
Medical Policy



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***Current Policy Effective Date: 11/1/26**
(See policy history boxes for previous effective dates)

Title: Pulmonary Rehabilitation, Outpatient

Description

Outpatient pulmonary rehabilitation is a multidisciplinary approach to reducing symptoms and improving quality of life in individuals with compromised lung function. Pulmonary rehabilitation programs generally include an individual assessment followed by therapeutic interventions including exercise training, education, and behavior change.

Medical Policy Statement

Outpatient Pulmonary rehabilitation is **established** when criteria are met

Inclusionary and Exclusionary Guidelines

Inclusions:

A **single course** of pulmonary rehabilitation in the outpatient ambulatory care setting is established for the treatment of chronic obstructive pulmonary disease when **all** of the following are met:

- individuals have moderate to severe disease **and**
- are experiencing disabling symptoms **and**
- have significantly diminished quality of life despite optimal medical management

A **single course** of pulmonary rehabilitation is **established** in an outpatient ambulatory care setting for those considered appropriate candidates:

Preoperative conditioning prior to:

- Lung volume reduction surgery, **OR**
- Lung transplantation

Postoperative rehabilitation programs are established following lung transplantation

Exclusions:

- More than one course of pulmonary rehabilitation, either as maintenance therapy in individuals who initially respond or in individuals who fail to respond or whose response to an initial rehabilitation program has diminished over time
- Home-based pulmonary rehabilitation programs
- Pulmonary rehabilitation programs following other types of lung surgery, including but not limited to lung volume reduction surgery **when provided outside of preoperative conditioning**, and surgical resection of lung cancer.
- Pulmonary rehabilitation programs in the outpatient ambulatory care setting for the treatment of post-acute sequelae of SARS-CoV-2 infection.
- Pulmonary rehabilitation programs in all other situations

Contraindications:

This list is not all inclusive:

- Severe psychiatric disturbance
 - dementia,
 - organic brain
 - syndrome
- Significant or unstable medical conditions;
 - heart failure
 - acute cor pulmonale
 - substance abuse
 - significant liver dysfunction
 - metastatic cancer
 - disabling stroke

CPT/HCPCS Level II Codes

Established codes:

94625	94626				
G0237	G0238	G0239	G0302	G0303	G0304
S9473					

Other codes (investigational, not medically necessary, etc.):

G0305

Notes:

- *The above code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.*
 - *Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.*
 - *Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.*
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Background

Pulmonary Rehabilitation

In 2013, the American Thoracic Society and the European Respiratory Society defined pulmonary rehabilitation as a “comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to exercise training, education, and behavior change.”¹ Pulmonary rehabilitation programs are intended to improve patient functioning and quality of life. Most research has focused on patients with chronic obstructive pulmonary disease, although there has been some interest in individuals with asthma, cystic fibrosis, or bronchiectasis.

Pulmonary rehabilitation is also routinely offered to patients awaiting lung transplantation and lung volume reduction surgery. Pulmonary rehabilitation before lung surgery may stabilize or improve patients’ exercise tolerance, teach patients techniques that will help them recover after the procedure, and allow healthcare providers to identify individuals who might be suboptimal surgical candidates due to non-compliance, poor health, or other reasons.

Candidates for pulmonary rehabilitation should be medically stable and not limited by another serious or unstable medical condition.

A pulmonary rehabilitation outpatient program is a comprehensive program that generally includes team assessment, individual training, psychosocial intervention, exercise training, and follow-up. The overall length of the program and the total number of visits for each component may vary from program to program. The program must have active medical supervision that includes, at a minimum, either a registered nurse, respiratory therapist or exercise physiologist providing direct supervision and a physician available on-site. Team assessment includes input from a physician, respiratory care practitioner, nurse, and psychologist, among others.

Exercise training includes strengthening and conditioning, and may include stair climbing, inspiratory muscle training, treadmill walking, cycle training (with or without ergometer), and supported and unsupported arm exercise training. Exercise conditioning is an essential component of pulmonary rehabilitation. Education in disease management techniques without exercise conditioning does not improve the health outcomes of individuals who have chronic obstructive pulmonary disease. Individual training includes breathing retraining, bronchial hygiene, medications, and proper nutrition. Psychosocial intervention is addressed to support system and dependency issues.

Follow-up to a comprehensive outpatient pulmonary rehabilitation program may include supervised home exercise conditioning.

Summary of Evidence

Chronic Pulmonary Disease Rehabilitation

For individuals with moderate-to-severe chronic obstructive pulmonary disease (COPD) who receive a single course of outpatient pulmonary rehabilitation, the evidence includes numerous systematic reviews of randomized controlled trials (RCTs). Relevant outcomes are symptoms, functional outcomes, and quality of life. The published studies found improved outcomes (i.e., functional ability, quality of life) in individuals with moderate-to-severe COPD who underwent a comprehensive pulmonary rehabilitation program in the outpatient setting. Among the many randomized trials, the structure of the pulmonary rehabilitation programs varied, so it is not possible to provide guidance on the optimal components or duration of a pulmonary rehabilitation program. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with idiopathic pulmonary fibrosis who receive a single course of outpatient pulmonary rehabilitation, the evidence includes 3 systematic reviews of RCTs. Relevant outcomes are symptoms, functional outcomes, and quality of life. Significant differences favoring pulmonary rehabilitation over usual care were seen in 6 minute walk (6MWD) in the short term. Starting at 3 months post-intervention, outcomes did not differ between groups. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with bronchiectasis who receive a single course of outpatient pulmonary rehabilitation, the evidence includes a systematic review of RCTs. Relevant outcomes are symptoms, functional outcomes, and quality of life. The systematic review included 4 RCTs on pulmonary rehabilitation for individuals with bronchiectasis found that some, but not all, outcomes improved more with pulmonary rehabilitation than with non-exercise control conditions immediately after the intervention. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Although most evidence is published about outpatient pulmonary rehabilitation for chronic obstructive pulmonary diseases, observational studies have reported on outcomes from pulmonary rehabilitation for other chronic pulmonary diseases. Clinical guidelines from pulmonary organizations have supported the use of outpatient pulmonary rehabilitation for individuals who are experiencing disabling symptoms and have significantly diminished quality of life despite optimal medical management. Therefore, outpatient pulmonary rehabilitation may be considered medically necessary for this population. The policy does **not** group the following conditions: COPD, idiopathic pulmonary fibrosis, or bronchiectasis as chronic pulmonary disease.

Preparation for Lung Surgery

For individuals with scheduled lung surgery for volume reduction, transplantation, or resection who receive a single course of preoperative outpatient pulmonary rehabilitation, the evidence includes RCTs and observational studies. Relevant outcomes are symptoms, functional outcomes, and quality of life. There is a lack of large RCTs comparing pulmonary rehabilitation with no pulmonary rehabilitation for preoperative candidates undergoing lung volume reduction surgery, lung transplantation, or lung cancer resection. Moreover, the available studies have evaluated exercise programs, but not necessarily comprehensive pulmonary rehabilitation programs. Also, the few small RCTs and observational studies have only reported short-term

outcomes and there was inconsistent evidence of benefit on these outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Findings from the National Emphysema Treatment Trial have suggested that pulmonary rehabilitation is an appropriate component of care for individuals with COPD before undergoing lung volume reduction surgery. Also, pulmonary rehabilitation is considered the standard of care in individuals undergoing lung transplantation to maximize preoperative pulmonary status. Thus, pulmonary rehabilitation may be considered medically necessary for individuals considered appropriate candidates for lung volume reduction surgery or lung transplantation.

Pulmonary Rehabilitation After Lung Surgery

For individuals who have had lung volume reduction surgery who receive a single course of outpatient pulmonary rehabilitation, the evidence includes a case series. Relevant outcomes are symptoms, functional outcomes, and quality of life. No published RCTs were identified. The case series evaluated a comprehensive pulmonary rehabilitation program after lung volume reduction surgery in 49 patients who had not received preoperative pulmonary rehabilitation. Health-related quality of life was higher at 3 to 6 months and 12 to 18 months post-surgery. The series did not provide data on patients who underwent lung volume reduction surgery and did not have postoperative pulmonary rehabilitation, or patients who had preoperative pulmonary rehabilitation. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have had lung transplantation who receive a single course of outpatient pulmonary rehabilitation, the evidence includes RCTs, a systematic review, and a case series. Relevant outcomes are symptoms, functional outcomes, and quality of life. Neither of the 2 RCTs identified in a 2010 systematic review reported on functional outcomes, but uncontrolled studies have reported improvements in functional outcomes. An RCT, published after the systematic review, found that patients who had a postsurgical exercise intervention walked more 1 year post discharge than before and had a significantly greater 6MWD. Findings on other outcomes were mixed. The most recent RCT (2017) did not identify a difference in outcomes with longer duration of pulmonary rehabilitation. Case series data also support improvements in 6MWD after post-operative pulmonary rehabilitation. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have had lung cancer resection who receive a single course of outpatient pulmonary rehabilitation, the evidence includes 2 RCTs. Relevant outcomes are symptoms, functional outcomes, and quality of life. One small RCT evaluated a comprehensive pulmonary rehabilitation program in patients who underwent thoracotomy for lung cancer. The trial was terminated early, had a high dropout rate, and reported mixed findings. An exercise-only intervention in patients who had lung cancer surgery had mixed findings and did not evaluate functional outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Post-Acute Sequelae of SARS-CoV-2 Infection

