TODAY I WILL DISCUSS...

1. Medicare requirements for the Individualized Treatment Plan (ITP)
2. AACVPR Program Certification requirements for the ITP
3. Core Components are the key
4. Making your ITP functional
5. Individualize to target behavior change
6. Best practice examples

GRQ, LLC
I am a co-author of a book that has an ITP template.
WHAT’S WORKING—WHAT’S NOT?
Medicare provisions

- Cardiac rehabilitation program and intensive cardiac rehabilitation: Conditions of coverage - 42 CFR section 410.49

- Pulmonary rehabilitation program: Conditions for coverage - 42 CFR Section 410.47

- Federal Register, Nov 25, 2009, Vol. 74, No. 226, pgs 62002 (PR) and 62004 (CR)
Cardiac and Pulmonary

- Outcomes assessment
  - Done at beginning and end of program
  - Objective clinical measures of exercise performance ("effectiveness of PR program")
  - Self-reported measures of exertion (RPE or Borg dyspnea scale) and behavior
Cardiac and Pulmonary

- Each program decides what measures will be tracked
  - pre & post ("outcomes assessment") versus
  - every 30 days ("ITP")
INDIVIDUALIZED TREATMENT PLAN

- Written care plan tailored to *individual patient* = *opportunity*
- Comprehensive components
  - Initial assessment
  - Interventions
  - Re-assessment
  - Evaluation
5 components of ITP:

1. Diagnosis
2. Plan for exercise frequency, intensity, modality, & duration
3. Measureable and expected outcomes
4. Individualized goals
5. Estimated timetables to achieve identified outcomes goals

*Each of these components should be part of the ITP, i.e., one document, but obviously not one page
Cardiac and Pulmonary

- Written plan established, reviewed, and signed by a physician every 30 days
- *In consultation with staff!*
- Entry ITP-developed over 1st 1-2 sessions
Cardiac and Pulmonary

- Every 30 days = Calendar Days
- Example: 1x/wk for one month = 30 calendar days
- Final ITP with program completion
- Some MACs allow flexibility in “30-day” rule; some do not
  - CMS: “...not intended to be a rigid protocol”
Cardiac and Pulmonary

- Components
  - Physician-prescribed exercise
    - What does this mean?
  - Psychosocial assessment
  - Education, training, counseling, risk factor modification
  - Tailored to each patient’s individual needs

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Cardiac and Pulmonary

- Medical Director is
  - Involved substantially in directing progress of individuals in the program
  - “A plan is developed by a physician in conjunction with the interdisciplinary team.”
    - Fed Reg, 11-25-2009, pg 61880

- Pulmonary only
  - Including direct patient contact related to the periodic review of patient’s treatment plan
  - What does that mean?
So who signs the ITP?

- Cardiac - “a physician”- no reference to medical director
- Pulmonary - “If the plan is developed by the referring physician who is not the PR physician*, the PR physician must also review and sign the plan prior to initiation of PR.”
  *Only the medical director needs to sign the pulmonary rehab ITP
  *PR physician here refers to medical director
Suggestion for PR ITP:
- Add statement with MD signature to document MD direct contact, such as,
- “I have seen this patient and agree with the plan for the next 30 days.”

CR & PR ITP:
- You don’t need more than one MD’s signature on the ITP.
Disclaimers
 I do not represent AACVPR regarding program certification.
 I do not serve on the AACVPR program certification committee.

Facts
 The program certification process is continually evolving & improving.
 Program certification requirements do not equate to CMS requirements.

Personal Opinions
 Going through the AACVPR program certification process is an excellent QI experience whether you submit application or not.
 Allow a year to complete the process.
Four required categories (domains)

- Education
- Nutrition
- Psychosocial
- Exercise
AACVPR Program Certification Requirements for the ITP

- HIPAA Compliant on submission
- Categories labeled if AACVPR template is not used
- Single document (that does not mean one page)
- Assessment & reassessment scores should be on the ITP
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Intervention</th>
<th>Evaluation</th>
<th>Follow-up</th>
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<tbody>
<tr>
<td>Psychosocial</td>
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<tr>
<td>Education</td>
<td>Education</td>
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</tbody>
</table>

