ZIMMET HEALTHCARE SERVICES GROUP, LLC

Respiratory Therapy & Pulmonary Rehab Billing in Long-Term Care

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This document expresses the professional opinion of Zimmet Healthcare Services Group, LLC ("ZHSG") regarding Pulmonary Rehabilitation and Respiratory Therapy ("PR-RT") services provided in Skilled Nursing Facilities ("SNFs").

ZHSG is an independent consulting firm, unaffiliated with any government agency, contractor, or regulator. The conclusions that follow are based on our interpretation of existing federal and state regulations. We were not contracted or engaged to produce this memorandum and derive no financial benefit from its distribution or impact.

To be clear, I'm not the Sheriff of Reimbursement-town, either.

The volume of inquiries we receive regarding SNF-based PR-RT makes this a document of convenience. It clarifies our longstanding position on the reimbursement-compliance risk from a regulatory perspective, supported by the first data-driven analysis across billing, cost reporting, and quality ratings.

In matters of financial significance, inquiries often escalate into debate and, at times, argument. We have no interest in such discourse because only one opinion matters. Like thousands of others across the SNF-economy, we wait for definitive guidance from CMS – and we have no authority to issue waivers, permissions, or hall passes. So take a deep breath, relax, then slowly exhale...

At Issue

First, this is not a clinical discussion. We do not consider outcomes because outcomes do not change reimbursement mechanics or coverage guidelines. The question is whether PR-RT is billable to Medicare Part B in the long-term care setting. It is, but only in tightly defined and limited circumstances.

Utilization patterns in a growing number of SNFs cannot be reconciled with statutory qualifiers. This is not anecdotal; we cross-contextualized recent provider-specific Medicare Part B claims, cost reports, Medicare and Medicaid PDPM capture, PBJ and other relevant CMS data across typical Skilled Nursing Facilities. The findings took our breath away.

Respiratory Therapy

Respiratory Therapy is not categorically equivalent to Physical, Occupational, or Speech Therapy – confusion is rooted in nomenclature. RT encompasses a broad spectrum of clinical modalities defined by the service, not the clinician delivering it. In fact, in many states, services commonly furnished by Respiratory Therapists fall within the scope of practice of Registered Nurses and, in some jurisdictions, Licensed Practical Nurses. In other words, a nebulizer treatment delivered by an RN, or an RT, or a physician, is a nebulizer treatment. On the other hand, Restorative Nursing and Physical Therapy may appear similar to a casual observer, but the respective activities are defined by who provides it. Respiratory Therapy, using CMS terminology, is deemed "routine" care in nursing facilities. This is a rule with few exceptions.

Medicare - Medicaid

The point of controversy arises with long-stay, dual-eligible residents, for whom Medicaid is the primary payer; Medicare Part B functions as supplemental insurance, not secondary coverage.

Medicaid rate construction is state-specific and too detailed for a full breakdown here. In general terms, a SNF's "base rate" is calculated using allowable costs from prior years. Many states include routine respiratory care in their calculations, some do not. For the typical, non-vent provider, the impact is minimal but the concept matters. If respiratory care costs are included in the Medicaid rate, then billing Medicare Part B for the same services is a duplication risk. This does not, by itself, create a pathway for Medicare billing when RT is excluded from the Medicaid rate; rather, inclusion serves as a disqualifier even before Medicare Part B coverage rules apply.

Examples of routine respiratory care include:

- Nebulizer or inhaler administration
- Chronic oxygen monitoring
- Maintenance breathing exercises
- Generic education absent a new skilled need
- Services nursing staff can safely and effectively provide

Medicare Part B reimbursement in SNFs hinges on the distinction between "routine" and "ancillary" services, subject to a narrow band of coverage. Medicare Part B does not cover routine SNF care, but it may cover discrete Skilled Respiratory Therapy services (HCPCS G0237–G0239) when they are:

- Physician-ordered and medically necessary
- Dependent on the skills of a licensed respiratory therapist
- Time-limited and goal-directed
- Not already included in the Medicaid per diem

If an RN can safely deliver respiratory treatment at the skilled care level, the treatment is, by definition, routine care that Medicare Part B does not recognize (even when excluded from the Medicaid rate). Outside this narrow band, whether an improper payment is duplicative does not change the compliance outcome. "Time-limited" is not an open-ended concept. Routine maintenance care, even when repeated daily, does not qualify.