For individuals who have post-acute sequelae of SARS-CoV-2 infection, the evidence includes systematic reviews of RCTs and cohort studies. Relevant outcomes are symptoms, functional outcomes, and quality of life. One systematic review pooled data from 10 RCTs and found significant improvement in quality of life, dyspnea scores, and functional capacity with

telerehabilitation compared with sham intervention, no intervention, or usual care including face-to-face intervention. Lung function and adverse events were not different between groups. Other systematic reviews also found benefit with ambulatory pulmonary rehabilitation in these patients, but the data were not pooled and the evidence is limited by a small number of studies most of which are observational in nature. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Repeat or Maintenance Rehabilitation

For individuals who have had an initial course of pulmonary rehabilitation who receive repeat or maintenance outpatient pulmonary rehabilitation, the evidence includes RCT. Relevant outcomes are symptoms, functional outcomes, and quality of life. This small RCT had methodologic limitations and did not report inpatient and outpatient outcomes separately; it also lasted only 3 weeks. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Home-Based Rehabilitation

For individuals who have an indication for outpatient pulmonary rehabilitation who receive a single course of home-based pulmonary rehabilitation, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. Most studies of home-based pulmonary rehabilitation have compared outcomes with standard care. Very few have compared home-based pulmonary rehabilitation with hospital- or clinic-based pulmonary rehabilitation, and the available studies are mostly of low quality. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Rationale

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. The following is a summary of the key literature to date.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice. The following is a summary of the key literature to date.

This evidence review focuses on comprehensive, multidisciplinary programs that include an exercise component plus other modalities. Where there is a lack of evidence on multidisciplinary pulmonary rehabilitation programs, interventions that are strictly exercise will be considered. In this regard, exercise constitutes the primary intervention that improves outcomes and that if exercise alone improves outcomes, then it would be expected that exercise plus other modalities will improve outcomes to the same degree or greater.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Clinical Context and Test Purpose

The purpose of a single course of outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals with moderate-to-severe chronic obstructive pulmonary disease (COPD).

The relevant population of interest is individuals with moderate-to-severe COPD.

The therapy being considered is a single course of outpatient pulmonary rehabilitation. Pulmonary rehabilitation programs include an individual assessment followed by therapeutic interventions including exercise training, education, and behavior change.

Comparators of interest include usual care without outpatient pulmonary rehabilitation. Treatment includes physical exercise, diaphragmatic breathing, oxygen therapy, bronchodilators, and steroid regimens.

The general outcomes of interest are symptoms, functional outcomes, and quality of life.

The existing literature evaluating a single course of outpatient pulmonary rehabilitation as a treatment for moderate-to-severe COPD has varying lengths of follow up. While studies described below all reported at least 1 outcome of interest, at least 6 months duration of follow-up is desirable to fully assess outcomes.

Review of Evidence

Systematic Reviews

Numerous RCTs and several systematic reviews of RCTs have been published. Most recently, Puhan et al (2016) published a Cochrane review that evaluated pulmonary rehabilitation programs for patients who had an exacerbation of COPD.² To be included, the rehabilitation program needed to begin within 3 weeks of initiating exacerbation treatment and had to include physical exercise. Twenty trials (N=1477) met inclusion criteria. Rehabilitation was outpatient in 6 trials, inpatient in 12 trials, both inpatient and outpatient in 1 trial and home-based in 1 trial. In a pooled analysis of 8 trials, there was a statistically significant reduction in the primary outcome (rate of hospital admissions) for pulmonary rehabilitation compared with usual care (odds ratio [OR]=0.44; 95% confidence interval [CI], 0.21 to 0.91). Several secondary outcomes also favored the pulmonary rehabilitation group. In a pooled analysis of 13 trials, there was a significantly greater improvement from baseline on the 6-minute walk distance (6MWD) in the pulmonary rehabilitation groups (mean difference [MD]=62.4 meters; 95% CI, 38.5 to 86.3 meters). Moreover, a pooled analysis of health-related quality of life found a significantly greater improvement after pulmonary rehabilitation versus control (MD= -7.80; 95% CI, -12.1 to -3.5). However, in a pooled analysis of 6 trials, there was no statistically

significant difference between groups in mortality rate, (OR =0.68; 95% CI, 0.28 to 1.67). Trials had a mean duration of only 12 months, which may not be long enough to ascertain a difference in mortality rates. Participants in all the studies included in this analysis could not be blinded and this may have introduced bias for outcomes to some degree. Also, some studies did not assess the outcomes of those participants who dropped out of the pulmonary rehabilitation or were lost to follow-up.

McCarthy et al (2015) published a Cochrane review that included RCTs assessing the effect of outpatient or inpatient pulmonary rehabilitation on functional outcomes and/or disease-specific quality of life (QOL) outcomes in patients with COPD.³ Pulmonary rehabilitation programs had to be at least 4 weeks in duration and include exercise therapy with or without education and/or psychological support. Sixty-five RCTs (N=3822) met inclusion criteria. Severity of COPD was not specifically addressed by the Cochrane reviewers, but article titles suggest a focus on patients with moderate-to-severe COPD. In the pooled analyses, there was statistically significantly greater improvement in all outcomes in the pulmonary rehabilitation groups than in usual care groups. Also, between-group differences on key outcomes were clinically significant. For example, on all 4 important domains of the validated Chronic Respiratory Questionnaire (dyspnea, fatigue, emotional function, and mastery) the effect was larger than the accepted minimal clinically important difference of 0.5 units. Also, the between-group difference in maximal exercise capacity exceeded the minimal clinically important difference of 4 watts and the between-group difference in 6MWD (a mean difference of 43.93 meters) was considered clinically significant.

Rugbjerg et al (2015) published a systematic review that identified 4 RCTs (N=489 participants).⁴ Inspection of the trial designs for the 4 RCTs indicated that none evaluated a comprehensive pulmonary rehabilitation program in patients who met the criteria for mild COPD. Rather than being comprehensive pulmonary rehabilitation programs, all interventions were exercise-based. One intervention included an educational component and another used a qigong intervention, which included breathing and meditation in addition to exercise. Also, none of the RCTs enrolled a patient population only with mild COPD. Roman et al (2013)⁵ and Gottlieb et al (2011)⁶ included patients with moderate COPD, Liu et al (2012)⁷ included patients with mild-to-moderate COPD, and van Wetering et al (2010)⁸ included patients with moderate-to-severe COPD. Conclusions cannot be drawn about the efficacy of pulmonary rehabilitation in patients with mild COPD from this systematic review.

Tables 1 and 2 summarize the characteristics and results of the Puhan et al (2016)² and McCarthy et al (2015)³ studies. The study by Rugbjerg et al (2015)⁴ is not included in Tables 1 and 2 because of study overlap.

Table 1. Systematic Review Characteristics

Study	Dates	Trials	Participants	Intervention	N (Range)	Design	Duration
Puhan (2016) ²	Up to Mar 2010*; Mar 2010 to Oct 2015	20	PR patients (N=1477) who met inclusion criteria and had an exacerbation of COPD	Inpatient and outpatient PR	1477 (26-389)	RCT	3-18 mo
McCarthy (2015) ³	Up to Jul 2004; Jul 2004 to Mar 2014	65	Patients (N=3822) with mean ages ranging from 31.3 to 74.1 years; in-patient, out-patient, community-based or home-based rehabilitation	Outpatient or inpatient PR ≥4 wk that includes exercise therapy +/- education and	3822 (12-350)	RCT	≥24 mo

			program of ≥ 4 weeks on continuous oxygen; those with clinical diagnosis of moderate-to-severe COPD and best recorded FEV1 <0.7 ; exercise therapy/ intervention (rehabilitation) vs. standard care (control)	psychological support (range of PR exercise program = 7 wk to 6 mo)			
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COPD: chronic obstructive pulmonary disease; FEC: functional exercise capacity; MEC: maximal exercise capacity; PR: pulmonary rehabilitation; RCT: randomized

* A previous review included information from studies up to this date.

Table 2. Systematic Review Results

Study	Rate of Hospital Readmission	6-minute Walk Distance
Puhan (2016) ²	n=810; 8 trials	n=819; 13 trials
N=1477		
PR compared with usual care	Relative effect (95% CI) OR=0.44 (0.21, 0.91)	Change from baseline, random effects (95% CI) MD= 62.38 m (38.45, 86.31 m)
McCarthy (2015) ³	NR	n=1879; 38 studies
N=3822		
PR compared with usual care	NR	Random, effect size (95% CI) MD=43.93 (32.64, 55.21)

CI: confidence interval; MD: mean difference; NR: not reported; OR: odds ratio; PR: pulmonary rehabilitation.

IDIOPATHIC PULMONARY FIBROSIS

Clinical Context and Test Purpose

The purpose of a single course of outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals with idiopathic pulmonary fibrosis.

Review of Evidence

Systematic Reviews

Three systematic reviews with meta-analyses have evaluated the use of pulmonary rehabilitation in individuals with idiopathic pulmonary fibrosis. A crosswalk of studies included in each review is found in the Appendix (Table A1). Tables 3 and 4 summarize the characteristics and results of the systematic reviews, respectively.

