

TO: Board of Directors
House of Delegates
Chartered Affiliate Presidents
PACT Co-ordinators

FROM: Toni Rodriguez, EdD, RRT
AARC President

RE: **AARC's Medicare Respiratory Therapy Part B Initiative**

DATE: February 12, 2007

Introduction and Background

Over the last 20 years, AARC has sought to expand access to respiratory therapists by patients outside the hospital. We have focused primarily on the homecare setting and specifically on the home health benefit under Medicare. As you may recall, the home health benefit is highly restrictive and only available to Medicare beneficiaries that are virtual prisoners within their own homes. The bills we had introduced in previous Congresses sought to create a scenario that would permit respiratory therapists to make home visits which would permit measurement of outcomes traceable to the intervention of the RT. Tactically, it was and continues to be, important to us to provide access to these extraordinarily medically fragile patients. The trade-off was that in the near term, patients not homebound but requiring respiratory care services would not have access to RTs under Medicare. We felt that if we were successful in generating positive outcomes through our inclusion in the somewhat limited home health benefit, we could then leverage those outcomes to help document the unique value that respiratory therapists bring to their patients regardless of care setting.

Our strategy was a good one; however, in the intervening years since we embarked on the homecare initiative, several significant changes have taken place within the health care system and Medicare itself. Examples of these changes are:

1. The recognition that patients with chronic diseases require effective and aggressive disease management support.

2. There has been a virtual explosion in the variety and type of aerosol medications proven valuable in the treatment in patients with chronic lung diseases.

Some of you may recall that 20 years ago, “controller” medications were not available. Aerosol therapy consisted primarily of bronchodilator and medications to thin secretions. We now have a wide assortment of aerosol medications and an even wider assortment of aerosol delivery devices. In recent years, we have witnessed a dramatic increase in problems associated with aerosol delivery. Several studies have documented the inadequacy of education on both the professional caregiver and patient side of the equation outside of the hospital, including physician practices. The scientific literature has also made us aware of the value of disease management and the need for patients with chronic diseases to comply with physician orders, especially in the use of “controller” medications.

There is also a growing recognition of the value of tobacco cessation interventions. Even though respiratory therapists are front and center in terms of their involvement with this intervention in hospitals due to their limited access outside the hospital, they have not realized their potential in terms of helping patients.

Finally, we must not forget about all the patients dependent upon oxygen in their homes and other respiratory related devices such as ventilators, CPAP units, etc. Without reimbursement, we all know that care will not occur. Without access to qualified professionals, we all know that quality may be lost.

Yes, respiratory therapists need to be permitted to make home visits. And, yes, respiratory therapists now need to be permitted to render services as part of a physician practice under the Medicare Part B benefit. This is true even though approximately 75% of our profession is employed in hospitals. We recognize future trends and realize that respiratory therapists must have access to patients similar to that enjoyed by other non-physicians, such as physician assistants, nurse practitioners, and clinical nurse specialists. If respiratory therapists are permitted to practice under the Part B section of Medicare, patient access to these therapists will increase geometrically.

At present, respiratory therapists can provide services in a physician practice setting as “incident to a physician’s service.” By Medicare law and regulation “incident to a physician’s service” requires that the physician be on site and immediately available. Many of our colleagues are providing services under this section of Medicare regulations. However, the messages have come to us loud and clear from patients, physicians, and others that there needs to be more participation under Part B circumstances by respiratory therapists if we are to optimize patient care by assuring appropriate disease management, aerosol device selection, patient education, tobacco cessation, office space spirometry, and the list goes on.

Besides the physician, professionals who are recognized in the law as providers of Medicare Part B services are extremely limited and must meet a higher standard than colleagues who do not have separate recognition under Part B. Part B activities by non-

physicians are undertaken with a minimum of physician supervision or in collaboration with the physician. This is quite different than the incident to physician service regulations that require direct on-sight supervision by the physician. Here's an example of what I mean in terms of differences:

Registered nurses are permitted to be employed in physician practices and can render services on behalf of the physician incident to the physician's service, and therefore, under direct supervision. On the other hand, advanced practice nurses who have a higher educational and credentialing requirement are permitted to render services as Part B providers. This means they can furnish a service that the physician would otherwise render directly regardless of the physician's proximity.

