The above professional medical organizations are seeking clarification of key changes that have been put in place to address the broad impact of Cov-19 on the Medicare program. The following concerns and questions are specific to cardiac rehabilitation and pulmonary rehabilitation services during this crisis.

1. **Physician supervision – regulatory vs statutory requirements.**
   We appreciate the amendment to the definition of direct supervision by CMS (FR, Vol. 85, No. 66, pg. 19246) to allow cardiac and pulmonary rehabilitation services to meet that requirement through virtual presence with audio/video real-time communications technology during the national health emergency (NHE). However, it is unclear to us if that provision has the effect of overriding current statutory language at 1861(eee)(2)(B) that states, in part, “a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program….”. Before issuing broad directives to our cardiac and pulmonary rehab programs, we want to confirm that the modification of rules during the NHE signal that **ALL** aspects of the statutory language can be met through audio visual or other similar electronic technologies.

   Please clarify this nuanced but important aspect of physician involvement.

2. **Both cardiac and pulmonary rehabilitation are subject to time sensitive components to satisfy appropriate provision of services tied to CPT 93797/98 and HCPCS code G0424, respectively.** To
ensure that we accurately inform the thousands of individuals who are integral to the multi-disciplinary team that provides these services, do the revised rules under the NHE permit use of codes 93797 (nonmonitored cardiac rehab) and G0424 (pulmonary rehab) solely through telephonic communication, or is a visual component required? We acknowledge that the Agency’s answer to this question is tied to #1, above, as we readily recognize that a physician would not be physically immediately available in the event of a medical emergency.

If the Agency agrees that all requirements for physician involvement can be met during a telephonic or similar audio and visual electronic communication, can a member of the hospital’s multi-disciplinary team reach out to a Medicare beneficiary enrolled in cardiac or pulmonary rehab telephonically and, after a ≥ 31 minute encounter, bill for those services under the hospital outpatient framework? The nuance is, does the team member need to visually witness (“real time”) the beneficiary exercising when required or is it acceptable to meet the exercise requirement when the beneficiary states he/she exercised earlier that same day?

We acknowledge this presumes the home is an extended PBD site of service for our patients who are not being allowed to come to the cardiac or pulmonary rehab center during this crisis.

3. If the Agency believes that it is inappropriate to bill for services using 93797 or G0424 without a visual component or without meeting a real time requirement, we strongly urge the Agency to clarify use of telehealth codes to permit reimbursement for members of the multi-disciplinary team to contact their patients in accordance with the definitions of those codes and bill accordingly through the hospital outpatient methodology.

4. Lastly, current policy for access to pulmonary rehabilitation services is tied to specific diagnoses. We strongly urge the Agency to expand coverage criteria to include Medicare beneficiaries hospitalized with a diagnosis of Covid-19. The disease is primarily a respiratory disease and there is likely strong benefit from pulmonary rehabilitation during the recovery process. We recognize several key caveats:
   a. We are recommending this expansion ONLY for patients hospitalized with a diagnosis of Covid-19.
   b. We are recommending that this expansion of coverage be in place for one year after discharge from the hospital.
   c. We recognize that the scientific basis for such a recommendation is very limited; however, rehabilitation of these patients is obviously a key intervention for their full recovery and ability to return to gainful employment/activities of daily living. Many of these hospitalized patients may not meet current coverage criteria and it will likely take more than a year, at best, for appropriate studies to be completed to provide the evidence base that is often provided to CMS and others to expand coverage.