A Cochrane review by Downman et al (2021) evaluated the efficacy and safety of pulmonary rehabilitation in patients with interstitial lung disease in terms of short-term (≤ 6 months) and long-term outcomes (6 to 11 months); a priori subgroup analyses were performed for participants with idiopathic pulmonary fibrosis.⁹ In patients with idiopathic pulmonary fibrosis, there were significant improvements in 6MWD and Saint George's Respiratory Questionnaire results with pulmonary rehabilitation versus standard treatment in the short-term, but the benefits did not last in the long term (Table 4). Additionally, pulmonary rehabilitation improved dyspnea scores based on the modified Medical Research Dyspnea Scale (0 to 4 point scale; 0 indicates no dyspnea) in studies with a follow-up duration of 8 to 12 weeks (MD=-0.41; 95% CI, -0.74 to 0.09). Long-term survival was not improved with pulmonary rehabilitation versus standard treatment in studies with a follow-up of 6 to 11 months (OR=0.32; 95% CI, 0.08 to 1.19).

The meta-analysis by Yu et al (2019) evaluated pulmonary rehabilitation for exercise tolerance and quality of life for patients with idiopathic pulmonary fibrosis.¹⁰ They analyzed results of 5 RCTs (N=190). In addition to better 6MWD and Saint George's Respiratory Questionnaire results with pulmonary rehabilitation than with standard treatment (Table 4), forced vital capacity was significantly higher for the pulmonary rehabilitation group (MD=3.69; 95% CI, 0.16 to 7.23; p=.04). However, pulmonary rehabilitation had no significant effect on lung diffusing capacity determined by the single-breath technique (MD=3.02; 95% CI, -0.38 to 6.42; p=.08). The results of this study suggest the benefits of pulmonary rehabilitation lie in its effect on quality of life, and it may slow the decline of lung function in patients with idiopathic pulmonary fibrosis.

Cheng et al (2018) looked at 4 RCTs and evaluated results in terms of short-term (9 to 12 weeks) and long-term (6 to 12 months) outcomes.¹¹ They found significant benefits in the short term as measured by 6MWD and Saint George's Respiratory Questionnaire, but the benefits did not last in the long term.

Table 3. Systematic Review Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Downman (2021) ⁹	Through April 2020	21	n=10 studies of patients with mixed ILD etiologies, including IPF; n=9 studies of patients with IPF only; n=5 studies of other ILD etiologies	NR	RCTs	3 wk-4 yr
Yu (2019) ¹⁰	2008-2016	5 (7 articles)	Patients with diagnosed IPF	190 (21-32)	RCTs	10 wk-11 mo
Cheng (2018) ¹¹	2008-2017	4 (5 articles)	Patients with diagnosed IPF	142 (21-61)	RCTs	9 wk-11 mo

ILD: interstitial lung disease; IPF: idiopathic pulmonary fibrosis; RCT: randomized controlled trial

Table 4. Systematic Review Results

Study	6MWD		SGRQ	
Downman (2021) ⁹	8 trials	3 trials	6 trials	2 trials
	Short term (3-12 wk)	Long-term (6-11 mo)	Short-term (8 wk-6mo)	Long-term (6-11mo)
MD, fixed effects	37.25	1.64	-7.91	-3.45
95% CI	26.16 to 48.33	-24.89 to 28.17	-10.55 to -5.26	-7.43 to 0.52
P value	<.00001	.9	<.00001	.09
Yu (2019) ¹⁰	5 trials		3 trials	
MD, fixed effects	48.60		-7.87	
95% CI	29.03 to 68.18		-11.44 to -4.30	
P value	<.001		.031	
Cheng (2018) ¹¹	4 trials	2 trials	3 trials	2 trials
	Short-term (9-12 wk)	Long-term (6-12 mo)	Short-term (9-12 wk)	Long-term (6-12 mo)
WMD, random effects	38.38	17.02	-8.40	-3.45
95% CI	4.64 to 72.12	-26.87 to 60.81	-11.4 to -5.36	-8.55 to 1.64

P value	<.05	.43	<.001	.088
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6MWD: 6-minute walk distance; CI: confidence interval; MD: mean difference; SGRQ: Saint George's Respiratory Questionnaire (lower score is better); WMD: weighted mean difference

BRONCHIECTASIS

Clinical Context and Test Purpose

The purpose of a single course of outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals with bronchiectasis.

Review of Evidence

Systematic Review

Lee et al (2017) published a systematic review of RCTs on pulmonary rehabilitation in patients with non-cystic fibrosis bronchiectasis.¹² Reviewers identified 4 RCTs. They selected studies of exercise-only interventions as well as exercise combined with education and/or another intervention. The control intervention had to be something other than exercise-based. A pooled analysis of 3 RCTs immediately after an 8-week intervention found significantly greater incremental shuttle walk distance in the intervention compared with the control group (MD=66.6; 95% CI, 51.8 to 81.7). A pooled analysis of 2 trials found significantly greater improvement in the Saint George's Respiratory Questionnaire score postintervention (MD = -4.65; 95% CI, -6.70 to -2.60). There was no significant difference postintervention on the Leicester Cough Questionnaire (total) scores. Reviewers did not conduct meta-analyses of data beyond the immediate postintervention period.

Randomized Controlled Trials

Araújo et al (2022) conducted an RCT in Brazil on the effects of pulmonary rehabilitation in individuals with bronchiectasis.¹³ Adults with bronchiectasis confirmed with high-resolution computer tomography were randomized to receive outpatient pulmonary rehabilitation (3 weekly sessions; n=20) or a control intervention consisting of usual care, airway clearance therapy, and breathing exercises (n=21) for 3 months. Physical capacity (measured by 6MWD), dyspnea, quality of life (measured by the Saint George's Respiratory Questionnaire), fatigue, respiratory muscle strength, and fibrinogen levels were measured before and after treatment. At the end of the 3 month period, the 6MWD increased by a mean of 54 meters in the rehabilitation group versus 12 meters in the control group (p<.01). Additionally, fibrinogen showed a significant reduction in the rehabilitation group compared to control (-92.8 vs. -47.1 mg/dl; p<.01) at 3 months from baseline; quality of life improved at a greater magnitude in the rehabilitation group (-7.5 vs. 3.2; p<.01), which exceeded the minimal clinically important difference of 4 points. This study was limited by its small sample size and short follow-up period.

PREOPERATIVE PULMONARY REHABILITATION PROGRAMS

Clinical Context and Test Purpose

The purpose of a single course of preoperative outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals with scheduled lung surgery for volume reduction, transplantation, or resection.

Review of Evidence

Lung Volume Reduction Surgery

Pulmonary rehabilitation prior to lung volume reduction surgery represents a distinct subset of patients with COPD, and the National Emphysema Treatment Trial required all candidates to undergo a vigorous course of pulmonary rehabilitation. The final National Emphysema Treatment Trial results supported the treatment effectiveness in a subset of patients with COPD.¹⁴

Lung Transplantation

A systematic review of the literature on pulmonary rehabilitation for lung transplant candidates was published by Hoffman et al (2017).¹⁵ Interventions had to include exercise training but did not have to be part of a comprehensive pulmonary rehabilitation program and could have taken place in the inpatient or outpatient setting. Reviewers identified 6 studies (2 RCTs and 4 case series). Both RCTs evaluated the impact of exercise (not comprehensive pulmonary rehabilitation) on outcomes; additionally, 1 was conducted in the inpatient setting, and the included only 9 patients. Conclusions on the impact of a comprehensive pulmonary rehabilitation program before lung transplantation on health outcomes cannot be drawn from this systematic review.

Observational Study

Nicholson et al (2025) published results of a single-center, retrospective case series evaluating pre-lung transplantation pulmonary rehabilitation in transplant candidates with cystic fibrosis.¹⁶ Participants (N=86) underwent pulmonary rehabilitation 2 to 3 times weekly until the time of transplantation. The median pulmonary rehabilitation time was 87 days (24 to 36 sessions). Treadmill speed and biceps and quadriceps training volumes significantly improved with pulmonary rehabilitation compared to baseline speeds and volumes ($p<.05$). However, 6MWD remained unchanged with pulmonary rehabilitation. Additionally, the presence of at least 1 respiratory exacerbation was associated with a lower progression in treadmill speed over rehabilitation sessions (MD, -0.36 mph; 95% CI, -0.67 to -0.04; $p=.028$).

Lung Cancer Resection

Randomized Controlled Trials

Several small RCTs have evaluated preoperative pulmonary rehabilitation for patients undergoing lung cancer resection. Morano et al (2013) conducted a single-blind study in Brazil.¹⁷ Patients with non-small-cell lung cancer eligible for lung resection were randomized to 4 weeks of an exercise-only pulmonary rehabilitation program (5 sessions per week) or chest physical therapy; there were 12 patients in each group. All patients in the pulmonary rehabilitation group and 9 of 12 in the chest physical therapy group subsequently underwent surgery (the other 3 patients had inoperable disease). Several short-term postoperative outcomes were assessed. Patients in the pulmonary rehabilitation group spent significantly fewer days in the hospital (mean, 7.8 days) than patients in the chest physical therapy group (mean, 12.2 days; $p=.04$). Also, patients in the pulmonary rehabilitation group spent fewer days with chest tubes (mean, 4.5 days) than the physical therapy group (mean, 7.4 days; $p=.03$). The trial did not assess longer-term functional outcomes after surgery.