Pulmonary Rehabilitation (HCPCS G0424)

Medicare Part B covers Pulmonary Rehabilitation as an outpatient benefit. Coverage is restrictive and subject to program requirements that include:

- A qualifying diagnosis (e.g., moderate to very severe COPD; limited non-COPD conditions only when explicitly authorized by the local MAC)
- A physician-prescribed, comprehensive program including exercise, education, psychosocial assessment, and outcomes measurement
- Direct supervision by a physician or qualified non-physician practitioner

These requirements mark the divide between formal outpatient treatment and episodic respiratory assistance embedded in custodial care. It is more than a divide; it is a chasm.

Operationally, only a small subset of long-stay residents qualifies for reimbursable PR, and sustainability in the SNF setting is limited. Long-term care generally follows resolution of acute respiratory instability; residents requiring active pulmonary rehabilitation would typically not yet be clinically appropriate for SNF placement.

Physician or External Outpatient Services

Certain physician or external outpatient services (e.g., ventilator management, diagnostics) may be separately billable. These exceptions are definable and narrow. They do not convert routine respiratory therapy furnished by the SNF into a Medicare Part B-covered ancillary by association.

Current Billing Patterns and Compliance Risk

Recent SNF-based PR-RT billing patterns diverge sharply from statistically plausible scale and scope. Classic markers of a questionable program include:

- Large proportions of LTC residents enrolled
- Near daily or ongoing therapy for chronic conditions
- Utilization clustering at reimbursement thresholds
- Uniform documentation across residents
- Services furnished exclusively to FFS Medicare Part B residents

The last point is critical. Programs restricted to a single payer class raise immediate compliance concerns and routinely cited by enforcement agencies as indicative of non-incidental utilization.

In other words, you cannot document a cure for structurally non-compliant utilization.

Frequently Argued Questions (FAQ)

Why did RT utilization surge?
Systemic overutilization may begin as a simple oversight: a service appears on a claim and is paid. No front-end edit is triggered because the codes are valid in narrow circumstances. Payment suggests coverage, utilization expands, ideas are shared, and well-intentioned vendors spread the practice, often indemnifying providers if the service is denied. At that point, the practice becomes normalized.

But so many providers are billing it.
As stated: normalized.

My documentation is exemplary.
Documentation of improperly normalized services is often framed to support the conclusion that service was appropriate, and reimbursable. Starting with the conclusion and building a narrative that fits is a time-tested approach. Time has spoken many times.

Why are the MACs paying claims?
Medicare operates on a pay-and-review basis. There are limited front-end edits for services that are technically reimbursable in narrow circumstances. Enforcement follows patterns, not first claims. It can take a while.

How do you interpret the data?
Cross-contextualization. Discrepancies between staffing, utilization, expenses, and Part B billing become visible when claims, cost reports, and operational data are reviewed together. A SNF's data profile is important, and it's not invisible.

Isn't the contractor responsible?
Ultimately, no. The SNF's provider number is the billing identifier. Contractors design and staff programs, but liability follows the billing provider. Indemnification clauses do not override CMS rules and routinely fail when enforcement occurs. Financially, indemnity covers what the SNF paid the contractor, not the amount Medicare paid the SNF. In other words, it's a net negative either way.

What level of utilization is reasonable?
For illustration, at the high end, a 100-bed SNF without ventilator capacity may statistically support three or four residents per month with appropriate Part B-covered PR-RT needs, each receiving a short course of care. Monthly revenue may be in the $1,500 range (in total); the cost would likely outweigh revenue due to staffing logistics.

What is my exposure?

We don't know how Medicare would proceed if our position is accurate on the matter. One near certainty is they take back what was paid.

Anything else I should know?

