

PULMONARY DISCIPLINE

North Carolina
Cardiopulmonary
Rehabilitation Association
46th Annual Symposium

DISCLOSURE

I have no actual or potential
conflict of interest in
relation to this
program/presentation

Discussion Topics



**2026 Reimbursement
Updates**



**Home Health and PR
Delivery**



Virtual PR

Purpose
AACVPR Consensus Statement on
VPR and Remote
Modes of Delivery
Requirements



Discussion

Final 2026 Reimbursement Rates

	Procedure Code	APC	On-Campus & Excepted Off-campus HOPD Payment Rate	Non-Excepted Off-Campus HOPD Payment Rate	PFS Non-Facility Payment Rate	PFS Non-Facility Payment Rate (Non-Qualifying APM)
CR	93797	5771	131.70	52.66	17.79	17.70
	93798	5771	131.70	52.68	26.18	26.05
ICR	G0422	5771	131.70	131.70	133.60	132.94
	G0423	5771	131.70	131.70	133.60	132.94
SET	93668	5733	60.27	24.11	15.44	15.36
PR	94625	5733	60.27	24.11	87.95	87.51
	94626	5733	60.27	24.11	109.77	109.22
ORS	G0237	5731	29.55	11.82	12.76	12.69
	G0238	5731	29.55	11.82	11.41	11.36
	G0239	5732	38.16	15.26	14.43	14.36



Cardiac Rehabilitation



Pulmonary Rehabilitation



Supervised Exercise Therapy



Outpatient Respiratory Services

Home Health Care (HHC) and CR/PR



Unless a policy states otherwise, MC beneficiaries **MAY** receive both HHC and CR/PR concurrently



CR/PR are physician services and physician services are **excluded** from HH consolidated billing rules.

"The CPT codes used for CR/PR services do not conflict with any of the HHC consolidated billing codes." (National Director of Home Care)

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch 7, §30.1.1):



"The patient may be considered homebound if the absences from the home are infrequent or for periods of relatively short durations or are for the need to receive health care treatment."

Medicare and Home Health Care official government booklet (CMS Product No. 10969 August 2023):

"You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like an occasional trip to the barber, a walk around the block, or attendance at a family reunion, funeral, graduation, or other infrequent or unique event. You can still get home health care if you attend adult day care or religious services."

Adapted from AACVPR The Pulse Digest post by Matthew Thomas, March 19, 2026

Consensus Statement on the Virtual and Remote Delivery of Cardiac and Pulmonary Rehabilitation and Their Components

Joel W. Hughes, PhD; Robert Berry, MS, ACSM-CEP; Todd M. Brown, MD, MSPH; Brian Carlin, MD; Kariann Drwal, MS, CCRP, ACSM-CEP, ATC/LAT; Steven J. Keteyian, PhD; David Z. Prince, MD; Wen-Chih Wu, MD, MPH

J Cardiopulm Rehabil Prev 2025;45(6):387-396.

Supplemental Digital Content:**Consensus Statement on the Virtual and Remote Delivery of Cardiac and Pulmonary Rehabilitation and their Components**

AACVPR convened a writing group to define virtual and remote delivery of CR-PR and their components. This **Supplemental digital content** includes additional information such as the statutory definitions, additional tables, and a longer discussion of reimbursement.

Statutory Definitions**Pulmonary Rehabilitation**

The statute for PR [42 CFR 410.47(b)(2)] is similar to that for CR, and states:

Components. Pulmonary rehabilitation must include all of the following:

- (i) Physician-prescribed exercise during each pulmonary rehabilitation session.
- (ii) Education or training that is closely and clearly related to the individual's care and treatment which is tailored to the individual's needs and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life. Education must include information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
- (iii) Psychosocial assessment.
- (iv) Outcomes assessment.
- (v) An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

Delivery Models of Pulmonary Rehabilitation

• Traditional “In-Center” Delivery

- Patient and PR professional are in the **same location/same time**

• Virtual Delivery

- **Two-way, audio-visual communication**
- Patient and PR professional are **not in the same location**
- PR professional observes patient in real-time using an audio-visual platform

• Remote Delivery

- Communication occurs outside the exercise session
- Patient submit **logged data, such as exercise and/or vital signs or symptoms** via phone or digital tool
- May include periodic **in-person, video or telephone encounters**

• Hybrid Delivery

- Combines two or more of the above delivery methods

Synchronous/In-Person



Synchronous/Real-time Audio-visual (Virtual)



Asynchronous (Remote)



Why Virtual???