Benzo et al (2011) conducted 2 small exploratory RCTs evaluating PR before lung cancer resection.¹⁸ Eligibility criteria included having moderate-to-severe COPD and being scheduled for lung cancer resection either by open thoracotomy or by video-assisted thoracoscopy. The

first trial had poor recruitment, enrolling only 9 patients. The second study enrolled 19 patients into a 10-session, preoperative pulmonary rehabilitation program (n=10) or usual care (n=9). The mean number of days in the hospital was 6.3 in the pulmonary rehabilitation group and 11.0 in the control group (p=.058). Three (33%) patients in the pulmonary rehabilitation group and 5 (63%) patients in the control group experienced postoperative pulmonary complications (p=.23). The trial sample size was too small to detect statistically and clinically significant differences between groups. Trialists recommended conducting a larger multicenter randomized trial in this population.

Tables 5 and 6 summarize the characteristics and results of the RCTs, respectively.

Table 5. Summary of Key RCT Characteristics

Study	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
Morano (2013) ¹⁷	Brazil	1	Mar 2008 to Mar 2011	Patients undergoing lung cancer resection and who have non-small cell lung cancer resection by open thoracotomy (or video-assisted); and previous pulmonary disease, interstitial lung disease, or obstructive airway disease, with impaired respiratory function by spirometry (N=24)	PR: Strength/endurance training + education; 5 sessions/wk for 4 wk (20 sessions) (n=12)	CPT breathing exercises + education; 5 sessions/wk for 4 wk (20 sessions) (n=12)
Benzo (2011) ¹⁸	US	2	NR	Patients who require lung cancer resection by open thoracotomy (or video-assisted); moderate-to-severe COPD (N=19)	PR: 10 preoperative PR sessions involving customized protocol with nonstandard components (exercise prescription based on self-efficacy, inspiratory muscle training; slow breathing) (n=10)	Usual care (n=9)

COPD: chronic obstructive pulmonary disease; CPT: chest physical therapy; NR: not reported; PR: pulmonary rehabilitation; RCT: randomized controlled trial

Table 6. Summary of Key RCT Results

Study	Hospital Stay at 4 Weeks, mean (SD)	ICU Stay (days) at 4 Weeks	Postoperative Hospitalizations
Morano (2013) ¹⁷	N=31 patients at t=0; 24 in analysis; 21 in final analysis	N=31 patients at t=0; 24 in analysis; 21 in final analysis	NR
PR (exercise) n=12	7.8 (4.8)	2 (2-3) ^a	NR
CPT (control) n=9	12.2 (3.6)	2 (2-4.5) ^a	NR
P-value	.04	.20	NR
Benzo (2011) ¹⁸	N=17	N=17	NR
PR arm	6.3 (3.0)	0.6 (1.9) ^b	NR
Usual care	11.0 (6.3)	1.7 (3.1) ^b	NR
P-value	.06	.39	NR

CPT: chest physical therapy; ICU: intensive care unit; NR: not reported; PR: pulmonary rehabilitation; RCT: randomized controlled trial; SD: standard deviation.

^a Median (25th-75th percentile).

^b Mean (SD).

The purpose of Tables 7 and 8 is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of evidence supporting the position statement.

Table 7. Relevance Limitations

Study	Population ^a	Intervention ^b	Comparator ^c	Outcomes ^d	Follow-Up ^e
Morano (2013) ¹⁷				3. No CONSORT reporting of harms was addressed	1. Short duration of follow-up (4-weeks)
Benzo (2011) ¹⁸	4. Recruitment not met.				

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified;

e Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 8. Study Design and Conduct Limitations

Study	Allocation ^a	Blinding ^b	Selective Reporting ^c	Follow-Up ^d	Power ^e	Statistical ^f
Morano (2013) ¹⁷	4. Inadequate control for selection bias: the participants were not evenly randomized			1. High loss to follow-up or missing data	1. Power is not reported	
Benzo (2011) ¹⁸						

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

d Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of

crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for

e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

f Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Com

Observational Study

Bradley et al (2013), in a nonrandomized comparative study evaluated an outpatient-based pulmonary rehabilitation intervention in 58 lung cancer patients who were candidates for surgery.¹⁹ This United Kingdom based study also evaluated a comparison group of 305 patients, also surgical candidates, who received usual care. Patients in the 2 groups were matched by age, lung function, comorbidities, and type of surgery. In a within-group analysis, there was a statistically significant 20-meter improvement in 6MWD in the intervention group before and after participation in a 4-session presurgical pulmonary rehabilitation program. In between-group analyses, there were no statistically significant differences between the intervention and comparisons groups in clinical outcomes such as postoperative pulmonary complications, readmissions, and mortality after surgery.

Lung Volume Reduction Surgery Postoperative Pulmonary Rehabilitation Programs

Clinical Context and Test Purpose

The purpose of a single course of outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals who have had lung volume reduction surgery.

Review of Evidence

No RCTs evaluating comprehensive pulmonary rehabilitation programs after lung volume reduction surgery were identified. Bering et al (2009) reported on a case series involving 49 patients with severe emphysema who participated in a pulmonary rehabilitation program after lung volume reduction surgery.²⁰ Patients underwent lung volume reduction surgery at a single center and had not received pulmonary rehabilitation at that institution pre-surgery. After hospital discharge, patients underwent an outpatient comprehensive pulmonary rehabilitation program for 4 hours a day, 5 days a week for 2 weeks. The program included a multidisciplinary team including a variety of components including dietary, physical therapy, physical exercise, psychosocial, occupational therapy, and respiratory therapy. The primary outcome was health-related quality of life measured by the 36-item Short-Form Health Survey. Compared with pre-lung volume reduction surgery scores, significantly better scores were achieved on the Physical Component Summary and Mental Component Summary at both time point 2 (3 to 6 months post-lung reduction volume surgery) and 3 (12 to 18 months post-lung volume reduction surgery). Study limitations included no comparison with patients who had lung volume reduction surgery and no pulmonary rehabilitation, and the difficulty disentangling the impacts of lung volume reduction surgery from that of pulmonary rehabilitation on outcomes. Moreover, patients had not received pulmonary rehabilitation before lung volume reduction surgery, so the treatment effects of pre-surgery versus post-surgery lung volume reduction surgery could not be determined.

Lung Transplantation Postoperative Pulmonary Rehabilitation Programs

Clinical Context and Test Purpose

The purpose of a single course of outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals who have had lung transplantation.

Review of Evidence

Systematic Reviews

Exercise training after lung transplantation (not necessarily provided in comprehensive pulmonary rehabilitation programs). Wickerson et al (2010)²¹ published a systematic review of the available literature in which the researcher had evaluated any exercise intervention in conjunction with lung transplantation. Seven studies (a cohort made up of RCTs, controlled trials, and prospective cohorts) met the inclusion criteria, including 2 RCTs targeting lumbar bone mineral density. Also included in the review were uncontrolled studies that reported improvement in functional status as a byproduct of an exercise-program intervention.¹⁹

Randomized Controlled Trials

Langer et al (2012) conducted an RCT in the United Kingdom that examined activity-related outcomes in lung transplant recipients after exercise training.²² The trial included 40 patients who underwent single- or double-lung transplantation and had an uncomplicated postoperative period. Following hospital discharge, patients were randomized to a supervised exercise program 3 times a week for 3 months (n=21) or usual care with instructions to exercise (n=19). Patients in both groups had 6 individual counselling sessions in the 6 months after discharge. Six patients dropped out of the trial, 3 in each group. The primary outcome was daily walking time assessed by activity monitors. At the end of the 3-month intervention and one-year post-discharge, mean walking time was significantly longer in the intervention group. At 1 year, the exercise group walked a mean of 85 minutes per day while the control group walked a mean of 54 minutes per day (p=.006). Other outcomes related to daily physical activity were reported as secondary outcomes and some, but not all, significantly favored the intervention group. Mean 6MWD at 1 year was 86% of predicted in the exercise group and 74% of predicted in the control group (p=.002). The trial had a small sample size and may have been underpowered to detect clinically meaningful differences between groups on secondary outcomes.

Fuller et al (2017) published an RCT reporting on the impact of short (7-week) versus long (14-week) rehabilitation programs for patients who underwent lung transplantation.²³ The primary outcome was change in the 6MWD. Secondary outcomes included the strength of the quadriceps and hamstring muscles (as measured by an isokinetic dynamometer), and quality of life (as measured by the 36-Item Short-Form Health Survey). In both the 7- and 14-week rehabilitation groups, participants increased their 6MWD (mean improvement in 7-week group, 202 meters versus 14-week group, 149 meters). At 6 months after transplantation, the mean difference between groups was 59.3 meters, favoring the 7-week group (95% CI, 12.9 to 131.6 meters). The increases in strength in quadriceps and hamstring muscles in both groups did not differ statistically. The 36-Item Short-Form Health Survey summary scores of the domains of physical health and mental health both increased over time with no significant difference between groups at any time point.

Tables 9 and 10 summarize the characteristics and results of the RCTs, respectively.