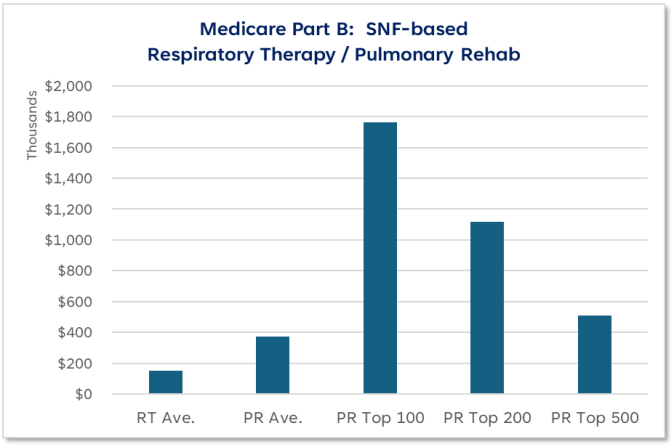
Yes. The impact extends beyond payment and may include:

- Operations: Clustered treatments distort Direct Care hours when residents are in treatment with RTs for extended periods; scheduling and PBJ reporting are affected.
- Case-Mix: Medicaid's transition from RUGs to PDPM is budget neutral in most states. RT-driven Special Care High capture inflates CMI. When one facility is overpaid, others subsidize it.
- Quality: When reported acuity increases without added Direct Care staff, the denominator used to calculate the staffing component can lower a SNF's Five Star rating.
- Litigation: Distorted Data Profiles make impactful soundbites for the Plaintiff's Bar, starting with a facility's sudden shift to high-acuity care without adjusting nursing hours.
- Valuation & Underwriting: Medicare Part B is fragile driver of financial performance. PR-RT at scale can blow up the underwriter's model. No one wants to be on the wrong side of that transaction.

By the Numbers

The number of SNFs billing PR–RT began climbing in Q1 2022. By 2024, my firm had addressed inquiries from operating companies representing thousands of providers considering the program. More than 1,000 submitted Medicare claims at least for one quarter in 2023; that number abruptly fell to 608 in the first quarter 2024, and then began to climb again. For the 12 months ended 6/30/25, 708 providers billed at least one discipline, with average PR net reimbursement approaching $400,000 annualized.

Net Medicare Part B revenue, 7/1/24 - 6/30/25



Air Compliance Index

Take our simple self-diagnosis test by answering True or False to these questions specific to your Respiratory / Pulmonary care program (non-vent unit).

- ☐ An RT is always onsite or on-call when required.
- ☐ RTs - not nurses - handle urgent respiratory interventions.
- ☐ Program cessation would impair regulatory compliance or resident safety.
- ☐ Services are patient-specific, time-limited, and goal-directed; there is no standard utilization protocol.
- ☐ Nursing staff cannot safely provide the services.
- ☐ Residents rarely begin treatment shortly after Medicare Part A benefits end.
- ☐ When residents begin treatment shortly after Medicare Part A coverage ends, it is likely due to a significant change in their clinical risk profile.

Answer the next two only if services are under contract with a third-party company:

- ☐ Documented respiratory care failures existed before the vendor contract began.
- ☐ The vendor is paid in full for their services, even if Medicare denies the claim.

If you answered "True" to all questions above, then breathe easy.

Every "False" is a pollutant released in your environment – it doesn't take much for the Air Compliance Index to make it unsafe to go outside.

Author's Note

Medicare coverage controversies are nothing new. In fact, this is the second time around for Respiratory Therapy. Under SNF cost-based reimbursement in the 1990s, Medicare permitted certain respiratory costs to shift from "Routine" to "Ancillary" when programs and therapists were managed by acute care hospitals. The payer at the time was Medicare Part A. SNF PPS implementation abruptly ended the practice while multiple cases remained under review. The payment mechanics differ today, but the pattern is familiar.

New billing pathways emerge, utilization accelerates, payments flow, and confidence builds—until enforcement catches up. Medicare Part A and Medicaid dominate SNF payment policy discussions, but Medicare Part B plays a meaningful role across the SNF-economy. Differences in perspective are common in this area and often persist in the absence of definitive guidance.

