Supervision of Cardiac and Pulmonary Rehabilitation Services

The Issue

The undersigned groups support legislation 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 allowed non-physician practitioners (NPPs) to meet physician supervisory requirements for many outpatient services. Unfortunately, the way the MIPPA law was drafted precluded extending this flexibility 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) of2008."

We believe current law imposes a more stringent requirement for direct physician supervision for CR and PR than should be required, making it a challenge 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

The legislation 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 many 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 bipartisan legislation was introduced in the House by Rep. Lynn Jenkins (R-KS) and Rep. John Lewis (D-GA) as HR 1155 and S 1361 was in the Senate, by Senators Crapo (R-ID), Stabenow (D-MI) and Klobuchar (D-MN).

Supporters

- The American Association of Cardiovascular and Pulmonary Rehabilitation
- American College of Cardiology
- American Heart Association
- Association of Black Cardiologists
- Association of Rehabilitation Nurses
- 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 National Coalition for Women with Heart Disease
- The Women's Heart Alliance

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[2] The Current and Potential Capacity for Cardiac Rehabilitation Utilization in the United States. Quinn R. Pack, MD, et al. Journal of Cardiopulmonary Rehabilitation and Prevention. 2014; 34: 318-326.

[3] Safety of Monitoring Exercise for Early Hospital-based Cardiac Rehabilitation. Chul Kim, Chang Jin Moon, Min Ho Lim. Ann Rehabil Med. 2012 April; 36(2): 262–267.

[4] Safety of cardiac rehabilitation in a medically supervised, community-based program. Scheinowitz M, Harpaz D. Cardiology. 2005;103(3):111-7. Epub 2005, Jan 19.