Table 9. Summary of Key RCT Characteristics

Trial	Countries	Sites	Participants	Interventions	
				Active	Comparator
Langer (2012) ²²	UK	1	Patients aged 40-65 y who had undergone a single or bilateral LTX with no postoperative complications (N=40)	Exercise program (3 x/wk for 3 mo) (n=21)	Usual care with added instruction to exercise (n=19)
Fuller (2017) ²³	US	1	Post-LTX patients aged ≥18 years (N=66; 33 women; mean age=51+/-13 y) who had undergone either single LTX or bilateral LTX	Longer-duration (14-wk) rehabilitation program after LTX	Shorter (7-wk) rehabilitation program after LTX

LTX: lung transplantation; RCT: randomized controlled trial; U.K. United Kingdom

Table 10. Summary of Key RCT Results

Study	Daily Walking Time	Mean Improvement in 6MWD From Baseline(SD)	6MWD Difference Between Groups
Langer (2012) ²²			
N=40	N=34 (final)	NR	NR
3-mo exercise program (baseline/final)=21/18	Mean=85 min/day at 1 y (SD=27 min)	NR	NR

Usual care (baseline/final)=19/16	Mean=54 min/day at 1 y (SD=30 min)	NR	NR
Mean difference	26 min (adjusted)	NR	NR
95% CI	8 to 45 min	NR	NR
P-value	.0006	NR	NR
Fuller (2017) ²³			
N=66	NR	N=64 at 6 mo	N=64 at 6 mo
Longer-duration (14 wk) PR program	NR	+149 m(169 m)	NA
Shorter-duration (7 wk) PR program	NR	+202 m (72 m)	NA
P-value	NR	.5	NR
Mean difference	NR	NA	59.3 m favoring 7-wk group
95% CI	NR	NR	12.9 to 131.6 m

6MWD: 6-minute walk distance; CI: confidence interval; NR: not reported; OR: odds ratio; PR: pulmonary rehabilitation; RCT: randomized controlled trial; SD: standard deviation

The purpose of Tables 11 and 12 is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of evidence supporting the position statement.

Table 11. Relevance Limitations

Study	Population ^a	Intervention ^b	Comparator ^c	Outcomes ^d	Follow-Up ^e
Langer (2012) ²²					
Fuller (2017) ²³	1. Selection criteria not clear		2. Fitness activity monitor not validated as comparator for this clinical scenario.		

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified;

e Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 12. Study Design and Conduct Limitations

Study	Allocation ^a	Blinding ^b	Selective Reporting ^c	Follow-Up ^d	Power ^e	Statistical ^f
Langer (2012) ²²		1. Patients not blinded. Blinding not feasible. Outcome assessment not blinded.				
Fuller (2017) ²³		1. Patients not blinded. Blinding not feasible. Outcome assessment not blinded.			1,2. Power is affected by small sample size, underpowered to detect meaningful differences	

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

d Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for

e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

f Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Com

Case Series

Munro et al (2009) published a case series that evaluated a comprehensive pulmonary rehabilitation program after lung surgery.²⁴ The 7-week program, which started 1 month postsurgery, consisted of 1 hour of supervised exercise 3 times a week and a weekly group education session facilitated by a multidisciplinary team (e.g., nurse, dietician, occupational therapist, social worker). Compared with baseline, on program completion, both forced expiratory volume in 1 second and forced vital capacity had improved significantly ($p < .001$). For example, mean forced expiratory volume in 1 second was 71% at 1 month post-surgery and 81% at 3 months. Similarly, 6MWD improved significantly: mean distance was 451 meters at 1 month and 543 meters at 3 months posttransplant. The study lacked a control group. Hence, the degree of improvement that would have occurred without participation in a pulmonary rehabilitation program is unknown.

Section Summary: Lung Transplantation Postoperative Pulmonary Rehabilitation Programs

A systematic review of exercise training after lung transplantation (not necessarily provided in a comprehensive pulmonary rehabilitation program) identified 7 controlled and uncontrolled studies and did not pool study findings. Neither RCT identified reported functional outcomes, but the uncontrolled studies reported improvements in functional outcomes. An RCT, published after the systematic review, found that patients who had a post-surgical exercise intervention walked more 1-year post-discharge and had a significantly greater 6MWD. The most recent RCT (2017) did not identify a difference in outcomes with longer duration of pulmonary rehabilitation. Findings on other outcomes were mixed. Case series data also support improvement in the 6MWD after postoperative pulmonary rehabilitation.

Lung Cancer Resection Postoperative Pulmonary Rehabilitation Programs

Clinical Context and Test Purpose

The purpose of a single course of outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals who have had lung cancer resection.

Review of Evidence

Randomized Controlled Trials

Stigt et al (2013) published an RCT evaluating a multicomponent post-surgery pulmonary rehabilitation program in patients with resectable lung cancer.²⁵ The trial was conducted in the Netherlands. Before thoracotomy, 57 patients were randomized to pulmonary rehabilitation or usual care. The 12-week pulmonary rehabilitation program started 4 weeks after surgery and consisted of exercise training, pain management, and visits with a medical social worker. The trial was terminated early because the institution started offering video-assisted thoracoscopic surgery, at which point few patients chose thoracotomy. Data on 49 patients (pulmonary rehabilitation=23, usual care=26) were analyzed. The primary end point was quality of life, as measured by the difference between groups in change in the total Saint George's Respiratory Questionnaire score from baseline to 12 months. This difference was 2.71 points, which was not statistically significant ($p = .69$). However, 6MWD (a secondary outcome) improved

significantly in the pulmonary rehabilitation group versus the usual care group at 3 months. The between-group difference in 6MWD was 94 meters ($p=.024$). A limitation of this analysis is that only 8 of 23 patients in the pulmonary rehabilitation performed a 6MWD at 3 months; the other 15 patients had dropped out or did not take the test. Eleven of 25 patients in the usual care group performed the 6MWD.

An exercise-only intervention after lung cancer surgery (not comprehensive pulmonary rehabilitation) was evaluated in an RCT published by Edvardsen et al (2015).²⁶ This single-blind study was conducted in Norway and included lung cancer patients at 4 to 6 weeks post-surgery. Sixty-one patients were randomized to an exercise program 3 times a week for 20 weeks or to usual care. The exercise intervention took place at local fitness centers and was supervised by trained personal trainers and physical therapists. A significant improvement was reported for the primary outcome (change in peak oxygen uptake from baseline to the end of the intervention) in the intervention group than in the control group (between-group difference, 0.26 L/min; $p=.005$). Findings on secondary outcomes were mixed. For example, the between-group difference in forced expiratory volume in 1 second was 0.6% predicted (95% CI, -4.2% to 5.4%; $p=.738$) and the difference in stair run was 4.3 steps (95% CI, 1.6 to 7.1; $p=.002$). This trial did not report other functional outcomes (e.g., 6MWD).

Post-Acute Sequelae of SARS-CoV-2 Infection

Clinical Context and Therapy Purpose

The purpose of a single course of outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without outpatient pulmonary rehabilitation, in individuals who have sequelae of SARS-CoV-2 infection.

Review of Evidence

Systematic Reviews

Numerous systematic reviews and meta-analyses have evaluated pulmonary rehabilitation programs in patients who have sequelae of SARS-CoV-2 infection (COVID-19), but few have specifically evaluated pulmonary rehabilitation in the ambulatory setting. A comparison of trials included in the selected systematic reviews is available in Table A2 in the Appendix. Table 13 describes characteristics of 3 systematic reviews and Table 14 includes results for the single pooled analysis.

Dillen et al (2023) evaluated ambulatory rehabilitation in patients with persistent symptoms after COVID-19.²⁷ The systematic review was not specific to pulmonary rehabilitation; however, 5 RCTs and 5 cohort studies evaluated breathing exercises alone or physical training with breathing exercises as part of rehabilitation and found benefit for several outcomes including dyspnea, pulmonary function, quality of life, and functional capacity.

Two systematic reviews focused on telehealth interventions in patients with post-acute COVID-19. Calvache-Mateo et al (2023) compared telerehabilitation to no intervention, usual care, placebo, or face-to-face intervention (Tables 13 and 14).²⁸ Pulmonary rehabilitation methods varied amongst the studies, but the majority of studies included respiratory training or breathing exercises. Telerehabilitation sessions were conducted 3 to 7 times weekly and

varied in duration from 20 to 60 minutes. The study found improved QOL, dyspnea, and functional capacity; however, there was high heterogeneity with a limited number of small studies. Pescaru et al (2023) conducted a systematic review of 3 RCTs and 4 cohort studies evaluating telerehabilitation in patients with post-acute COVID-19 (Table 13). The programs were diverse, and the data were not pooled.²⁹ There was great variability in findings with some improvements in dyspnea, quality of life, physical health, and mental health. However, the observational nature of many of the studies along with small sample sizes prohibit any conclusions regarding the benefit of telerehabilitation for these patients

Table 13. Systematic Review Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Dillen (2023)	Through May 2022	10	Patients with persistent COVID-19 symptoms	718 (20-150)	RCT/cohort	NR
Calvache-Mateo (2023)	Through July 2023	10	Patients with long COVID-19 undergoing pulmonary rehabilitation	866 (17-150)	RCT	4 to 17 weeks
Pescaru (2023)	Through April 2023	7	Patients with post-acute COVID-19 undergoing pulmonary rehabilitation	412 (67-622)	RCT/cohort	4 to 10 weeks

NR: not reported; RCT, randomized controlled trial.

Table 14. Systematic Review Results

Study	Dyspnea	FVC	QOL	Functional capacity	Adverse events
Total N	489	247	669	450	575
Pooled effect (95% CI)	MD: 4.95 (2.81-7.08) ^a	MD: 0.21 (-0.17-0.60)	MD: 0.59 (0.09-1.09) ^b	MD: 0.75 (0.39-1.11) ^c	OR: 0.53 (0.27 to 1.02)
I ² (p)	98% (<.00001)	66% (.03)	90% (<.00001)	66% (.01)	0% (.78)
Range of N	48-148	44-107	44-129	44-148	44-129
Range of effect sizes	0.18-28.5	-0.10-0.78	-0.51-2.75	0.31-1.37	0.30-2.50

CI: confidence interval; FVC: forced vital capacity; MD, mean difference; OR, odds ratio; QOL, quality of life.