### Assessment - Psychosocial
- Goal: To quit smoking
- To decrease to < 10 cigs/day in the last year

### Assessment - Nutrition
- Present Weight: 214 lbs
- Height: 5'11" feet
- Weight Goal: 200 lbs
- Pre Weight: 214 lbs
- Pre BMI: 32.4

### Assessment - Education
- Learning Needs Goal:
  - To improve knowledge of cardiovascular disease management evidenced by self-reporting

### Intervention - Psychosocial
- Discussed trigger action and coping techniques
- Referral to smoking cessation specialist

### Intervention - Nutrition
- Needs modification in:
  - Diet
  - Exercise
  - Psychological Issues
- Update nutrition information

### Evaluation - Nutrition
- Body Fat: 38.4%

### Intervention - Education
- Reviewed / Discussed

### Follow-up - Psychosocial
- Non-smoker
- Decreased to < 10 cigs/day

### Follow-up - Nutrition
- Progress toward normal ranges?

### Follow-up - Education
- Self reports improvement in knowledge of CAD management
AHA/AACVPR Scientific Statement:
Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update

Joint ACCP/AACVPR Evidence-Based Clinical Practice Guidelines:
Pulmonary Rehabilitation
1. Nutritional counseling
2. Weight management
3. Blood pressure management
4. Lipid management
5. Diabetes management
6. Tobacco cessation
7. Psychosocial management
8. Physical activity counseling
9. Exercise training
INITIAL PATIENT ASSESSMENT

Assessment (my preferred term)
- Medical history from patient ands from records
- “Tell me your story.”

Interventions
- Plan that prioritizes goals and intervention strategies
  - Involve the patient
- Discharge plan reflects progress toward short & long term goals
- Communication with patient, appropriate family, and PCP
- Appropriate medications and immunizations

Expected Outcomes
- ITP
- Outcome Report
- Discharge Plan

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Assessment
- Nutritional Intake
- Eating Habits and alcohol consumption
- Establish target goals related to weight, hypertension, diabetes, heart failure, kidney disease, other
- Co-morbidities

Interventions
- Specific dietary modifications to achieve goals above
- Education of patient and family
- Incorporation of behavior change models and compliance strategies

Expected Outcomes
- Patient adheres to prescribed diet
- Patient understands prescribed diet
- Plan has been developed to address problems
Assessment
 Height, Weight, Waist Circumference. Calculate BMI

Interventions
 Establish short and long term target goals
 Develop a combined diet, physical activity/exercise, and behavioral program based on goals
 Aim for energy deficit

Expected Outcomes
 Short-term-- continue to assess and modify interventions
 Provide referral if goals are not achieved
 Long-term--Patient adheres to diet and physical activity program

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#3 - Blood Pressure Management

**Assessment**
- Assess resting, both arms, and orthostatic
- Assess current treatment and compliance
- Assess potential drug interactions

**Interventions**
- Monitor drug therapy in concert with PCP
- Implement interventions based on BP levels

**Expected Outcomes**
- Short term - continue to assess & modify interventions to goal
- Long term - maintain at goal
Assessment
- Fasting total, HDL, LDL, and triglycerides
- Assess impact of diet, drugs, other conditions
- Assess current treatment and compliance
- Repeat lipid profiles as per guidelines
- Assess creatine kinase and liver function per NCEP

Interventions
- Therapeutic Lifestyle Change diet counseling
- Weight management counseling
- Drug treatment as appropriate per NCEP and AHA/ACA
- Monitor effectiveness and adverse reactions along with PCP/cardiologist

Expected Outcomes
- Treatment to goal
#5 - Diabetes Management

Assessment
- Presence or absence of diabetes - obtain FBG and HbA1c
- History of s/s and complications (CAD, eyes, kidneys, feet, neuropathy and hypo/hyperglycemia)
- Identify physician managing diabetes and treatment
- Consider stratification to High Risk

Interventions
- Educate patient and staff to s/s, self-monitoring
- Plan blood sugar testing, education, and exercise based on medications or insulin use and schedule
- Referral to certified diabetic educator and support group