This paper reflects our opinion. We have no insight into state or federal intent, but the notion that Medicare would sustain large-scale, long-term respiratory or pulmonary spending in SNFs while simultaneously advancing managed-dual and shared-savings models defies policy direction and fiscal reality.

It is difficult to envision Medicare opening the wind tunnel on this one. Don't hold your breath. Providers already deeply invested in these programs should come up for air.

Marc Zimmet

Special thanks to Greg Pino from New Jersey Respiratory Associates for the feedback and perspective.

Medicare Part B: Case Study

ZHSG defines eight discrete SNF "Data Domains" that drive a provider's profile. SNF data is fragmented and subject to systemic distortion; meaningful analysis requires contextualization across multiple domains, even before considering state-specific factors that render benchmarking studies, such as national cost report compendiums, of little value. The following analysis is sourced from our analytics platform, z-INTEL *(full access is available on a trial basis)*.

We selected a "Standard Set" provider with significant PR-RT billing for a case study. The freestanding facility is located east of the Mississippi, operates between 120 and 160 dual-licensed beds, with no other certification that would be expected to drive performance outliers, yet Medicare Part B paid the facility $1.65 million for Respiratory Therapy and Pulmonary Function services over the most recently available 12-month window (through 6/30/25).

Medicare Part B Utilization & Reimbursement

Revenue Codes	Ancillary Service	Q3 2024		Q4 2024		Q1 2025		Q2 2025		Total	
		Units	Amount	Units	Amount	Units	Amount	Units	Amount	Units	Amount
041X	Respiratory Services	8,279	$223,757	12,285	$334,603	9,790	$223,166	8,587	$214,706	38,941	$996,232
042X	Physical Therapy	2,723	$49,862	3,079	$55,757	2,748	$48,876	2,646	$46,977	11,196	$201,471
043X	Occupational Therapy	2,938	$53,338	2,646	$47,450	2,157	$37,653	2,417	$43,037	10,158	$181,478
044X	Speech Therapy Language Pathology	471	$29,387	453	$28,121	345	$21,400	371	$23,863	1,640	$102,771
046X	Pulmonary Function	9,567	$37,756	9,560	$67,719	20,007	$218,939	26,131	$327,565	65,265	$651,979
063X	Pharmacy - Extension of 025X	33	$1,816	15	$1,024	14	$1,039	-	-	62	$3,879
077X	Preventive Services	33	$1,003	14	$531	25	$775	-	-	72	$2,309
091X	Behavioral Health Treatments/Services - Extension of 090X	-	-	-	-	-	-	275	$7,880	275	$7,880
Total		24,044	$396,918	28,052	$535,204	35,086	$551,848	40,427	$664,029	127,609	$2,147,999

Worksheet C of the 2024 Medicare cost report compares ancillary costs and charges. The closest comparable line item to PR-RT is Oxygen (Inhalation) Therapy. Note that Total Charges are not collectable; the figures serve as a benchmark for Medicare Part A allocation.

	Cost Center Description	Total (from Wkst. B, Pt. I, col. 18)	Total Charges
		1	2
ANCILLARY SERVICE COST CENTERS			
40	Radiology	17,662	10,839
41	Laboratory	9,711	9,321
42	Intravenous Therapy		5,252
43	Oxygen (Inhalation) Therapy	74,079	1,364,823
44	Physical Therapy	434,231	2,005,915
45	Occupational Therapy	484,183	2,091,517
46	Speech Pathology	201,433	437,406
47	Electrocardiology		
48	Medical Supplies Charged to Patients		117
49	Drugs Charged to Patients	158,009	136,587
50	Dental Care - Title XIX only		
51	Support Surfaces		
52	Other Ancillary Service Cost	4,009	

	Cost Center Description	Total Cost (from Wkst. B, Pt. I, col. 18)	Program Part A Cost (from Wkst. D., Pt. I, col. 4)
		1	4
ANCILLARY SERVICE COST CENTERS			
40	Radiology	17,662	3,877
41	Laboratory	9,711	2,775
42	Intravenous Therapy		
43	Oxygen (Inhalation) Therapy	74,079	
44	Physical Therapy	434,231	74,619
45	Occupational Therapy	484,183	77,494
46	Speech Pathology	201,433	40,178
47	Electrocardiology		
48	Medical Supplies Charged to Patients		
49	Drugs Charged to Patients	158,009	55,143
50	Dental Care - Title XIX only		
51	Support Surfaces		
52	Other Ancillary Service Cost	4,009	

Worksheet D reports Medicare Part A ancillary services. We calculated the utilization ratio by dividing Part A charges by total charges (columns removed for simplification). No charges appear attributable to this population, suggesting participation may have varied by payer.