^a As measured by the Modified Medical Research Council Scale, the Multidimensional Dyspnea-12 Scale, or the Transition Dyspnea Index.

^b As measured by the EuroQOL 5-Dimension, Short Form 12 or 36 Health Survey, Kansas City Pulmonary-Behavioral Inventory of Lung Disease, St. George's Respiratory Questionnaire, or Short Health-related Quality of Life Questionnaire.

^c As measured by the 6 minute walk test or Ruffier test.

REPEAT or MAINTENANCE OUTPATIENT PULMONARY REHABILITATION PROGRAMS

Clinical Context and Test Purpose

The purpose of repeat or maintenance outpatient pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as usual care without repeat or maintenance outpatient pulmonary rehabilitation, in individuals who have had an initial course of pulmonary rehabilitation.

Review of Evidence

Repeat Outpatient Pulmonary Rehabilitation Programs

Repeat pulmonary rehabilitation programs provide additional rehabilitation services after initial participation in a pulmonary rehabilitation program. Repeat programs are those that include patients who failed to respond to an initial program or whose response to an initial rehabilitation program diminished over time.

Carr et al (2009) prospectively identified Canadian patients with moderate-to-severe COPD who experienced an acute exacerbation within 12 months of participating in a pulmonary rehabilitation program.³⁰ All patients had initially completed a 6-week inpatient program or a 12-week outpatient program. Patients were then randomized to receive 3 weeks of pulmonary rehabilitation therapy or usual care. The repeat pulmonary rehabilitation program consisted of exercise and education; patients could choose inpatient or outpatient versions. Over a mean of 14 ± 11 weeks, 41 patients developed an exacerbation. Seven patients withdrew from the trial, and the remaining 34 were randomized to a repeat pulmonary rehabilitation program within 1 month of the exacerbation (n=17) or to no repeat pulmonary rehabilitation program (n=17). One patient in the intervention group dropped out; of the remaining 33 patients, 25 (76%) experienced an exacerbation of moderate severity; the remaining 8 had severe exacerbations. Nine (56%) of 16 patients in the intervention group chose an inpatient program and 7 chose an outpatient program. Patients were assessed before the repeat pulmonary rehabilitation program, immediately after (3 weeks later), and again 12 weeks after the beginning of the exacerbation (5 weeks after completing the repeat rehabilitation program). The primary outcome was change in health-related quality of life, as measured on the 4 domains of the chronic respiratory questionnaire scores. There was no statistically significant difference between groups in mean change in chronic respiratory questionnaire scores. Among patients in the intervention group, the magnitude of improvement in the domains of dyspnea (0.7 points) and fatigue (0.5 points) met or exceeded the minimal clinically important difference. In the control group, the magnitude of change in all domains did not meet the minimal clinically important difference. Change in the 6MWD (a secondary outcome), did not differ significantly between groups at either follow-up. Outcomes were not reported separately for the inpatient or outpatient programs (this evidence review addresses outpatient programs). Trialists recommended that future evaluations of repeat pulmonary rehabilitation programs include patients with more serious exacerbations, last longer than 3 weeks, and start as close in time as possible to the exacerbation. Conclusions about repeat PR programs cannot be drawn from 1 study with 33 subjects.

Maintenance Outpatient Pulmonary Rehabilitation Programs

Randomized Controlled Trials

In 2012, an Ontario Health Technology Assessment evaluated pulmonary rehabilitation for patients with COPD.³¹ Reviewers identified 3 RCTs (N=284) assessing maintenance pulmonary rehabilitation programs for individuals with COPD who had successfully completed an initial pulmonary rehabilitation program. The trials excluded patients who had experienced a recent acute exacerbation of COPD. All maintenance programs consisted of supervised exercise sessions; program duration was 3 months in 1 program and 12 months in the other 2. One program also included an unsupervised exercise component and another included educational sessions. Reviewers judged study quality as generally poor due to methodologic

limitations (e.g., inadequate information on randomization, allocation concealment, blinding, and lack of clarity around the use of an intention-to-treat analysis). In a pooled analysis of data from 2 trials (n=168), there was a significantly greater improvement in 6MWD in patients who participated in the maintenance program than in those in a control group (MD=22.9 meters; 95% CI, 5.2 to 40.7). The confidence interval was wide, indicating lack of precision in the pooled estimate. Also, reviewers considered the minimal clinically important difference to be 25 to 35 meters walked, and meta-analysis of trial findings did not meet this threshold of difference between groups.

Wilson et al (2015) published a single-blind RCT comparing maintenance pulmonary rehabilitation to standard care without maintenance pulmonary rehabilitation in patients who had COPD and had completed at least 60% of an initial pulmonary rehabilitation program.³³ One hundred forty-eight patients were randomized; 110 (74%) completed the trial and were included in the analysis. The maintenance program consisted of a 2-hour session every 3 months for 1 year. The session included an hour of education and an hour of supervised individualized exercise training. The primary efficacy outcome was change from baseline (post pulmonary rehabilitation) in the chronic respiratory questionnaire dyspnea domain. Among trial completers, mean chronic respiratory questionnaire dyspnea score changed from 2.6 to 3.2 among patients receiving maintenance pulmonary rehabilitation and from 2.5 to 3.3 among controls. The difference between groups was not statistically significant. Secondary outcomes, including other chronic respiratory questionnaire domains, scores on the endurance shuttle walk test, and a number of exacerbations or hospitalizations, also did not differ significantly between groups.

Several RCTs were published after the Ontario assessment. Güell et al (2017) published findings of a 3-year trial of patients with severe COPD.³² A total of 143 patients attended an initial 8-week outpatient pulmonary rehabilitation program, and 138 were then randomized to a 3-year maintenance program (n=68) or a control group (n=70). The maintenance intervention consisted of home-based exercises, calls from a physical therapist every 2 weeks, and supervised training sessions every 2 weeks. The control group was advised to exercise at home without supervision. Some outcomes, but not others, favored the intervention group at 2 years, but outcomes did not differ significantly between groups at 3 years. For example, compared with baseline, at 2 years the 6MWD increased by 2 meters in the intervention group and decreased by 32 meters in the control group (p=.046). At 3 years, compared with baseline, the 6MWD decreased by 4 meters in the intervention group and decreased by 33 meters in the control group (p=.119). The chronic respiratory questionnaire dyspnea score, at 2 years compared with baseline, decreased by 0.4 points in the intervention group and by 0.3 points in the control group (p=.617); findings were similar at 3 years. The trial also had a high dropout rate.

HOME-BASED PULMONARY REHABILITATION PROGRAMS

Clinical Context and Test Purpose

The purpose of a single course of home-based pulmonary rehabilitation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as a single course of ambulatory care-based pulmonary rehabilitation, in individuals with an indication for outpatient pulmonary rehabilitation.

Review of Evidence

Systematic Reviews

Evaluation of home-based pulmonary rehabilitation programs requires evidence that these programs are at least as effective as programs conducted in the ambulatory care setting. The programs also need to be comprehensive and be feasible in the United States health care system.

Vieira et al (2010) identified 12 RCTs comparing home-based pulmonary rehabilitation with pulmonary rehabilitation in another setting or to standard care in patients with COPD.³⁵ The comparison intervention in 3 trials was a hospital-based program; in 8 trials, it was standard care; and in 1 trial, both comparisons were made. The methodologic quality of the studies was considered average to poor, and most had small sample sizes and short follow-up durations. Reviewers did not pool trial findings and findings of individual studies were mixed. Three trials that compared home-based pulmonary rehabilitation with standard care reported on between-group differences in quality of life. In all 3 studies, differences were reported as statistically significant. The 2 trials that reported differences in exercise capacity found home-based pulmonary rehabilitation to result in significantly greater improvement in the 6MWD or constant work rate test than standard care. On the other hand, in the 3 trials comparing home-based pulmonary rehabilitation and hospital-based programs, there were no statistically significant differences between groups in quality-of-life changes. Moreover, in the 2 trials that assessed maximal work level and the 2 trials that assessed the 6MWD, outcomes did not differ significantly from home-based or hospital-based pulmonary rehabilitation programs. Reviewers commented that their analysis was limited by the low quality of the randomized trials and short-term length of follow-up.

Several RCTs and systematic reviews of RCTs have assessed home-based pulmonary rehabilitation programs. A comparison of trials included in systematic reviews is available in Table A3 in the appendix. Among the systematic reviews, Liu et al (2014) identified 18 RCTs evaluating home-based pulmonary rehabilitation programs.³⁴ Most trials compared pulmonary rehabilitation with usual care, and none of the selected trials compared home-based and clinic-based programs. Only 2 trials were conducted in the United States, and both were published in the 1990s. All trials reported different outcomes over different timeframes, and pooled analyses only included data from 2 to 4 studies. For example, a pooled analysis of 3 studies (n=112) reporting the Saint George's Respiratory Questionnaire total score found statistically significant improvement in symptoms with home-based pulmonary rehabilitation compared with control (effect size, -11.33; 95% CI, -16.37 to -6.29). A pooled analysis of data from 4 studies (n=167) found a significantly increased 6MWD after 12 weeks in the pulmonary rehabilitation group compared with control (effect size, 35.9; 95% CI, 9.4 to 62.4). The latter analysis had a wide confidence interval, indicating an imprecise estimate of effect.

