TO: SKILLED NURSING FACILITIES

FROM: MARYLAND MEDICARE, PART A

DATE: FEBRUARY 26, 1999

SUBJECT: MARYLAND MEDICARE PART A BULLETING REGARDING
RESPIRATORY THERAPY IN SKILLED NURSING FACILITIES

DESCRIPTION:

Goal- The purpose of this bulletin is to differentiate between those services for which the Maryland Medicare Fiscal Intermediary (FI) will recognize payment to Skilled Nursing Facilities (SNF's) under Part A for the services of respiratory therapists as ancillary services, and those respiratory therapy services that will be considered routine nursing services.

Certain respiratory therapy services require the expertise and skills of a respiratory therapist, while others do not. These latter services may be performed by nurses or other qualified personnel. As such, they are considered routine nursing services and may not be billed to Medicare as ancillary services under the 0410-0419 revenue code series *even if performed by a registered respiratory therapist.* Instead, these costs should be included in the routine nursing cost center.

Definition-Respiratory therapy (respiratory care) is defined as those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

Respiratory therapy services include but are not limited to:

1. The application of techniques for support of oxygenation and ventilation in the acutely ill patient. These techniques include, but are not limited to:

- Establishment and maintenance of artificial airways;
- Ventilation therapy and other means of airway pressure manipulation;
- Precise delivery of concentrated oxygen;
- Techniques to aid removal of secretions from the pulmonary tree.

2. The therapeutic use and monitoring of medical gases (especially oxygen), bland and pharmacologically active mists and aerosols and such equipment as resuscitators and ventilators;

3. Bronchial hygiene therapy, including deep breathing and coughing exercises, intermittent positive pressure breathing (IPPB), chest physiotherapy (CPT), and nasotracheal suctioning;

4. Diagnostic tests for evaluation by a physician, e.g. arterial blood gas analyses, pulmonary function tests;

5. Periodic assessment and monitoring of the acute and chronically ill patients for, and the effectiveness of, respiratory therapy services.

Note: *Such services may be performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel according to the professional state licensure.

INDICATION AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY

Criteria for Determining if Respiratory Therapy is Reasonable and Necessary

To be considered reasonable and necessary for the diagnosis or treatment of an individual's illness or injury, respiratory therapy services furnished to a beneficiary must be:

1. Consistent with the nature and severity of the individual's complaints and diagnosis,
2. Reasonable in terms of modality, amount, frequency and duration of the treatments,
3. Generally accepted by the professional medical community as being safe and effective treatment for the purpose used.

Consistent with the Nature and Severity of the Individual's Symptoms and Diagnosis.

A patient's primary or secondary diagnosis alone may justify the need for respiratory therapy, (e.g. acute respiratory failure, pneumonitis, retained secretions, atelectasis, chronic obstruction pulmonary disease). However, there may be cases in which the primary or secondary diagnosis alone does not justify the need for respiratory therapy, but the medical evidence indicates a combination of diagnoses which may justify therapy. In such cases, the intermediary will obtain documentation from the provider which explains the medical necessity for the therapy.

Reasonable in Terms of Modality, Amount, Frequency and Duration of the Treatment.

Although respiratory therapy services may be reasonable and necessary based on the nature and severity of the patient's condition, they must also be reasonable and necessary with respect to modality, amount, frequency and duration. For example, while a patient may require a particular type of modality to accomplish a certain therapeutic objective, the reasonableness and medical necessity may be questionable where more than one type of modality is used at the same time to accomplish the same therapeutic objective, e.g. IPPB and incentive spirometry.

Generally accepted by the professional medical community

Respiratory therapy services are to be accepted by the community as being safe and effective treatment for the purpose used. In addition, the intermediary will make a distinction between respiratory therapy services and routine nursing services.

The following constitute respiratory care services that can be safely and effectively administered by a skilled nursing facility's nursing staff. As such, they are not billable to Maryland Medicare Part A Fiscal Intermediary as ancillary services.

- Administration of "maintenance" aerosolized medicated hand held nebulizer (hhn) treatments when a patient's cardiopulmonary status has stabilized or is at baseline;
- Ongoing administration of a metered dose inhaler (after the initial instruction and follow-up session);
- Ongoing instruction or administration of pulmonary breathing exercises (Deep Breathing and Cough, Incentive Spirometry, Respiratory Muscle Trainer, etc. after initial instruction and follow-up session;
- Routine pulse oximetry measurements (Spo2);
- Maintenance suctioning of artificial airways; and
- Routine tracheotomy care.

