

Improving Efficiency in Care Delivery and Patient Access in Cardiac Rehabilitation

What Is Cardiac Rehabilitation?

Cardiac rehabilitation, or CR, is an intervention proven to improve quality of life (Shepherd, 2012), increase exercise tolerance and function (Epstein, 2020), decrease risk of subsequent cardiovascular events, and lower mortality rates (Martin, 2024).

CR has been found to reduce overall premature mortality by about 20% and cardiac deaths by about 30% in comparison with usual care for cardiac patients (Jolliffe, 2001; Heran, 2011). While cardiovascular-related deaths appeared to be declining since the 1950s, these deaths have increased in recent years, with 931,578 fatal cardiovascular, or CV, events in 2021 (Martin, 2024).

Exercise programs for cardiac patients, commonly referred to as cardiac rehabilitation programs, are defined by the Centers for Medicare & Medicaid Services as formal physician-supervised programs that include prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. CR personnel need to safely and effectively: 1) conduct exercise testing; 2) implement exercise therapy for coronary disease, heart failure, and other conditions; 3) interpret cardiac rhythms; 4) deliver effective education that promotes health behavioral change; and 5) maintain certification in basic life support and Advanced Cardiac Life Support techniques from the American Heart Association.

Cardiac rehabilitation consists of three phases. Phase I is the inpatient phase, where patients begin receiving education and training on their disease process and symptom monitoring, identifying of risk factors, monitoring hemodynamic stability and response to intervention, and ensuring safety and ability to perform tasks related to self-care and mobility prior to hospital discharge. Phase II is the outpatient phase and is the program described previously in this brief. Phase III is the maintenance phase in which the patient demonstrates adherence to and independence with their exercise program and education received in Phases I and II.

Cardiac Rehab Can Help Decrease Health Care Costs

Not only is the number of individuals affected by cardiovascular disease significant, but the health care costs of the disease are enormous. The estimated direct and indirect cost of heart disease from 2019 to 2020 was \$252.2 billion in the United States. This cost includes coronary heart disease, heart failure, hypertensive disease, cardiac dysrhythmias, rheumatic heart disease, cardiomyopathy, pulmonary heart disease, and other or ill-defined heart diseases (Martin, 2024).

Cardiovascular diseases accounted for 12% of total U.S. health expenditures in 2019 to 2020, more than any major diagnostic group (Martin, 2024).



Exercise-based CR in low-risk patients after myocardial infarction, percutaneous coronary intervention, or heart failure has reduced hospital admissions and improved health-related quality of life compared with usual care (Anderson, 2014). CR has also been shown to reduce hospital readmissions by 18% (Medina-Inojosa, 2021).

A 2024 study of over 600,000 Medicare beneficiaries (ages 65 and older) demonstrated that CR added 1.344 quality-adjusted life-years and saved \$40,472 in costs over the remaining lifetimes of participants (Shepard, 2024).

Difficulties In Access To Cardiac Rehabilitation In Current Model

Despite cardiac rehabilitation's effectiveness, only 28.6% of eligible Medicare beneficiaries participate in CR (Oehler, 2023). Of those who participate, the dropout rate is cited at 24%-50%, despite evidence that there is a dose-response to CR, i.e., the more sessions attended, the better the outcomes (Resurrección, 2018; Medina-Inojisa, 2021). CR participants who attend all 36 Medicare-covered sessions experience a 47% lower risk of death and a 31% lower risk of heart attack compared with those who attend only one session (Alfaraidhy, 2022). Aside from intrapersonal and interpersonal factors, the dominant themes for dropout or lack of enrollment center on access: logistical reasons (transport, distance); cardiac rehabilitation program characteristics (inconvenient timing, cardiac rehabilitation equipment); and health system reasons (financial assistance for transport, long waiting list) (Resurrección, 2018).