Another systematic review was published by Neves et al (2016).³⁷ However, this review combined home- and community-based pulmonary rehabilitation programs in analyses so no conclusions can be drawn on the impacts of home-based programs compared with programs based in the ambulatory care setting.

Stafinski et al (2022) identified 12 RCTs and 2 comparative observational studies (N=2293) to include in their systematic review evaluating home-based pulmonary rehabilitation programs in individuals with COPD.³⁶ Nine studies compared home-based pulmonary rehabilitation to usual care, 4 compared to outpatient-pulmonary rehabilitation, and 1 compared home-based to

outpatient pulmonary rehabilitation or usual care. The overall quality for most outcomes was considered low to very low, based on the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) tool. Health-related quality of life was measured across studies using the COPD assessment test, chronic respiratory disease questionnaire (CRQ), and the Saint George's respiratory questionnaire. In a meta-analysis comparing home-based to outpatient pulmonary rehabilitation in RCTs (n=2 studies) immediately after treatment, there were no differences between groups in changes in the dyspnea domain of the CRQ (MD=0.36; 95% CI, -1.34 to 2.06; p=.68), the emotional function domain of the CRQ (MD=-0.35; 95% CI, -0.83 to 0.14; p=.16), or the fatigue domain of the CRQ (MD=0.06; 95% CI, -1.16 to 1.27; p=.93). In all 4 studies comparing home-based to outpatient pulmonary rehabilitation, the 6MWD statistically significantly increased after both interventions, and the gains were similar between programs. This study demonstrated that there were no appreciable differences between home-based and outpatient pulmonary rehabilitation programs in short-term outcomes. A meta-analysis was not able to be performed on most outcomes due to a high level of heterogeneity and limited data. Additionally, long-term outcomes were not evaluated in included studies.

Randomized Controlled Trial

A study with a large sample size that compared home-based pulmonary rehabilitation with outpatient clinic-based pulmonary rehabilitation was published by Maltais et al (2008).³⁸ This noninferiority trial was conducted in Canada. Eligibility criteria included stable COPD for at least 4 weeks before study participation and no previous participation in pulmonary rehabilitation programs; 252 patients were included. All patients initially completed a 4-week self-management education program. They were then randomized to 8 weeks of self-monitored home-based exercise training or outpatient hospital-based exercise training. The exercise program included aerobic and strength exercises conducted 3 times a week. Patients were followed for 40 weeks after completion of the exercise program. Both interventions produced similar improvements in the chronic respiratory questionnaire dyspnea domain scores at 1 year: improvement in dyspnea of 0.62 (95% CI, 0.43 to 0.80) units in the home intervention (n=107) and 0.46 (95% CI, 0.28 to 0.64) units in the outpatient intervention (n=109). The difference between treatments at 1 year was considered clinically unimportant. The trial did not evaluate a comprehensive pulmonary rehabilitation program.

Chung et al (2025) published results of an RCT comparing a home, smartphone app-guided pulmonary rehabilitation program to standard outpatient pulmonary rehabilitation in patients with chronic respiratory diseases and an indication for pulmonary rehabilitation.³⁹ This multicenter, single-blind RCT took place in sites across Seoul, South Korea and included 88 patients with chronic respiratory diseases, including COPD, asthma, or lung cancer. Most patients (96.6%) included in the study had COPD. Forty-one patients were in the intervention group, a 12-week app-guided rehabilitation program, and 47 patients were in the control group, standard outpatient treatment for 12 weeks. At the end of the 12-week rehabilitation period, there were no significant differences in 6MWD, dyspnea scores, and quality of life questionnaires between groups. Assuming a clinically minimal effective change of 25 meters in 6MWD, only 7 out of 41 participants among the intervention group achieved the minimal clinically important differences after the rehabilitation program. None of the participants experienced hospitalization or emergency room visits during the study period.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings and include a description of management of conflict of interest.

American Thoracic Society and European Respiratory Society

A 2015 joint statement on pulmonary rehabilitation was issued by the American Thoracic Society (ATS) and the European Respiratory Society.⁴⁰ The statement included the following relevant conclusions:

- "Pulmonary rehabilitation (PR) has demonstrated physiological, symptom-reducing, psychosocial, and health economic benefits in multiple outcome areas for patients with chronic respiratory diseases."
- "The evidence indicates that patients who benefit from PR include not only persons with moderate to severe airflow limitation but also those with mild to moderate airflow limitation with symptom-limited exercise tolerance, those after hospitalization for chronic obstructive pulmonary disease (COPD) exacerbation, and those with symptomatic non-COPD respiratory conditions."
- "Patients graduating from a PR program stand to benefit from a home, community-based, or program-based maintenance exercise program to support the continuation of positive exercise behavior."

In 2017, the Society issued a joint statement on the management of COPD exacerbation.⁴¹ For patients hospitalized with a COPD exacerbation, they suggest "the initiation of pulmonary rehabilitation within 3 weeks after hospital discharge" (strength: conditional; quality of evidence: very low). In addition, "[they] suggest not initiating pulmonary rehabilitation during hospitalization" (strength: conditional; quality of evidence: very low).

In 2021, the ATS published a report from a workshop that was convened to achieve consensus on the essential components of pulmonary rehabilitation and to identify requirements for successful implementation of emerging program models.⁴² A Delphi process involving experts from across the world identified 13 "essential" components of pulmonary rehabilitation that must be delivered in any program model, encompassing patient assessment, program content, method of delivery, and quality assurance; an additional 27 "desirable" components were also identified. See the full text of this publication for further details.

In 2023, the ATS published a clinical practice guideline on pulmonary rehabilitation for adults with chronic respiratory disease.⁴³ Several recommendations regarding pulmonary rehabilitation were reported, which are summarized in Table 15.

Table 15. American Thoracic Society Recommendations for Pulmonary Rehabilitation in Adults with Chronic Respiratory Disease

Recommendation Statement	Strength and Quality of Evidence
For adults with stable chronic obstructive pulmonary disease (COPD), we recommend participation in pulmonary rehabilitation	strong recommendation, moderate-quality evidence
For adults with COPD, we recommend participation in pulmonary rehabilitation after hospitalization for an exacerbation of COPD	strong recommendation, moderate-quality evidence
For adults with interstitial lung disease, we recommend participation in pulmonary rehabilitation	strong recommendation, moderate-quality evidence
For adults with pulmonary hypertension, we suggest participation in pulmonary rehabilitation	conditional recommendation, low-quality evidence
For adults with stable chronic respiratory disease, we recommend offering the choice of center-based pulmonary rehabilitation or telerehabilitation	strong recommendation, moderate-quality evidence
For adults with COPD, we suggest either supervised maintenance pulmonary rehabilitation or usual care after initial pulmonary rehabilitation	conditional recommendation, low-quality evidence

Global Initiative for Chronic Obstructive Lung Disease

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) updates their guidelines annually on the diagnosis, management, and prevention of COPD.⁴⁴ In their 2026 guidance, GOLD notes that:

"Pulmonary rehabilitation should be considered as part of integrated patient management... Optimum benefits are achieved from programs lasting 6 to 8 weeks. Available evidence indicates that there are no additional benefits from extending pulmonary rehabilitation to 12 weeks. Supervised exercise training at least twice weekly is recommended, and this can include any regimen from endurance training, interval training, resistance/strength training; upper and lower limbs ideally should be included as well as walking exercise; flexibility, inspiratory muscle training and neuromuscular electrical stimulation can also be incorporated. In all cases the rehabilitation intervention (content, scope, frequency, and intensity) should be individualized to maximize personal functional gains."

The benefits to patients with COPD from pulmonary rehabilitation cited in the guidelines are listed in Table 16.

Table 16. Benefits of Pulmonary Rehabilitation in Patients with COPD (GOLD guidelines)

Pulmonary Rehabilitation Benefit	LOE
Pulmonary rehabilitation improves dyspnea, health status, and exercise tolerance in stable patients.	A
Pulmonary rehabilitation reduces hospitalization among patients who have had a recent exacerbation (≤ 4 weeks from prior hospitalization).	B
Pulmonary rehabilitation leads to a reduction in symptoms of anxiety and depression.	A
Pulmonary rehabilitation leads to an improvement in sleep quality.	C

COPD: chronic obstructive pulmonary disease; GOLD: Global Initiative for Chronic Obstructive Lung Disease; LOE: level of evidence.

Related to the setting of pulmonary rehabilitation, the GOLD guidelines state that "community-based and home-based programs have been shown to be as effective as hospital-based programs in randomized controlled trials, as long as the frequency and intensity are equivalent." This statement cites studies described alone or included in systematic reviews in the Rationale Section (Maltais et al 2008 and Holland et al 2017).

National Institute for Health and Care Excellence

In 2020, NICE issued a rapid guideline on managing the long-term effects of COVID-19.⁴⁵ The guideline was most recently updated in January 2024. The guideline recommends using a "multidisciplinary approach to guide rehabilitation, including physical, psychological and psychiatric aspects of management. The evidence showed that breathlessness, fatigue and 'brain fog' are among the most commonly reported long-term symptoms, so support for these should be part of the person's rehabilitation plan

United States Preventive Services Task Force Recommendations

Not applicable

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 17.