Another dimension to this initiative is accessibility. If we are successful in achieving our goal with this initiative, respiratory therapists who are qualified under Part B will be positioned in terms of patient access similar to that of the physician assistant, and the nurse practitioner and the advance clinical nurse specialist.

Moreover, respiratory therapists' services will be billable through the physician practice and trackable from an outcome standpoint in order that specific outcomes generated by the respiratory therapist can be documented. Right now, under the incident to provision the physician bills for the service using only his or her provider number. Under our initiative, when the respiratory therapist performs the service, the RT will have their own identifier that the physician will have to include on the claims form. This change is strategic in the importance of the advancement of our profession because it not only will reinforce the value of highly qualified respiratory therapists in Part B settings, but will also serve to objectively contrast the unique bundle of skills and knowledge that all respiratory therapists possess. The potential for confusing our scope of practice as a subsection of another profession's broader scope of practice will diminish and thus we will have eliminated one of the largest obstacles between where we are now as a profession and where we should be in terms of patient access and services provided in a variety of care settings.

How Can We Achieve This Lofty Goal?

We have enough published evidence to document the need for our services in terms of disease management, aerosol therapy, diagnostics, tobacco cessation, oxygen therapy and ventilatory support.

But, in order to meet that need, we must qualify advanced level respiratory therapists to provide services under Part B. Previously, I mentioned several other professions that have achieved that position. The standards are high, which is why that group of professions is not very large. Indeed, as in the case of nursing, just the advanced level nurses are eligible to furnish services as a separate Part B benefit. The standards for participation have been set for years. They require at least a Bachelor's degree and an advanced level credential.

To us this means respiratory therapists who have earned at least a Bachelor's degree in a health-related science and have earned the Registered Respiratory Therapist credential. They, then, will serve as our trailblazers and help generate the documentation regarding the value of all respiratory therapists.

But, what about our colleagues who do not qualify for what will be a new top rung on our career ladder? They can continue to practice as they do now. Yes, they practice in hospitals, but they also practice in physician offices and render services incident to the physician. This model will not be changed because of our initiative, but what will change if we are successful, is this profession's image, impact on patient care, and its ability to document its unique value. So, even though an entry level therapist will not be eligible for participation in the new initiative, they will nonetheless reap the benefits in terms of enhancement of our professional image and reinforcement of our unique value outside the hospital. AARC can then document those outcomes and leverage to the fullest that evidence to advocate for even broader access for the rest of our profession.

What About Homecare?

Pursuit of inclusion under Part B regulations of Medicare does not exclude homecare. Indeed, if we are successful, our advanced level respiratory therapist will be positioned to provide home visits, visits to skilled nursing facilities, and other visits commonly undertaken by physicians themselves. We, therefore, are not abandoning homecare, but rather we are expanding access with the new initiative to include other settings beyond homecare. One of the advantages with this Initiative would be the advanced level therapist will not be limited to visiting patients who are qualified for just the home health benefit. They will actually be able to make a house call in order to assess the patient's living conditions, equipment status, education level, etc. Of course, that visit will have to be medically necessary, ordered by the physician, and billed through the physician practice. But, nonetheless, patients who up to now were denied access to RTs can have that access under the new initiative.

Conclusion

I'm sure that each and every one of you could fast forward your vision to five or ten years from now, and I'm sure you will agree that if respiratory therapists are to position themselves to be of maximum benefit to their patients and healthcare delivery system, they'll need to be involved in activities which promote early detection, effective therapy and optimum management of patients with chronic lung diseases.

I hope that you'll agree that this new initiative marks the advent of a new era for our profession. We know that the future will demand efficient chronic disease management if we are to balance cost with care. We want to leave the era of the respiratory therapist having to wait patiently for their patients with chronic lung diseases to exacerbate so they can treat them in the hospital. We want to position respiratory therapists so they can manage these patients and bring about an avoidance or minimization of exacerbations, and therefore, a reduction in health care resource consumption.

I'm excited about our initiative, and I hope you are too. It represents a huge opportunity for the AARC and respiratory therapists throughout the country to step up and evolve to that next generation of therapists. I hope that the foregoing comments have helped you understand the importance of the initiative and the need for universal support. Please feel free to contact me with any questions you might have. I will be calling upon each and every one of you to help by putting your shoulders to the wheel and helping to move our profession forward on behalf of our patients.