Variable	Facility
Nursing: Extensive Services	11.7%
Nursing: Special Care High	39.7%
Nursing: Special Care Low	17.6%
Nursing: Clinically Complex	13.5%
Nursing: Behaviors and Cognitive Performance	5.2%
Nursing: Physical Function Reduced	12.3%
End-Split: Isolation	11.7%

The Medicare Part A PDPM Nursing component provides additional context.

Ventilator and/or tracheostomy care are scored ES3 (both) or ES2 (one). Isolation alone qualifies for ES1.

Extensive Services and Isolation account for 11.7% of the PDPM mix. This means that the facility likely did not provide (or less likely, capture) ventilator/tracheostomy care to its Medicare Part A population for the year.

The facility reported employing a half-time Respiratory Therapist and no contract RT hours. Reported direct-care nurse staffing averaged 3.5 hours per resident day, below the 4.16 case-mix benchmark. Time spent with RTs may affect how care delivery is operationalized; however, CMS' staffing methodology does not account for RT time. As a result, staffing ratings are calculated solely on reported nursing hours. Additional data would be required to assess any relationship between respiratory service utilization and staffing outcomes, but the facility's one-star rating in the Staffing domain is noted for context.

	OCCUPATIONAL CATEGORY	Paid Hours Related to Salary in col. 3		Half time FTE on payroll, zero contract hours reported by facility.		
		4				
Direct Salaries			Contract Labor			
	Nursing Occupations			Nursing Occupations		
1	Registered Nurses (RNs)	4,575	14	Registered Nurses (RNs)		
2	Licensed Practical Nurses (LPNs)	51,454	15	Licensed Practical Nurses (LPNs)	8,897	
3	Certified Nursing Assistants/Nursing Assistants/Aides	89,105	16	Certified Nursing Assistants/Nursing Assistants/Aides	12,389	
4	Total Nursing (sum of lines 1 through 3)	145,134	17	Total Nursing (sum of lines 14 through 16)	21,286	
5	Physical Therapists	7,624	18	Physical Therapists		
6	Physical Therapy Assistants		19	Physical Therapy Assistants		
7	Physical Therapy Aides		20	Physical Therapy Aides		
8	Occupational Therapists	5,929	21	Occupational Therapists		
9	Occupational Therapy Assistants		22	Occupational Therapy Assistants		
10	Occupational Therapy Aides		23	Occupational Therapy Aides		
11	Speech Therapists	2,391	24	Speech Therapists		
12	Respiratory Therapists	1,053	25	Respiratory Therapists		
13	Other Medical Staff		26	Other Medical Staff		

Hours Per Resident Day	
	Facility
Reported RN HPRD	0.26
Reported LPN HPRD	1.18
Reported Nursing Aide HPRD	2.06
Reported Total Nursing HPRD	3.5
Adjusted RN HPRD	0.24
Adjusted LPN HPRD	1.1
Adjusted Nursing Aide HPRD	1.92
Adjusted Total Nursing HPRD	3.26
Case-Mix RN HPRD	0.73
Case-Mix LPN HPRD	0.93
Case-Mix Nursing Aide HPRD	2.5
Case-Mix Total Nursing HPRD	4.16

I am not familiar with this provider and make no allegation of improper conduct. Certain specialty units within SNFs can justify atypical utilization. This facility does not appear to fall into that category, and most providers we reviewed exhibited similar profiles, but as noted earlier, SNF data is fragmented, distorted, and frequently non-comparable.

It is possible that material context is missing. Either way, we await CMS clarification of coverage. Absent that, the pattern is difficult to ignore. In fact, it's ***unbe-reathable!***