiac Rehab Not Warranted for Diagnosis</td>
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</tbody>
</table>
The audits looked at GO424 specifically — Pulmonary Rehabilitation for the Diagnosis of COPD. The CMS NCD clearly states that “Medicare covers pulmonary rehabilitation items and services for patients with moderate to very severe COPD (defined as GOLD classification II, III, IV). See below the FEV1 & FEV1/FVC ratio requirement for each classification.


![Classification of Severity of Airflow Limitation in COPD](image)

When you admit your patient into pulmonary rehabilitation, do you have spirometry to prove the patient qualifies based on the FEV1 and FEV1/FVC ratio? When the chart is audited are the PFTs sent?

Does your documentation support the need for your skill set and for medical necessity?

Looking just at MAC 11 pulmonary rehabilitation denials by state the **TOP 4 Reasons are listed in the table below.**

**North Carolina**

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Description</th>
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<tbody>
<tr>
<td>5D901/5H901</td>
<td>Pulmonary Rehab Not Warranted For Diagnosis</td>
</tr>
<tr>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely</td>
</tr>
<tr>
<td>5D902/5H902</td>
<td>Documentation Did Not Include the Required Components</td>
</tr>
<tr>
<td>5D903/5H903</td>
<td>Physician Must Be Readily Available</td>
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</tbody>
</table>

**South Carolina**
<table>
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<tr>
<th>Denial Code</th>
<th>Denial Description</th>
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<tbody>
<tr>
<td>5D901/5H901</td>
<td>Pulmonary Rehab Not Warranted for Diagnosis</td>
</tr>
<tr>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely</td>
</tr>
<tr>
<td>5D902/5H902</td>
<td>Documentation Did Not Include the Required Components</td>
</tr>
<tr>
<td>5D903/5H903</td>
<td>Physician Must Be Readily Available</td>
</tr>
<tr>
<td>5D169</td>
<td>Services Not Documented</td>
</tr>
</tbody>
</table>

**Virginia**

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<tr>
<th>Denial Code</th>
<th>Denial Description</th>
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<tbody>
<tr>
<td>5D901/5H901</td>
<td>Pulmonary Rehab Not Warranted for Diagnosis</td>
</tr>
<tr>
<td>5D902/5H902</td>
<td>Documentation Did Not Include the Required Components</td>
</tr>
<tr>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely</td>
</tr>
<tr>
<td>5D903/5H903</td>
<td>Physician Must Be Readily Available</td>
</tr>
</tbody>
</table>

**Internal AUDITS** of your documentation should be done quarterly by each pulmonary rehabilitation program to verify staff documentation meets Medicare expectation. Only through an internal audit will you be prepared for the “REAL AUDIT” when records are requested by Medicare. Look at the list above. How can we as practitioners be providing medically necessary services and not always have the correct diagnosis, records not submitted timely, documentation that did not include required components and did not have the physician supervision met.

Providing medically necessary services to our pulmonary patients and assuring your program survival all hinges on documentation. Read your MAC LCD for Respiratory Therapy and the NCD for pulmonary rehabilitation. Pulmonary Rehabilitation across the U.S. needs to be at 100% Reimbursed — what will it take for us to get there?

**Nutritional Aspects of Rehabilitation**

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What Impact Does Quality Nutrition Have on Respiratory Function?

Alisa C. Krizan, MS, RD, LD

Nutrition is a fundamental aspect of patient care and is now recognized to have an impact on patient care outcomes. Nutrition therapy can impact respiratory function in different ways. Nutrition is an important determinant of outcomes, since either over- or underfeeding could impact a pulmonary rehabilitation participant’s respiratory status.

There has been a global trend of increase in the number of patients with COPD, and as estimated by the World Health Organization (WHO), COPD will become the third leading cause of death in the world in 2020. This will pose a considerable medico-economic burden.

In the Cochrane Review updated in 2012, results of a meta-analysis of data revealed that nutritional supplement therapy produced body weight recovery and raised the fat free mass index, with a consequential improvement of exercise tolerance in COPD patients who were undernourished.

The prescription for appropriate caloric intake needs to take into consideration the nutrient composition, including protein, carbohydrate and fat composition. Appropriate physical exercise is also an effective addition to stimulate caloric intake.