Expected Outcomes
- Self monitoring, medical management, provider communication, FBG and HbA1c to guidelines, BP management
Assessment
- Smoking/other tobacco use status; quantity and duration
- Readiness to change
- Psychosocial factors related to successful cessation
- Exposure to second-hand smoke

Interventions
- If reluctant to change behaviors, use “5 Rs”
  - Relevance, Risks, Rewards, Roadblocks, Repetition
- If willing to change behaviors, use “5 As”
  - Ask, Advise, Assess, Assist, Arrange
- Education and counseling, physician contact, support groups, pharmacological therapy

Expected Outcomes
- Quit date established with patient
- Quit smoking and adhere to therapy and counseling
- Complete abstinence from smoking and other products
- No exposure to environmental tobacco smoke
Assessment
- Identify clinically significant levels of depression, anxiety, anger or hostility, social isolation, marital/family distress, substance abuse, and sexual dysfunction/adjustment
- Identify use of psychotropic medications

Interventions
- Education and counseling, including family when possible
- Teach self-help strategies, establish supportive environment
- Refer to appropriate mental health specialists as needed

Expected Outcomes
- Absence of clinically significant psychological indicators
- Compliance with prescribed medications
- Ability to self-manage

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#8 - PHYSICAL ACTIVITY COUNSELING

Assessment
- Current activity level-domestic, occupational, recreational
- Evaluate relative to age, gender, and daily life
- Assess readiness to change behavior, self-confidence, barriers, and social support

Interventions
- Provide education, support, and counseling
- Individualize exercise program; consider work simulation
- Encourage accumulation of 30-60 minutes of moderate intensity activity most days of the week
- Counsel to minimize musculoskeletal injury

Expected Outcomes
- Increased participation in activities
- Improved psychosocial well-being, aerobic fitness, body composition, reduction in stress, etc.
Assessment
- Symptom-limited exercise testing, when available
- Risk stratification based on evaluation

Interventions
- Develop Ex Rx for aerobic and resistance training
- Specify modalities, frequency, intensity, duration, and progression, based on evaluation result
- Medical director or referring physician should review, modify as necessary, approve, and sign
- Include warm-up, cool-down, and flexibility exercises

Expected Outcomes
- Reduced symptoms, attenuated physiologic response to physical challenges, improved psychosocial wellbeing, increased fitness, flexibility, muscular endurance, and strength
- Reduced cardiovascular risk and mortality
Track meaningful outcomes
- If you don’t know your data, you don’t know how to get where you need to go
- Demonstrate improved patient outcomes
- If you aren’t getting where you need to go, you need to change something
- Individualize the plan to enhance behavior changes that lead to clinical outcomes
INDIVIDUALIZE PATIENT CARE

- Opportunity to individualize care
- Opportunity to obtain Medicare reimbursement for 1:1 or group counseling
- Make patient contract part of ITP?
- Include patient by assessing readiness to change for identified behaviors
1. Are you losing weight?
   a. Yes, I have been for more than 6 months.
   b. Yes, I have been but for less than 6 months.
   c. No, but I intend to in the next 30 days.
   d. No, but I intend to in the next 6 months.
   e. No, and I do not intend to in the next 6 months.

2. Have you reduced your stress level?

3. Are you increasing your exercise?

4. Do you want to stop smoking?

5. Do you want to lower your cholesterol?

6. Are you reducing fat in your diet?

7. Do you practice some form of daily relaxation?
Responses indicate that the participant is in the following stage for each behavior. Educational efforts should be targeted to the appropriate stage.

- **Maintenance** = Yes, I have been for more than 6 months.
- **Action** = Yes, I have been but for less than 6 months.
- **Preparation** (or pre-action) = No, but I intend to in the next 30 days.
- **Contemplation** = No, but I intend to in the next 6 months.
- **Pre-contemplation** = No, and I do not intend to in the next 6 months.