The Maryland Medicare medical review staff maintains that routine tracheotomy care, with very rare exception, is a nursing function in a skilled nursing facility and therefore is not reimbursable under ancillary respiratory therapy services (refer to sections 214.2 and 230.10 (f) of the Skilled Nursing Facility Manual, HCFA Pub. 12). In such exceptional circumstances, persuasive documented medical evidence justifying the medical necessity for a respiratory therapist to perform such services is required.

The following respiratory care services may require administration by a qualified respiratory therapist and will be covered as an ancillary service when reasonable and medically necessary.

- Airway care such as establishment of artificial airways (i.e., oropharyngeal, naso-endotracheal placement, specific tracheotomy care interventions such as changing foam cuff to portex tracheotomy in order to use passey muir valve);
- Management of mechanical ventilation which should comprise bundled charges for ventilator checks, adjustments, equipment changes, airway suctioning;
- Diagnostic tests for evaluation by a physician, e.g. blood gas analyses, pulmonary function tests;
- Bronchial hygiene therapy, including, chest physiotherapy (CPT), intermittent positive pressure breathing (IPPB), medicated aerosolized hand held nebulizer treatment (e.g., HHN);
- Periodic assessment and monitoring of the acute and chronically ill patients for indication for, and the effectiveness of, respiratory therapy services such as pulse oximetry for baseline value, titration of oxygen concentration, and when documentation supports compromised cardiopulmonary status;
- Patient training techniques which may include: the initial and a follow-up session when indicated for incentive spirometry or other breathing exercise to achieve sustained maximal inspiration (SMI), meter dose inhaler instruction.

Note: *The above services should include patient assessment and instruction, as these are an integral part of a specific therapy modality and should not be separately billed.

DOCUMENTATION OF MEDICAL NECESSITY

Orders

In order for Respiratory Therapy services to be reimbursable, the services must be specifically ordered by a physician and must include the following:

- type and frequency of therapy
- medication dosage, when applicable
- oxygen concentration, device and/or the specific flow rate must be ordered

The medical records must clearly support the continuing medical necessity for therapy ordered for a prolonged period of time. The diagnosis of "COPD" does not alone indicate the need for skilled administration of Respiratory Therapy (§230.10 3a of the Skilled Nursing Facility Manual HCFA Pub 13). Document the beneficiary's presenting clinical cardiopulmonary symptoms and compare them to the beneficiary's Vaseline (i.e., exacerbation or acute episode, adventitious breath sounds, pulse, respiratory pattern, use of accessory muscles, degree of shortness of breath (rest or with activity), increased inhaler use, as well as objective measurements such as peak flows, oxygen saturation, arterial blood gas, chest x-ray). This documentation must clearly support the medical necessity for the skilled intervention of a respiratory therapist to achieve the desired medical/therapeutic outcome. This medical documentation should be part of the physician progress notes and respiratory therapy notes.

BILLING

An itemized bill (itemized list of charges) that identifies the individual respiratory charges on a daily basis must accompany medical records requested for review. The daily RT documentation must match the itemized ledger for type, duration, and frequency of service billed. Failure to submit itemized charges prevents an appropriate review of Respiratory Therapy services and will result in denials of Respiratory Therapy charges.

Team conferences, discharge summaries, case management and written reports do not constitute a basis for generating a charge under the respiratory therapy ancillary revenue code. These services do not constitute direct medical services to the patient and a rot line item billable. The cost of these services should be included in the departmental charge structure.

<u>Type of Bill</u>
21X: Skilled Nursing Facility, Inpatient Part A
<u>Revenue Code</u>
0410: Respiratory Services

Oxygen therapy billed under revenue code 270 is covered provided the necessity and efficacy is documented. A prescription for "oxygen PRN" or "oxygen as needed" does not meet these requirements. Periodic assessment of arterial PO2 or oxygen saturation will determine the medical necessity for the service.

Questions related to Claims should be directed to Donald Doyle, (410) 561-4036; Audit and Reimbursement to Adam Weber, (410) 561-7948; and Medical Review to Dorothy Sewell, (410) 561-4108.

SOURCES OF INFORMATION

Skilled Nursing Facility Manual (HCFA Pub. 12) §214.2, 230.3, 230.10
Medicare Intermediary Manual (HCFA Pub. 13) §3101.10, 3133
Provider Reimbursement Manual (HCFA Pub. 15) §2604.3
Code of Federal Regulations (CFR) §413.5
Rhode Island Fiscal Intermediary Local Medical Policy

LMRP Number: 99-1

NOTE: This policy was archived effective 05/31/2004.