Benefits of PR

- ✓ Improves exercise capacity/tolerance
- ✓ Reduces dyspnea
- ✓ Improves HRQOL
- ✓ Decreases exacerbation frequency
- ✓ Reduces healthcare costs
- ✓ Safe for COPD and other chronic respiratory diseases
- ✓ Associated with reduced mortality
- ✓ Nationwide Korean Study – Reduces exacerbation and mortality in COPD

**Center-base PR is dramatically underutilized.
Virtual PR can expand access!!!**

Pulmonary Rehabilitation

—Live Better and *Live Longer*



Pulmonary Rehabilitation & Mortality in the United States



- COPD is the 3rd leading cause of death worldwide
- >16 million people diagnosed with COPD in the US



Pulmonary Rehabilitation

- ↑ Exercise capacity
- ↑ Quality of life
- ↓ Exacerbations



- Recent assessment of claims data for 197,396 Medicare beneficiaries discharged after hospitalization for COPD

↓37%

in mortality in those who received pulmonary rehabilitation within 3 months of hospital discharge



- **But only 3-4% of Medicare beneficiaries with COPD receive Pulmonary Rehabilitation**

Lindenauer et al., (2020). Association Between Initiation of Pulmonary Rehabilitation After Hospitalization for COPD and 1-year Survival Among Medicare Beneficiaries. JAMA. 323:1813-1823

Pulmonary rehabilitation helps patients feel better and live longer, but is underutilized

For more information about pulmonary rehabilitation, visit www.livebetter.org

ACCESSIBILITY

Most COPD patients – especially in rural areas – cannot reach PR centers reliably.

- **40%** of adults w/COPD have **poor access to PR**
- Rural areas ~ **89%** have **poor access**
- **Commute burden grows quickly:**
 - 15 miles = **73.2%** access
 - 25 miles = **86.6%** (~ 45-60 minutes in traffic)
 - 50 miles = **97.1%**, but often unrealistic for routine attendance
- **Rural Patient Reality**
 - Within 10 miles = **11.3%**
 - Within 15 miles = **24.3%**
 - Within 25 miles = **53.4%**
 - Within 50 miles = **88.6%** (2-hour round trip)

Virtual PR removes the distance barrier entirely

Figure 3.



[Open in a new tab](#)

Availability of pulmonary rehabilitation (PR) centers among Medicare beneficiaries with chronic obstructive pulmonary disease across the United States, 2018. PR center information is for 2020, and Medicare data are for 2018.

Access to Pulmonary Rehabilitation among Medicare Beneficiaries with Chronic Obstructive Pulmonary Disease. Ann Am Thorac Soc. 2023 Apr;20(4):516-522

Virtual Pulmonary Rehabilitation (VPR): CMS Policy Update ... *CMS-approved, home-based delivery beginning 2026*

Program Eligibility

- PR, CR, ICR
- HOPD and physician-office programs

CMS Requirements

- Patient located **in the home**
- **Real-time, two-way, continuous audio-visual** technology
- **Virtual-only or hybrid** delivery permitted
- Remote delivery (asynchronous delivery) not covered by CMS

Policy Status

- Authorized through **December 31, 2027**
- AACVPR advocating for permanent extension



Programs must maintain standard PR documentation, physician oversight, and safety protocols

Pulmonary Rehab Program Requirements

Statutory Foundation

- Defined by Social Security Act (§1861 ssa.gov)
- 42 CFR 410.49

Eligible Program Location

- Hospital Outpatient Department (on or off-campus)
- Physician Office-based program

Supervision

- Immediate supervision required (*can be virtual*)
- MD/DO medical director
- NP/PA/CNS may supervise (*effective January 2024*)

Documentation

- Physician-signed ITP
- Updated every 30 days
- Supports medical necessity & billing

These requirements apply specifically to patients with Medicare insurance. Non-governmental insurers often have varying requirements for CR-PR programs, although they tend to mirror those of Medicare.