Table 17. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT05990946	A Prospective, Randomized, Controlled Study to Evaluate the Impact of Remote Symptom Management Via Smartphone App Based on Electronic Patient-Reported Outcomes on Rehabilitation Exercise Adherence After Minimally Invasive Surgery in Lung Cancer Patients	736	Jun 2025
NCT06085261	Chronic Obstructive Pulmonary Disease: A Multi-center Supervised Tele-rehabilitation Study	360	Dec 2024
NCT04820257	Home-based Pulmonary Rehabilitation for COPD Patients	80	Dec 2028
<i>Unpublished</i>			
NCT03326089	Short and Long-term Effects of Oxygen Supplemented Pulmonary Rehabilitation in Idiopathic Pulmonary Fibrosis	20 (actual)	Aug 2023
NCT03299504	Factors Predicting Success in Lung Transplant Recipients Who Have Participated in the COLTT Program (Daily Intensive Post-hospitalization Rehabilitation): A Retrospective Review	105 (actual)	Apr 2018 (last updated 08/24/18)

NCT02426437	How Does Early Rehabilitation Affect Patient-centered Health Outcomes and Cardiovascular Risk in COPD Patients	87 (actual)	Dec 2019 (last updated 04/08/21)
NCT06077994	The Enhanced Pulmonary Rehabilitation Program With Digital Remote Patient Monitoring: A Feasibility Randomized Clinical Trial	78	Oct 2024 (last updated 09/08/25)

NCT: national clinical trial.

^a Terminated due to poor accrual

Regulatory Status:

N/A

Government Regulations

National:

National Coverage Determination (NCD) for Pulmonary Rehabilitation Services (240.8)

Effective date 9/25/2007, Implementation date 1/7/2008

Item/Service Description

A. General

Pulmonary rehabilitation was defined in a 1999 joint statement of the American Thoracic Society and the European Respiratory Society as a multi-disciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy and an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities. Integrated into the individualized treatment of the patient, pulmonary rehabilitation is designed to reduce symptoms, optimize functional status, increase participation, and reduce health care costs through stabilizing or reversing systematic manifestations of the disease.

Although services that make up pulmonary rehabilitation individually may be covered under Medicare and fall into various applicable benefit categories, the Centers for Medicare & Medicaid Services (CMS) has determined that the Social Security Act (the Act) does not expressly define a comprehensive pulmonary rehabilitation Program as a Part B benefit. In addition, respiratory therapy services are identified as covered services under the Comprehensive Outpatient Rehabilitation Facility benefit and defined in 42 CFR 410.100(e)(1) to (2)(vi).

Indications and Limitations of Coverage

B. Nationally Covered Indications

N/A

C. Nationally Non-Covered Indications

N/A

D. Other

The CMS has determined that a national coverage determination (NCD) for pulmonary rehabilitation is not appropriate at this time. Local contractors should continue to make decisions under §1862(a) (1) (A) of the Act through their local coverage determination (LCD) process or by case-by-case adjudication.

Local:

There is no local coverage determination.

Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services 231 Pulmonary Rehabilitation (PR) Program Services Furnished on or after January 1, 2024

(Rev. 12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

Pulmonary rehabilitation (PR) means a physician or nonphysician practitioner supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Nonphysician practitioner means a physician assistant, nurse practitioner, or clinical nurse specialist as those terms are defined in section 1861(aa)(5)(A) of the Social Security Act (the Act).

Effective January 1, 2010, Medicare Part B pays for PR if specific criteria are met by the Medicare beneficiary, the PR program itself, the setting in which it is administered, and the physician administering the program, as outlined below. Covered Conditions:

As specified in 42 CFR 410.47, Medicare Part B covers PR for beneficiaries:

- With moderate to very severe COPD (defined as GOLD classification II, III, and IV), when referred by the physician treating the chronic respiratory disease;
- Who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks (effective January 1, 2022);
- Additional medical indications for coverage for PR program services may be established through a national coverage determination (NCD).

PR must include all of the following components:

Physician-prescribed exercise. Physician-prescribed exercise means aerobic exercise combined with other types of exercise (such as conditioning, breathing retraining, step, and strengthening) as determined to be appropriate for individual patients by a physician. Each PR session must include physician prescribed exercise.

Education or training. 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. Psychosocial assessment. Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

Outcomes assessment. Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes the following: (i) Evaluations, based on patient-centered outcomes, which must be measured by the physician or program staff at the beginning and end of the program. Evaluations measured by program staff must be considered by the physician in developing and/or reviewing individualized treatment plans. (ii) Objective

clinical measures of exercise performance and self-reported measures of shortness of breath and behavior. Individualized treatment plan.

Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following: (i) A description of the individual's diagnosis. (ii) The type, amount, frequency, and duration of the items and services furnished under the plan. (iii) The goals set for the individual under the plan. The individualized treatment plan detailing how components are utilized for each patient must be established, reviewed, and signed by a physician every 30 days. As specified at 42 CFR 410.47(e), the number of PR sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare Administrative Contractor (MAC).

PR Settings:

Medicare Part B pays for PR in a physician's office or a hospital outpatient setting. All settings must have the following: (i) A physician or nonphysician practitioner immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician or nonphysician practitioner meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27, and (ii) The necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

PR Medical Director Standards:

Medical director means the physician who oversees the PR program at a particular site. The medical director is the physician responsible for a PR program and, in consultation with staff, is involved in directing the progress of individuals in the program and must possess all of the following: (1) Expertise in the management of individuals with respiratory pathophysiology. (2) Cardiopulmonary training in basic life support or advanced cardiac life support. (3) Be licensed to practice medicine in the State in which the PR program is offered.

Supervising Practitioner Standards: Supervising practitioner means a physician or nonphysician practitioner that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished to individuals under PR programs. Physicians or nonphysician practitioners acting as the supervising practitioner must possess all of the following: (1) Expertise in the management of individuals with respiratory pathophysiology. (2) Cardiopulmonary training in basic life support or advanced cardiac life support.

(See Publication 100-04, Claims Processing Manual, chapter 32, section 140.4, for PR claims processing, coding, and billing requirements.)

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicaid Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Cardiac Rehabilitation, outpatient

- Transplant-Lung/Double Lung and Liver (combined)
 - Lung Volume Reduction Surgery (Retired)
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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through July 7, 2026, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
7/12/02	7/12/02	7/12/02	Joint policy established
9/10/03	9/10/03	10/3/03	Joint policy established
2/25/05	2/25/05	2/25/05	Routine maintenance
5/1/07	3/1/07	3/30/07	Routine maintenance
9/1/07	7/2/07	7/2/07	Routine maintenance
11/1/08	8/19/08	10/28/08	Code update only
11/1/09	8/18/09	8/18/09	Routine maintenance
7/1/10	4/20/10	4/20/10	Routine maintenance Code update – G0424 added to policy.
7/1/11	4/19/11	5/3/11	Routine maintenance
9/1/13	6/19/13	6/26/13	Routine maintenance; reformatted description and rationale to mirror BCBSA; updated policy criteria.
7/1/15	4/21/15	5/8/15	Routine maintenance Inclusions updated to include pulmonary rehabilitation prior to lung volume reduction surgery and lung transplant. Statement added to exclusions for pulmonary rehabilitation following lung surgeries other than lung transplant (e.g., lung volume reduction surgery and surgical resection of lung cancer.) Added procedure codes G0302-G0305
7/1/16	4/19/16	4/19/16	Routine maintenance
7/1/17	4/18/17	4/18/17	Routine maintenance
7/1/18	4/17/18	4/17/18	Routine maintenance

9/1/18	6/19/18	6/19/18	Request to add respiratory therapist and exercise physiologist for supervision. CMS section updated. Inclusions re-formatted, examples of respiratory disease provided.
9/1/19	6/18/19		Routine maintenance
9/1/20	6/16/20		Routine maintenance
9/1/21	6/15/21		Routine maintenance
9/1/22	6/21/22		Routine maintenance. G0424 deleted; 94625, 94626 added.
9/1/23	6/13/23		Routine maintenance (jf) Vendor Managed: NA New Ref: 13,27,28,29,32,35,39
9/1/24	6/11/24		Routine maintenance (jf) Vendor Managed: NA Added Ref: 26,27,28 & 29 ○ Added Pulmonary rehabilitation programs are considered investigational in all other situations under exclusions. ○ Replaced patients with individuals
9/1/25	6/17/25		Routine maintenance (jf) Vendor Managed: NA Safety and effectiveness removed from MPS Patients removed and replaced with individuals Added Ref: 42 and 43
9/1/26	N/A		Routine maintenance (jf/lk) Vendor Managed: NA Added Ref: 16, 39 • Edits to inclusions and exclusions to align with BCBSA. Added BCBSA Policy Guidelines after exclusion section. • Policy reviewed and tabled
11/1/26	8/18/26		Routine maintenance (jf/lk) Vendor Managed: NA Added Ref: 16, 39

			Edits to inclusions and exclusions to align with BCBSA. Added BCBSA Policy Guidelines after exclusion section. Original Title: Pulmonary Rehabilitation New Title: Pulmonary Rehabilitation, Outpatient
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Next Review Date: 2nd Qtr, 2027

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: PULMONARY REHABILITATION, OUTPATIENT

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered, policy criteria apply
BCNA (Medicare Advantage)	See Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.