EP/CEP Reimbursement Town Hall on Accreditation Q&A: You Asked. We Answered.

The task force has responded to all questions asked during the Nov. 22, 2021, EP/CEP Reimbursement Town Hall on Accreditation.

How long will it take to get reimbursement (provide milestones, timelines, etc.)?

This is a long-term project. With so many stakeholders involved — the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), insurers, etc. — it will take time to educate policymakers and others as to the benefit of further incorporating certified clinical exercise physiologists (CEPs) and certified exercise physiologists (EPs) into the health care system. The American College of Sports Medicine (ACSM) will advocate for CEPs and EPs until we are successful in ensuring that dedicated health care professionals like these are recognized for the important work they provide in the health care system.

What is the task force trying to bill for?

In October 2019, the AMA introduced several Category III codes that seem to describe services that CEPs can provide, e.g., health and wellness coaching, behavioral counseling and chronic-care management. These services would be provided outside of cardiac rehabilitation/pulmonary rehabilitation because any services delivered in those programs are included in the bundled charge and not separately billable. Some of these services could potentially be provided in either clinical or nonclinical settings. The use of these codes would not be exclusive to clinical exercise physiologists, and other disciplines may also be qualified to provide these services.

How do we communicate this to hospitals when they are hiring exercise physiologists or clinical exercise physiologists?

The ACSM Committee on Certification and Registry Boards (CCRB) is guided by a strategic plan that includes employer-engagement activities — among them recruitment, continuing education opportunities and advocacy of ACSM exercise professionals because their unique professional competencies. CCRB plans to engage directly with hiring managers to share information of the unique skill set (e.g., education, training, experience) of ACSM Certified Exercise Physiologists® (ACSM-EPs) and Certified Clinical Exercise Physiologists® (ACSM-CEPs) to drive toward comparable, competitive salaries and improve recruitment opportunities.

In addition to the Category I codes in cardiac rehab, is the task force going to pursue Category III codes (cancer, diabetes, etc.)?

The goal is to eventually expand the use of clinical exercise physiologists to include all of the chronic diseases and conditions where exercise has been shown to be of therapeutic benefit. Expansion into these areas has been largely hampered by lack of reimbursement for services provided. Realizing reimbursement for the Category III codes under consideration would facilitate this expansion. For example, individuals holding a current ACSM-CEP certification are eligible to become an American Diabetes Association Certified Diabetes Educator (ADA CDE).

How is ACSM working with established health care professionals to demonstrate that exercise physiologists and clinical exercise physiologists are uniquely qualified?

The task force is engaged with three projects: (1) describing the process to enter the workforce as an EP or CEP (including programmatic accreditation, how minimum education is established, how competency is maintained throughout a working career and how employers find ACSM-EPs and ACSM-CEPs (registration and national provider identification [NPI] numbers); (2) documenting cardiac rehabilitation and pulmonary rehabilitation programs' current billing practices; and (3) establishing evidence of efficacy of exercise in improving patient outcomes and reducing health care costs. The task force will engage with aligned organizations such as the American Heart Association and American Association of Cardiovascular and Pulmonary Rehabilitation to advocate and promote the importance of evidence-based exercise programs on patient health/well-being delivered by appropriately qualified exercise professionals to CMS and health insurance payers.

If an institution is already accredited for Bachelor of Science in Exercise Science, what will need to happen to develop a Master's of Science program in Exercise Science and get it accredited?

The undergraduate exercise science accreditation is considered by CAAHEP as a separate program from the graduate exercise physiology accreditation. However, much of the information that is required for the respective programs' self-studies is identical. The Committee on Accreditation for the Exercise Sciences (CoAES) helps by trying to match the subsequent site visits by merging them together, which reduces costs. The CoAES extended the COVID-19 fee waiver program until the end of the spring 2022 semester.

If site visits can be done virtually and at a lower cost, why is there a need to go to a two-day in-person site visit?

Neither the CoAES nor the other CoAs appointed by CAAHEP have a great deal of experience yet with virtual site visits, which were developed because of COVID-19 travel restrictions. While the CoAES feels comfortable so far with the virtual site visits, we do not yet know if they can be refined enough to completely take the place of face-to-face visits. The virtual site visits have been extended into the 2022 spring semester. Further decisions will be made as any new travel restrictions occur.

Has the American Kinesiology Association (AKA) taken a position on CoAES accreditation and ACSM certification value? What discussions have taken place with other health fitness professional-certification agencies?

It is unknown if AKA has taken a position on academic program accreditation or the value of certification. CoAES has the following sponsoring organizations, which include the major certification bodies: ACSM, American Council on Exercise, the American Kinesiotherapy Association, the American Red Cross, the National Academy of Sports Medicine and the National Council on Strength & Fitness. We are always looking for additional sponsoring organizations. The purpose of the ACSM Clinical Exercise Physiology Taskforce is to explore ways to get exercise professionals recognized for third-party reimbursement. These current procedural terminology (CPT) codes for health coaching have provided a model.

Is the ultimate goal to get CEPs and EPs licensed?

There are many steps that need to be taken before CEPs can seriously begin to talk about licensure. Chief among these is that the academic preparation of CEPs has yet to be standardized. ACSM took a huge step in this direction when it announced that all CEP certification candidates will have to come from an accredited program beginning in 2027. The long lead time is necessary for schools to bring their programs up to the required standards. Since the primary purpose of licensure is to protect the public against the unregulated practice of a profession, it remains to be seen if the issue of licensure is relevant once the standardization of academic preparation has been established. Licenses are issued by states, not the federal government. Nearly all successful licensure initiatives have been initiated and led by groups within the state. It is very difficult for national organizations, such as ACSM, to take a leading role in such efforts. The state-by-state issue also creates problems with portability and the ability to engage in the profession across state lines.

Licensure and reimbursement are two separate, albeit sometimes connected, issues. It would be illegal for an individual to bill for physical therapy (PT) services unless they are a licensed PT because practice of that profession is restricted to licensed individuals. The same is not true for cardio rehab (CR)/pulmonary rehab (PR) services because it is the facility that bills for the service, not an individual. CMS has not defined the disciplines that can provide CR/PR services beyond requiring a physician who is licensed in the state serve as medical director of the program.

Requiring a license for career advancement is a local hospital policy decision and is not the norm nationally.