Next Steps

We are awaiting guidance from CMS about

- Need to attach modifiers to charges for virtual sessions
- Need to register home addresses for patients

AACVPR will continue to advocate for the Sustainable Cardiopulmonary Rehabilitation in the Home Act (H.R. 783/S. 248) which aims to make this coverage permanent for HOPD-based programs

AACVPR will continue to support the permanent extension of COVID-19 era telehealth flexibilities to allow this coverage to be permanent for physician office-based programs as well

Definition of Pulmonary Rehabilitation (ATS / ERS)

Table 4

American Thoracic Society Core Components of Pulmonary Rehabilitation^a

Patient Assessment

1. An initial facility-based assessment by a health care professional
2. An exercise test at the time of assessment
3. A field exercise test
4. Quality of life measure
5. Dyspnea assessment
6. Nutritional status evaluation
7. Occupational status evaluation

Program Components

8. Endurance training
9. Resistance training

Method of Delivery

10. An exercise program that is individually prescribed
11. An exercise program that is individually progressed
12. Team includes a health care professional with experience in exercise prescription and progression

Quality Assurance

13. Health care professionals are trained to deliver

^aAdapted from Holland AE, Cox NS, Houchen-Wolloff L, et al. Defining Modern Pulmonary Rehabilitation. An Official American Thoracic Society Workshop Report. *Ann Am Thorac Soc*. May 2021;18(5):e12-e29, and organized by the domains of Patient Assessment, Program Components, Method of Delivery, and Quality Assurance.

Hughes et al. Consensus Statement on the Virtual and Remote Delivery of Cardiac and Pulmonary Rehabilitation and Their Components. *J Cardiopulm Rehabil Prev* 2025

“A comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies which include but are not limited to exercise, training, education, and behavior change. The goal of PR is to improve the physical and emotional condition of people with chronic respiratory disease and to promote long-term adherence to health enhancing behaviors.”

Key Elements

- Comprehensive, multidisciplinary intervention
- Individualized exercise training
- Education and behavior-change strategies
- Ongoing assessment and monitoring
- Focus on long-term self-management

Outcomes Assessment

Methods for Measuring Outcomes in Hybrid PR

Questionnaires to assess health related QOL, physical activity, nutrition, psychosocial issues and smoking habits and other behaviors can be completed through:

- Email
- Phone interview
- In-person visits (before and/or after rehab sessions that are part of a hybrid plan)
- Patient portal to EMR (e.g., My Chart)

Outcome	Measurement
Functional status/ Exercise capacity	6 MWD
Dyspnea	e.g., Baseline Dyspnea Index, Modified medical Research Council Scale
Health-related QOL	COPD Assessment Test, St. George Respiratory Questionnaire

AACVPR Guidelines for Pulmonary Rehabilitation Programs, 5th ed. 2020, p 92.

Patient Selection Process

- Determine which options are available
 - In-person, Virtual, Hybrid
- Develop patient selection criteria
 - Triaging patients
- Update your current ordering process
 - Update marketing & referring provider education materials
 - Collaborate with ordering providers and other services

Tip: Consider In-person evaluation for all patients

Considerations for Patient Selection

- Risk Stratification
- Medical History
- Telemetry/ Oximetry Monitoring
- Fall Risk
- Adherence
- Mental Health/ Cognitive Status

Tip: Start your program slow, consider starting with one patient population and then expanding.

Table 5

Categories of Patients That May Require More Careful Analysis and Discussion Before Enrollment in Virtual and Remote Cardiac and Pulmonary Rehabilitation

- Poorly compensated heart failure as determined by referring provider or medical director
- Compensated heart failure but undergoing medication titration
- Unstable angina (a contraindication for participation in cardiac rehabilitation per the American College of Sports Medicine Guidelines for Exercise Testing and Prescription 11th ed. p. 229).
- Complex arrhythmias
- Symptomatic valvular disease
- Resting systolic blood pressure >200 mmHg or diastolic blood pressure >100 mmHg
- Left ventricular assist device
- Staged percutaneous intervention planned with ongoing symptoms
- Documented history of syncope without a definite diagnosis and/or undergoing workup
- Uncontrolled paroxysmal or symptomatic tachycardia or bradyarrhythmia
- Pulmonary hypertension
- Severe hypoxemia
- Life expectancy <1 year
- Challenges utilizing technology required for participation, including communication barriers (ie, cognitive, hearing, language, etc.)
- Inconsistent bandwidth or telephone access
- Noncompliance with safety protocols
- Decline in clinical status
- New symptom onset
- Significant cognitive impairment