Many cross-sectional cohort studies have demonstrated a correlation between the daily fruit and vegetable intake and the forced expiratory volume % in one second (FEV1) in patients with COPD. The studies demonstrated the risk of development of COPD decreased by 24% in subjects whose fruit intake was 100 g/day. Study results demonstrating a diminished risk of development of COPD in subjects with an increased intake of dietary fiber contained in fruits, vegetables and grains have been analyzed. The nutrients most extensively investigated in respect to their effects in COPD patients are vitamins, and many study reports have dealt particularly with vitamin C and E, both of which have antioxidant effects.

Undernutrition in patients with COPD is an important risk factor for deteriorated quality of life and physical exercise performance, risk of exacerbation and vital prognosis. The important cause of undernutrition in these patients includes a caloric decrease and increased energy expenditure associated with aggravation of the disease state of COPD, and the effects of inflammatory hormones.

The Academy of Nutrition and Dietetics (AND) dietetic practice group (dpg) Sports, Cardiovascular and Wellness Nutrition (SCAN) can assist in locating a registered dietitian in your area. A SCAN RD is a Registered Dietitian with the training, expertise and desire to help you live and perform optimally through good nutrition at every stage of life. We can help you to EAT RIGHT! http://www.scandpg.org/

A Comparative Study on Portable Oxygen Concentrator Use during 6-Minute Walk Testing

Gerene Bauldoff, PhD, RN, FAACVPR

Epublished ahead of print on April 2, 2013, in the Respiratory Care journal, a comparative study was conducted by Carole LeBlanc and colleagues to compare portable oxygen concentrator (POC) ability to maintain pulse-oximetry measured oxygen levels (SpO2) during 6-minute-walk testing (6MW) in patients with chronic lung disease. A within-subject, repeated measures design was used where participants (18 with COPD, 3 with pulmonary fibrosis [PF]) completed four 6MW, a baseline walk with their usual portable oxygen system and one walk each with three different portable oxygen concentrators: EverGo (Respironics Inc, Murrysville, PA); iGo (DeVilbiss Healthcare, Somerset, PA), and Eclipse 3 (Caire Inc, Ball Ground, GA). The study aimed to test the upper limit of the POC to meet the patient's oxygenation need. Maximum pulse-dose settings were used to reflect “real life” use of pulse dosing conserve battery power during routine use. The 6MW tests were conducted following ATS 6MW standards and script. The authors report significant interaction between POC type and SpO2 as well as further 6MW distance and ability to maintain SpO2 during the walk (p < .01). The best results were seen with the Eclipse 3, the device with the largest bolus. Study limitations described a need for a priori testing of the devices to ensure advertised product specifications (this was assumed). Additional study limitations included the small number of PF patients limiting subgroup analysis and lack of measurement of respiratory rate, a potential confounding factor in a device’s ability to meet a patient’s oxygen demands. The authors speculate that the differences seen between devices were related to O2 pulse dose bolus volume. The authors describe participant comments and preferences between devices, recognizing that the EverGo was the lightest and smallest POC tested. Additionally it was reported that the Eclipse 3 and the iGo shared the same high oxygen production capability. The authors state the importance of the healthcare provider to provide product information and help direct the patient toward the most clinically appropriate oxygen system based on the patient’s preferences and lifestyle.

Impact on PR:
As part of our role as PR professionals, we may conduct the 6MW test as well as oxygen desaturation studies. It is imperative that we are knowledgeable regarding the options available in oxygen systems as many of our patients are oxygen-dependent. The evidence provided in this study adds to our knowledge, allowing us to make informed recommendations to our patients.

Reference:
Journal of Cardiopulmonary Rehabilitation and Prevention Highlights

Mark A. Williams, PhD, MAACVPR, JCRP Editor-In-Chief

To Get to the Journal of Cardiopulmonary Rehabilitation and Prevention:

- From the AACVPR Web page, click publications and follow the directions
- Find JCRP online at http://journals.lww.com/jcrjournal/pages/default.aspx
  - Check out the Published Ahead of Print section for new articles, which have not yet been published in the print version of JCRP

What's Coming in JCRP

July/August 2013 Issue

This issue is highlighted by an Invited Review titled “Caloric Restriction: Implications for Human Cardiometabolic Health” as well as various section papers in Cardiac Rehabilitation, Cardiopulmonary Disease, and Pulmonary Rehabilitation from Australia, Cyprus, Greece, India, Poland and the United States.