Exercise - Initial Assessment

Date:

Stages of change:

__ Pre Contemplation  __ Contemplation
__ Preparation            __ Action
__ Maintenance            __ Relapse

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RISK STRATIFICATION

- CMS does NOT require risk stratification
- AACVPR program certification does NOT require risk stratification
- What does risk stratification mean in 2012?
- 1970: Is exercise safe for cardiac patients?
- 1990: Research demonstrated it is
- 1980: Can cardiac rehab impact CVD progression?
- 1990: Research demonstrated it can
Risk stratification is most meaningful for:

- Stratifying patients for risk of disease progression
- Assisting patients in implementing interventions (behavior changes) that will reduce the likelihood of future cardiac events

See AACVPR Guidelines for Cardiac Rehab/Secondary Prevention, pgs 56-61
Two multi-state registries are available now:

- WiCORE
  - https://wicore.wisc.edu/

- Montana Outcomes Project
  - http://www.macvprmmontana.com/montana-outcomes-project/
AACVPR RESOURCES FOR THE ITP

- AACVPR Registry launches June, 2012
- Enrollment is open now
- Will link Certification and Registry databases
- Tools for tracking patient outcomes and program performance in meeting evidence-based guidelines
- Will provide national outcomes data for benchmarking
AACVPR Pulmonary Rehabilitation Outcomes Toolkit

- Contains most widely used measures in each domain

http://www.aacvpr.org/resources/resourcesform edicalprofessionals/pulmonaryrehabilitationoutcomestoolkit/tabid/490/default.aspx
Telemetry Vendor ITP documents

- Outstanding job in developing and continually evolving software
- Offer flexibility for individual program needs
  - Choice of tools
  - Ability to document supervising MD of the day?
- Medicare compliant
- Aid in patient and program outcomes analyses
INDIVIDUALIZED TREATMENT PLAN: Pulmonary Rehabilitation / RC SERVICES

**EXERCISE:** See MD orders.
Exercise workloads will be progressed gradually within limits of patient's ability.
Progression based on Borg dyspnea of 3-5 and absence of untoward symptoms during exercise.

**INDIVIDUAL COUNSELING:** Education on disease self-management strategies including:
- Dyspnea control techniques at rest, activity and ADLs
- Inhaled and respiratory medications
- Exacerbation prevention & management
- O2 Rx, system, safety
- ADL management and pacing
- Panic & depression management
- Nutrition & weight management
- Smoking cessation
- Home exercise plan & guidelines
- Intimacy
- Safe travel
- Advanced directives

**PATIENT GOALS**
- Breathe better
- Increase endurance/stamina
- Improve weight
- Control panic / anxiety
- Other:

**Problems / Goals**

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<thead>
<tr>
<th>Initial Assessment</th>
<th>Reassessment</th>
<th>Final Assessment</th>
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**Education by RN or RCP (sessions):**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Date/Initial:</th>
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<tbody>
<tr>
<td>Knowledge deficit of disease self-management strategies</td>
<td></td>
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<tr>
<td>Poor control of dyspnea</td>
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<tr>
<td>Barriers to learning: speech, hearing, vision, literacy, cognitive</td>
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<tr>
<td>☐ Effective partners with MD / team to prevent and manage disease-related impairments</td>
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**Hypoxemia Problem:**

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<tbody>
<tr>
<td>☐ Hypoxemia</td>
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<tr>
<td>☐ No home O2</td>
</tr>
<tr>
<td>☐ No port. O2</td>
</tr>
<tr>
<td>☐ Needs O2 Rx recommendation</td>
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<tr>
<td>☐ Poor knowledge O2 use/safety</td>
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<td>☐ DME</td>
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**Goal:**

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**Education topics: training by RN or RCP**

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<tr>
<td>☐ Disease overview</td>
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<tr>
<td>☐ Breathing strategies, dyspnea control at rest, with panic, exercise, ADLS</td>
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<tr>
<td>☐ Respiratory medication</td>
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<tr>
<td>☐ Exacerbation prevention, management</td>
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<tr>
<td>☐ Panic control</td>
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<tr>
<td>☐ Secretion clearance</td>
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<tr>
<td>☐ travel Clinitmacy</td>
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<tr>
<td>☐ Home exercise program</td>
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<td>☐ Advance directives</td>
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**Demonstrates disease self-management strategies**