Hughes et al, 2025

Patient & Health Care System Determinants

Patient Determinants

- Financial Barriers
- Transportation
- Employment
- Caregiver
- Technology available & technological literacy
- Communication barriers
- Patient preference
- Psychosocial status
 - Benefits/ deterrents with group setting

Health Care System Determinants

- Availability
- Wait Lists
- Geographic location
- Technology assistance



Patient Assessment

- In-person assessment is preferred and should precede initiation of any PR program, regardless of method of delivery
 - Optimal for performing physical assessment and functional testing
 - Assessment of functional capacity and responses to exercise
- Virtual/synchronous evaluation may be only option
 - Some tests can be completed via direct instruction and observation but may not be as reliable and reproducible as in the in-person setting
- Other clinical and environmental risk factors to consider when determining patient eligibility to participate in virtual/remote setting without in-person supervision
- Some patients may be more appropriate to start in-person, then transition to hybrid or virtual/remote program

Clinical Factors	Environmental / Technical Factors
Cardiovascular risk factors	Lack of accessibility or physical remoteness from emergency personnel
Fall risk	Unreliable internet bandwidth and telephone access, data caps for participants using smartphones
Neuro-cognitive barriers (increased impulsivity, decreased sensory and motor skills, lack of adherence to prescribed treatment and safety guidelines)	
Poorly controlled and/or severe hypoxemia	
Severe pulmonary hypertension	
Legally blind	
Substance and/or alcohol abuse	

Safety Steps for Virtual Rehab

- Medical Director Virtual Supervision
- Update existing policies & protocols as needed
 - Strategies to Prevent Adverse Events
 - Strategies to Manage Adverse Events
 - Tracking Adverse Events
- Collaborate with other departments
 - Telehealth
 - Information Technology
 - Patient Safety
- Complete additional staff training & drills in virtual modalities and emergency protocols
- Thorough intake assessment to ensure patient safety
 - Assistive devices, support system, home safety concerns, etc.
- Individualized Treatment Plans

Medical Emergencies- Home Exercise

- Emergency plan to address home exercise
 - Safety procedures at home
 - Exercise Prescription
 - Recognition and tracking of symptoms
 - Monitoring vitals
 - When to stop exercising
 - When and how to call EMS
 - Importance of updating the CR/PR team

Medical Emergencies during a Virtual Session

- Modify Exercise Prescription
- Cessation of Exercise
- Consultation with Medical Director
- Mental health/ suicide ideation
- Initiating EMS
 - Process to initiate EMS immediately
 - ***Know your patient's emergency contacts, physical location at each appointment.***

Tip- if completing group sessions consider patient/provider ratio and dealing with emergencies in a virtual group session (Technology for breakout availability, support staff).

Medical Director

Medical Director input and oversight in the virtual/remote setting are required to approve the ITP and help establish patient appropriateness for virtual/remote PR

CR and PR Exercise Prescription

- Benefits associated with CR and PR primarily tied to changes in skeletal muscle
- Have to train at similar intensities as traditional CR/PR to get similar benefits
- Resist urge to decrease intensity during virtual sessions
- Monitor exercise intensity via HR, RPE or Talk Test
- Use exercise videos or encourage walking in home if patient has no equipment
- Introduce virtual CR/PR based on patient presentation

CR and PR Exercise Progression

- Meet patient where they are initially
- Consider increasing duration over intensity for more deconditioned patients initially
- Goal: Minimum of 150 min/wk moderate intensity exercise
- Titrate intensity to top of range as patient demonstrates improvement
- Consult the AACVPR Consensus Statement on virtual CR and PR

Do non-exercise components of CR improve outcomes?