An initiative called Million Hearts was launched to address the top two causes of death in the U.S.: heart disease and stroke. The campaign, co-led by CMS and the Centers for Disease Control and Prevention working alongside other parts of the Department of Health and Human Services and the Department of Veterans Affairs, seeks to prevent 1 million preventable cardiovascular disease events in the next five years. On average, someone in the U.S. has a heart attack every 40 seconds, with about 605,000 new attacks and 200,000 recurrent attacks each year (Martin, 2024). The Million Hearts campaign efforts focus on building healthy communities and optimizing care. Care optimization has been centered on five pillars: 1) Improved appropriate aspirin and/or anticoagulant use; 2) Improved blood pressure; 3) Improved cholesterol management; 4) Improved rates of smoking cessation; and 5) Increased utilization of cardiac rehabilitation. Despite the 2011 launch and 2022 update of the HHS Million Hearts campaign, CR participation has not improved across the nation.

Unfortunately, CR-eligible participation statistics demonstrate greater disparities in CR utilization by several subpopulations, attributed to lower initial CR referral rates and lower participation rates. These disparities have been attributed to many factors that impede access: transportation; copays and finances; timing of programming that conflicts with work, childcare, and life roles; distance and time to program; physical abilities to use standard CR equipment; and language and cultural barriers.

Who are Physical Therapists?

Physical therapists help people optimize their quality of life. Physical therapists are movement experts who prescribe exercise, hands-on care, and patient education. They play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span and in a variety of settings. They help people rehabilitate from devastating injuries, manage chronic conditions, avoid surgery and prescription drugs, and create healthy habits. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. Physical therapists receive a clinical doctorate degree, the DPT, before taking a national physical therapy licensure exam. Physical therapists are licensed and have some level of direct access (i.e., can see patients without a physician referral) in all U.S. jurisdictions.

The Cardiovascular and Pulmonary Clinical Specialist Certification in Physical Therapy

The American Board of Physical Therapy Specialists is the governing body for specialization certification of licensed physical therapists. Specialization is the process by which a physical therapist builds on a broad base of professional education and practice to develop a greater depth of knowledge and skills related to a particular area of practice. Clinical specialization in physical therapy responds to a specific area of patient need and requires knowledge, skill, and experience exceeding that of the entry-level physical therapist. There are currently 10 areas of postgraduate specialization ranging from oncology to cardiovascular and pulmonary.

Eligibility requirements to become a board-certified clinical specialist in cardiovascular and pulmonary physical therapy include 2,000 clinical hours with this patient population (25% of which has to be within the last three years), current Advanced Cardiac Life Support certification by the American Heart Association, and submission of a data analysis project or case report. Candidates must then pass a rigorous examination that has been validated. Specialization certification lasts 10 years. Recertification requires direct patient care hours, engagement in professional development activities, a case reflection submission, and passing the validated exam. In 1981, APTA established the cardiovascular and pulmonary clinical specialization, and in 1985 the first of these specialists was recognized. As of July 2025 there

are 591 certified cardiovascular and pulmonary physical therapy clinical specialists. Individuals who hold these credentials work in all settings (academia, acute care, subacute care, outpatient, and home health) as well as across the lifespan (pediatrics through adults).

The Role of Physical Therapists in Cardiac Rehabilitation

PTs play an essential role in the rehabilitation of patients with heart failure and chronic obstructive pulmonary disease. Physical therapists have been involved in providing cardiac rehabilitation education for years, developing safe and effective exercise prescriptions for patients with a wide range of cardiac diagnoses and other complex medical issues. PTs perform posture and breath control assessment; movement and motor control testing; orthopedic and musculoskeletal examination; vestibular, oculomotor and balance screening; autonomic testing; inspiratory and expiratory muscle testing; gait speed and kinematics; gas exchange analysis; flexibility, strength, endurance, and power testing; and much more. These physical examination components are critical for developing an effective treatment plan to maximize functional exercise capacity, which is well known to reduce cardiovascular morbidity and mortality.

With baby boomers currently being the primary CR population, there is a growing trend for CR patients to be older and more medically complex (Alfaraidhy, 2022). These patients can benefit from greater individualization by PTs within CR programming, such as the addition of falls risk reduction exercises, treatment to address musculoskeletal pains, and more.