INVITED SCIENTIFIC REVIEW

- Caloric Restriction: Implications for Human Cardiometabolic Health; Bales et al (USA)

CARDIAC REHABILITATION

- Short- and Long-term Impact of an In-patient Quality Improvement Initiative: Results of the CABG-GAP Practice Improvement Project; Thomas et al. (USA)
- Reduction in Two-year Recurrent Risk Score and Improved Behavioural Outcomes After Participation in the Beating Heart Problems Self-management Program: Results of a Randomized Controlled Trial; Murphy et al (Australia)

Brief Reports

- Evaluation of the Psychometric Properties of the Greek Version of the Minnesota Living with Heart Failure Questionnaire; Lambrinou et al (Cyprus, Greece)
- The Impact of a Short-term Cardiac Rehabilitation on Changing Dietary Habits In Patients After Acute Coronary Syndrome; Borowicz-Bienkowska et al. (Poland)

CARDIOPULMONARY DISEASE

Brief Reports

- Implementing a Community-based Model of Exercise Training Following Cardiac, Pulmonary and Heart Failure Rehabilitation; Adsett et al. (Australia)
Performance Measures Task Force

Randal J. Thomas, MD, MS

The AACVPR Performance Measures Task Force has been recently organized, under the direction of Anne Gavic, AACVPR President, and the AACVPR Board of Directors. The task force is in the process of identifying its members, and developing a strategy to help promote the quality of care in cardiac and pulmonary rehabilitation. We are developing a plan for short- and long-term tactics that will help advance the development, testing and implementation of performance measures for cardiac and pulmonary rehabilitation services.

Task force members are currently participating in a joint project with the American College of Cardiology Foundation and the American Heart Association, to test the use of an electronic tool, developed with the help of the American Medical Association's Physician Consortium for Performance Improvement (PCPI) that can assess cardiac rehabilitation performance measures in electronic health records (EHRs). This step will be a significant advance for the prompt and accurate assessment of performance measure, and will help keep cardiac rehabilitation performance measures on the leading edge of progress within the field of quality improvement.

If any AACVPR members are interested in learning more about how their local hospitals or clinics might be able to participate in this project (CR3-e project), please notify Dr. Randal Thomas at thomas.randal@mayo.edu for more details.
MOKSACVPR Updates

Debra Hilton, RN, BSN, President MOKSACVPR

Well, I guess the old saying “If it thunders in February you will have frost in May” holds true. We are hoping that spring has finally popped her head out. Here in the mid-states we have just concluded our annual conference, “2013 – Will it be Lucky,” which took place April 19-20. We had 128 in attendance, a great lineup of speakers, plus all our wonderful vendors. We were so excited to have Karen Lui and Jane Knipper addressing the topic of reimbursement updates. That is a topic that we always need to keep on top of. We also had a station set up with computers for the recent “Call to Action” so those in attendance who had not had a chance to contact their senators could do so. We had an overwhelming response; by a show of hands at the conference’s end, most attendees took advantage of this opportunity. Thank you so much to Susan Hansen, Chuck Kitchen and the others who assisted to make the process run smoothly for everyone. We are already in the process of planning for next year.

I would also like to welcome our newest board member, Dianne Smith, Kansas Member at-Large, as well as all the retuning board members and committee chairmen. We are looking forward to another fabulous year for MOKSACVPR.

Calendar of Events/Education

October 2013

AACVPR 28th Annual Meeting, Gaylord Opryland Hotel, Nashville, Tennessee – October 3-5 – Click here for more information.

Do you have something interesting for publication? Please let us know! News & Views welcomes letters in good taste on any topic. All letters must be submitted with the writer's name (anonymous letters will not be published). Submissions are limited to one per writer per issue and may be edited to meet space requirements.

AACVPR National Office Contact Information

Please continue to send your questions and comments to AACVPR News & Views via aacvpr@aacvpr.org. Don't hesitate to suggest how AACVPR News & Views can continue to provide you access to information about our profession and AACVPR.

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