- **Yes.** (And, the whole is greater than the sum of the parts.)
- “The comprehensive delivery of the recommended core components is associated with reductions in mortality and morbidity.”
- Particularly **exercise**, **psychosocial management**, and **patient education**.

Kabboul, N. N., Tomlinson, G., Francis, T. A., Grace, S. L., Chaves, G., Rac, V., ... & Krahn, M. (2018). Comparative effectiveness of the core components of cardiac rehabilitation on mortality and morbidity: a systematic review and network meta-analysis. *Journal of clinical medicine*, 7(12), 514.

Technical Requirements

- For Providers
 - Must provide live, two-way, audiovisual communication
 - Web-based conferencing platforms allow multiple participants
 - Webcam and microphone
 - Headset recommended to reduce ambient noise
- For Patients
 - Internet capable device capable of running conferencing software
 - Stable internet connection (Wi-Fi preferred)
 - Ear buds or headset recommended

Required Patient Resources

- Access to an IT device – smart-phone, tablet or laptop
- Internet access
- An email address
- A quiet room with space suitable for exercise
- Exercise equipment

Service Provider Resources for VPR

- A large SMART TV screen IT device with cables to connect TV to computer.
- A computer/ laptop connected to the screen will be required to deliver the class.
- Use of WebEx/ MS Teams/Attend Anywhere platform (using a professional license) will support VPR delivery.
- Wireless headphones with microphone and an external camera are optional but may reduce noise disruption and improve view.
- Systems should be put in place locally so that patients can return questionnaires without cost.

Staffing

- The current PR guideline from the NCP Respiratory (2020) recommends the staff to patient maximum ratio is 1:8 for face-to-face exercise training.
- For VPR, a second person for IT and emergency support is recommended. This may be particularly important for the first number of classes.
- Other considerations regarding determining staffing resources include developing a concise escalation plan and SOP should emergency support be required.
- Completing a trial run with IT system locally to ensure relevant staff and patients are competent with its use may help to determine staff requirements.

Considerations (Home-grown programs)

- HIPPA compliance must be maintained
 - Caution patients against self-disclosing sensitive information
 - Discourage use of patient's full name when logging into session
- Partner with your health system's telehealth and IT departments
 - Use secure patient portals to protect patient privacy
- Vet patients before admitting to session
- Optimize visuals for mobile devices
- Hybrid programs: Class times and education schedule
 - Consider maintaining the same schedules between facility and virtual programs

Considerations (3rd party vendors)

- All of the home-grown program considerations apply
- Additional considerations:
 - Referrals
 - Hybrid or fully virtual
 - Billing
 - Revenue
 - Staff qualifications
 - Delivering other core components
 - Does the program meet YOUR standards for CR/PR
 - Patients may not realize their care has been transferred to a 3rd party

PR Reimbursement (Medicare Beneficiaries)

Provider must interact with patient for entire session duration using **real-time** a-v technology

All requirements and components of a PR program must be met

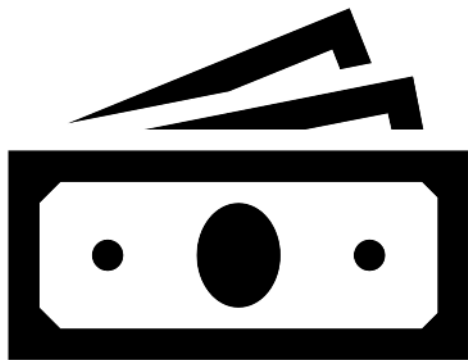
MD or non-MD supervision is required but virtual supervision is permitted when needed

CR/PR/ICR services have been permanently included in Medicare telehealth services list

CMS does not view the Remote Physiologic Monitoring (RPM) codes as being equivalent to the CPT codes used for CR-PR and does not reimburse these codes when used in this manner.

Services must be delivered in the home, not in other locations such as a community fitness center or gym

PR Reimbursement (Non-Governmental Payers)



- MCOs
- Private Payers
- Self-pay
- Private payers may not have same restrictions as billing under the Medicare system
- Important to know your program's payer mix and coverage determinations

Other Discussion

Questions???

Connie.Paladenech@advocatehealth.org

336-713-8850