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</tr>
<tr>
<td>☐ Dyspnea control during rest, ADLs and exercise</td>
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<tr>
<td>☐ Using Rxs as directed</td>
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<tr>
<td>☐ Mobilizes secretions effectively</td>
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<tr>
<td>☐ Demonstrates strategies for anxiety and depression management</td>
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</tbody>
</table>

**Demonstrates knowledge of O2 Rx at rest and with exercise**

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<tr>
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<td>☐ Demonstrates knowledge of O2 safety</td>
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<tr>
<td>☐ Using O2 as Rx'd</td>
</tr>
<tr>
<td>☐ Has home O2 as Rx'd</td>
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<tr>
<td>☐ Uses port. O2 as Rx'd</td>
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**Demonstrates knowledge of O2 Rx at rest and with exercise**

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<td>☐ Uses port. O2 as Rx'd</td>
</tr>
</tbody>
</table>
# Individual Cardiac Treatment Plan

**Name:**

**DOB:**

**Age:**

**Date entered program:**

**Diagnosis:**

**Risk strat for cardiac event:**

**Allergies:**

**Physician:**

**Office vs:**

### Exercise

#### Initial Assessment
- Stages of change: pre-contemplation
- contemplates, prep, act, maintain, relapse
- Other: ___________
- 6-MWT Stress test: Other: ___________
- Other: ___________
- RPE: ___________
- SPO2: ___________
- MET level: ___________

#### Exercise prescription
- Mode: ___________
- Frequency: ___________
- Duration: ___________
- Intensity: ___________
- Progression: ___________
- Angina with ex: ___________
- Resistance train: ___________

#### Hypertension
- Y N Medication Diet
- Resting BP: ___________
- Peak Exercise BP: ___________
- Meds: ___________

#### Intervention
- Type: ___________
- Frequency: ___________
- Duration: ___________
- Resistance training: ___________

#### Education
- Self pulse: ___________
- Ex safety: ___________
- B/S to report: ___________
- Low Na diet: ___________
- BP Medication: ___________

#### Target goal:
- Individual exercise Rx (1):
  - BP <140/90 or <130/80 if DM or CKD (1)
  - Aerobic active 30+ min 5 days per week (1)

### Re-Assessment

#### Exercise prescription
- Mode: ___________
- Frequency: ___________
- Duration: ___________
- Intensity: ___________
- Progression: ___________
- Angina with ex: ___________
- Resistance train: ___________

#### Hypertension
- Y N Medication Diet
- Resting BP: ___________
- Peak Exercise BP: ___________

#### Intervention
- Type: ___________
- Frequency: ___________
- Duration: ___________
- Resistance training: ___________

#### Education
- Self pulse: ___________
- Ex safety: ___________
- B/S to report: ___________
- Low Na diet: ___________
- BP Medication: ___________

#### Target goal:
- Individual exercise Rx (1):
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### Re-Assessment

#### Exercise prescription
- Mode: ___________
- Frequency: ___________
- Duration: ___________
- Intensity: ___________
- Progression: ___________
- Angina with ex: ___________
- Resistance train: ___________

#### Hypertension
- Y N Medication Diet
- Resting BP: ___________
- Peak Exercise BP: ___________

#### Intervention
- Type: ___________
- Frequency: ___________
- Duration: ___________
- Resistance training: ___________

#### Education
- Self pulse: ___________
- Ex safety: ___________
- B/S to report: ___________
- Low Na diet: ___________
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#### Target goal:
- Individual exercise Rx (1):
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<table>
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<tr>
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<th>Nutrition- Re-Assessment</th>
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<td>□Weekly Weights</td>
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<td>□Exercise Class to promote exercise &amp; daily activities for weight loss</td>
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<td><strong>Target Goal</strong></td>
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<tr>
<td>HbA1C &lt; 7%</td>
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<td>BMI &lt; 25</td>
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<td>LDL &lt; 70 HDL &gt; 60</td>
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2010 Cardiac and Pulmonary Rehabilitation Medicare Provisions; 42 CFR 410.47 & 410.49


Pgs 62002-62005
THANKS TO

AACVPR Program Certification Committee members-
- Bonnie Anderson, MS, RCEP
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- Susie Carter, RN
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