Current Challenges With the Medicare Cardiac Rehabilitation Program

Medicare Part B covers regular and intensive cardiac rehabilitation programs provided in a physician's office or hospital outpatient setting (including a critical access hospital) with a physician immediately available and accessible for consultation and emergencies.

Medicare Part B covers cardiac rehab for patients with at least one of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina (chest pain)
- A heart valve repair or replacement

- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable chronic heart failure
- Peripheral arterial disease with intermittent claudication (leg pain on exertion)

Under current Medicare policy, the cardiac rehabilitation model allows physicians, physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac rehabilitation programs. The required components of cardiac rehabilitation are typically provided by registered nurses and exercise physiologists, although other providers may provide care including physical therapists, occupational therapists, and others.

Cardiac rehabilitation is provided in a group setting of one provider to every four or five patients. However, in order to be reimbursed for cardiac rehabilitation, the providers are utilizing billing codes that are described as "incident to" physician codes, which means the providers providing care can only bill under the physician's National Provider Identification. Medicare limits cardiac rehabilitation programs to a maximum of two 1-hour sessions per day, up to 36 sessions over a period of 36 weeks. (There is an option for an additional 36 sessions if the Medicare Administrative Contractor approves the extension). In this model, there are two sets of charges – the charge of the visit of the supervisory practitioner and a bundled charge for the other providers who implement the monitored exercise and education.

Many patients who would be appropriate candidates for CR but who do not have access to cardiac rehabilitation programs due to distance often seek physical therapy to improve their function and exercise tolerance. PTs who manage these patients provide care on a 1-to-1 basis, without physician supervision, and bill using the 97000 series therapy CPT codes utilized by physical therapists.

Policy Recommendations to Improve Patient Access to Cardiac Rehab Under Medicare

To improve patient access to cardiac rehab, improve payment efficiencies, and provide flexibilities for providers and patients, the current cardiac rehab program should be modified to authorize licensed physical therapists who are board-certified clinical specialists in cardiovascular and pulmonary physical therapy to supervise patients' day-to-day cardiac rehabilitation care. These PT providers can improve access and efficiency in the delivery of these life-extending CR programs. As such, Congress should amend Title XVIII Section 1861(eee) of the Social Security Act to include these specialized therapy providers in their list of clinicians who can supervise cardiac rehabilitation programs.

CASE STUDY: Board Certified PT Specialist Bringing Access and Efficient to Veteran Population

The Veterans Health Administration is the largest health care system in the United States. There are 139 medical centers with oversight of regional outpatient clinics and about 1,000 total clinics for veterans to access care. Currently, 8.3 million veterans are enrolled in VA for their care. Veterans have higher rates of cardiovascular disease than the civilian population (Hinojosa, 2020) and rural patients exhibit higher heart failure rates than patients living in urban areas (Turecamo, 2023). As 61% of U.S. rural veterans are served by VHA, this is a population of 2.7 million veterans who may need access to cardiac rehabilitation.

To increase veterans' access to cardiac rehabilitation services, the Specialty Care Program Office of VHA created the VA National Center for Cardiopulmonary Rehabilitation. A physical therapist who is a board-certified clinical specialist in cardiovascular and pulmonary physical therapy is a co-chief consultant to this national center. This centralization allows tracking, standardization, and central guidance to build new programs in underserved areas, restructure existing programs, and determine how to reengage facilities that have stagnant

rehabilitation programs. This centralization also leads to decreased use of community care services and works toward one of VHA's priorities: connecting veterans to the soonest and best care. Research studies have demonstrated the whole health cardiac and pulmonary rehab approach leads to increased quality of life for the individual and decreased utilization of health care services. This decreased utilization of health care services leads to increased savings for medical centers. As the largest health care provider in the United States, this approach could lead to significant savings for VHA. Positioning a board-certified physical therapy specialist in this central role will lead to better and more efficient CR care for our veterans.

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