Supervision of Cardiac and Pulmonary Rehabilitation Services

The Issue
The undersigned groups support legislation, S. 488, that would allow physician assistants, nurse practitioners and clinical nurse specialists to supervise cardiac and pulmonary rehabilitation programs on a day-to-day basis under Medicare. This bill would not alter the requirement for medical direction of these programs – it would simply allow non-physician practitioners to meet the “direct supervision” requirement, which mandates that either an MD or DO be available and accessible at all times when services are being furnished under these programs.

In 2008, the Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275) established the cardiac and pulmonary rehabilitation program under Medicare. After this law was enacted, the Centers for Medicare and Medicaid Services (CMS) promulgated new regulations that allow non-physician practitioners (NPPs) to meet physician supervisory requirements for many outpatient services. Unfortunately, the way the MIPPA law was drafted would not allow these new rules to extend to cardiac and pulmonary rehabilitation programs. As a result, current law requires a level of direct physician supervision for cardiac and pulmonary rehabilitation that is inappropriately and unnecessarily more stringent than other outpatient services. This limitation can reduce access to cardiac and pulmonary rehabilitation services, particularly in physician shortage areas, and adds unnecessary costs for these high-quality programs.

Background
Cardiac rehabilitation (CR) and pulmonary rehabilitation (PR) are medically directed and supervised programs designed to improve a patient’s physical, psychological, and social functioning. Both programs utilize supervised exercise, risk factor modification, education, counseling, behavioral modification, psychosocial assessment and outcomes assessment. MIPPA established Medicare coverage for CR and PR as long as a physician, who serves as Medical Director\(^1\), ensures that the programs are safe, comprehensive, cost effective, and medically appropriate for individual patients. The Medical Director typically leads a multidisciplinary team of healthcare professionals that may include nurses, exercise physiologists, respiratory therapists, dietitians, health educators, behavioral medicine specialists, and other healthcare professionals.

Medicare also requires a physician to be immediately available for each CR and PR session – or “direct physician supervision.” This individual is typically not the Medical Director and is mainly responsible for responding if an emergency arises. In similar outpatient settings, federal regulation allows NPPs to provide certain aspects of “direct physician supervision” in accordance with scope of practice and state licensure laws.

\(^1\) CMS requirement based on Section 144 of the Public Law 110-275, titled, “Medicare Improvements for Patients and Providers Act (MIPA) of 2008.”
We believe current law imposes a more stringent requirement for direct physician supervision for CR and PR than should be required, making it challenging for CR and PR programs to operate in areas where physicians are scarce and imposing unnecessary costs in both rural and urban areas. Evidence also suggests that even if all eligible CR patients did have access to existing CR programs, current capacity would only be able to meet the needs of about half the patients. Limited resources, including physician supervision challenges, would prohibit the growth and expansion of CR programs to meet these needs.\(^2\) Although Congress has made it clear that the goal of the cardiac and pulmonary rehabilitation program is to enhance access to these important services, CMS has stated that a statutory change is needed to extend the same flexibility to CR and PR that is available for other hospital outpatient services.

**The Legislative Correction**

S. 488 would allow NPPs to provide day-to-day supervision of CR and PR programs. Medicare statute identifies these individuals as physician assistants, nurse practitioners and clinical nurse specialists.

The safety of CR in a medically supervised, community-based program is well established.\(^3,4\) Additionally, NPPs are already utilized in a number of critical care environments, including Critical Access Hospital emergency departments, hospitals and hospital clinics, emergency rooms, intensive care units, recovery rooms, cardiac catheterization laboratories, heart failure and arrhythmia clinics, community clinics, health centers, urgent care centers, walk-in clinics, and many other sites. NPPs are highly trained to respond should emergencies arise.

This legislation was introduced by Senator Chuck Schumer (D-NY) and Senator Crapo (R-ID). Last Congress, it was also cosponsored by Senators Baldwin (D-WI), Blumenthal (D-CT), Boxer (D-CA), Durbin (D-IL), Franken (D-MN), Gillibrand (D-NY), Grassley (R-IA), Harkin (D-IA), Markey (D-MA), Risch (R-ID), Thune (R-SD) and Warren (D-MA).

**Supporters**

- The American Association of Cardiovascular and Pulmonary Rehabilitation
- American College of Cardiology
- American Heart Association
- Association of Black Cardiologists
- Heart Failure Society of America
- National Association for Medical Direction of Respiratory Care
- National Women’s Health Network
- Mended Hearts
- Mended Little Hearts
- Preventive Cardiovascular Nurses Association
- Society for Women’s Health Research
- WomenHeart
- The Women’s Heart Alliance

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\(^4\) Safety of cardiac rehabilitation in a medically supervised, community-based program. Scheinowitz M, Harpaz D. Cardiology.