CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3058	**Date: August 29, 2014**
	Change Request 8758

Transmittal 2989, dated July 18, 2014, is being rescinded and replaced by Transmittal 3058, dated August 29, 2014 to remove language in section 140.3 that was included in error, and update the message text for Claim Adjustment Reason Code 119 in section 140.2.2.4. All other information remains the same.

SUBJECT: Cardiac Rehabilitation Programs for Chronic Heart Failure

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services to beneficiaries with stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks.

EFFECTIVE DATE: February 18, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 18, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/140/Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs
R	32/140.2/Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010
R	32/140.2.2.1/Correct Place of Service (POS) Code for CR and ICR Services on Professional Claims
R	32/140.2.2.2/Requirements for CR and ICR Services on Institutional Claims
R	32/140.2.2.4/Edits for CR Services Exceeding 36 Sessions
R	32/140.3/Intensive Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3058	Date: August 29, 2014	Change Request: 8758

Transmittal 2989, dated July 18, 2014, is being rescinded and replaced by Transmittal 3058, dated August 29, 2014 to remove language in section 140.3 that was included in error, and update the message text for Claim Adjustment Reason Code 119 in section 140.2.2.4. All other information remains the same.

SUBJECT: Cardiac Rehabilitation Programs for Chronic Heart Failure

EFFECTIVE DATE: February 18, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 18, 2014

I. GENERAL INFORMATION

A. Background: On June 4, 2013, the Centers for Medicare & Medicaid Services (CMS) initiated a national coverage analysis (NCA) to expand Medicare coverage of cardiac rehabilitation to beneficiaries diagnosed with chronic heart failure.

As per Sections 1861(s)(2)(CC) and 1861(eee)(1) of the Social Security Act, items and services furnished under a Cardiac Rehabilitation (CR) program may be covered under Medicare Part B. Among other things, Medicare regulations at 42CFR410.49 define key terms, address the components of a CR program, establish the standards for physician supervision, and limit the maximum number of program sessions that may be furnished. The regulations also describe the cardiac conditions that would enable a beneficiary to obtain CR services.

Specifically, coverage is permitted for beneficiaries who have experienced one or more of the following:

- Acute myocardial infarction within the preceding 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting or
- Heart or heart-lung transplant

This change request adds chronic heart failure to the list of cardiac conditions, see above, that would enable a beneficiary to obtain CR services.

CMS may add “other cardiac conditions as specified through a national coverage determination” (42 CFR §410.4(b)(vii).

B. Policy: Effective for dates of service on and after February 18, 2014, Medicare has determined that the evidence is sufficient to expand coverage for cardiac rehabilitation services under 42 CFR §410.49(b)(1)(vii) to beneficiaries with stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35%

or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks. Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures. (See section A above for indications covered 42 CFR §410.49(b)(1)(vii).

Refer to Pub. 100-03, National Coverage Determinations Manual, chapter 1, part 1, section 20.10.1, Pub. 100-04, Claims Processing Manual, chapter 32, section 140, Pub. 100-08, Medicare Program Integrity Manual, chapter 15, section 4.2.8, and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 232 for detailed information regarding chronic heart failure policy and claims processing. Note as referenced above that chronic heart failure is an added indication for purposes of coverage for cardiac rehabilitation programs. Change Request 6850 implemented this policy previously, so no actual editing changes will be necessary

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8758 - 04.1	Effective for dates of service on and after February 18, 2014, Medicare contractors shall cover cardiac rehabilitation services under 42 CFR §410.49(b)(1)(vii) to beneficiaries with stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks. Refer to Pub. 100-03 National Coverage Determinations Manual, chapter 1, part 1, section 20.10.1, Pub. 100-04, Claims Processing Manual, chapter 32, section 140, Pub. 100-08, Medicare Program Integrity Manual, chapter 15, section 4.2.8, and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 232 for detailed information regarding chronic heart failure policy and claims processing.	X	X							
8758 - 04.2	For claims with dates of service on or after February 18, 2014, Medicare contractors shall not search their files. However, contractors shall adjust claims brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8758 - 04.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Patricia Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (Coverage), Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage), William Ruiz, 410-786-9283 or William.Ruiz@cms.hhs.gov (Intermediary Part A Claims), April Billingsley, 410-786-0140 or April.Billingsley@cms.hhs.gov (Intermediary Part A Claims), Michelle Issa, 410-786-6656 or michelle.issa@cms.hhs.gov (Coverage), Wendy Knarr, 410-786-0843 or wendy.knarr@cms.hhs.gov (Supplier Claims Processing Dial Relay Services @9-711 then phone number)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

140 - Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs

(Rev.3058, Issued: 08-29-14, Effective: 02-18-14, Implementation: 08- 18-14)

Cardiac rehabilitation (CR) programs are defined as physician supervised programs that furnish physician prescribed exercise, cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment, outcomes assessment, and other items/services as determined by the Secretary under certain conditions. Intensive cardiac rehabilitation (ICR) programs are defined as physician supervised programs that furnish the same items/services under the same conditions as a CR program, but must also demonstrate, as shown in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements described in 42 CFR 410.49(c). Effective January 1, 2010, Medicare Part B pays for CR/ICR programs and related items/services if specific criteria is met by the Medicare beneficiary, the CR/ICR program itself, the setting in which it is administered, and the physician administering the program.

140.2 – Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010

(Rev.3058, Issued: 08-29-14, Effective: 02-18-14, Implementation: 08- 18-14)

As specified at 42 CFR 410.49, Medicare covers cardiac rehabilitation items and services for patients who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months; or
- A coronary artery bypass surgery; or
- Current stable angina pectoris; or
- Heart valve repair or replacement; or
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- A heart or heart-lung transplant*; or*
- *Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks (effective February 18, 2014).*

Cardiac rehabilitation programs must include the following components:

- Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished;
- Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to patients' individual needs;
- Psychosocial assessment;
- Outcomes assessment; and

- An individualized treatment plan detailing how components are utilized for each patient.

Cardiac rehabilitation items and services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all *times* items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for the direct supervision of physician's office services as specified at 42 CFR 410.26 and for hospital outpatient therapeutic services as specified at 42 CFR 410.27.

As specified at 42 CFR 410.49(f)(1), cardiac rehabilitation program 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 contractor.

140.2.2.1 – Correct Place of Service (POS) Code for CR and ICR Services on Professional Claims

(Rev.3058, Issued: 08-29-14, Effective: 02-18-14, Implementation: 08- 18-14)

Effective for claims with dates of service on and after January 1, 2010, place of service (POS) code 11 shall be used for CR and ICR services provided in a physician's office and POS 22 shall be used for services provided in a hospital outpatient setting. All other POS codes shall be denied. Contractors shall adjust their prepayment procedure edits as appropriate.

The following messages shall be used when contractors deny CR and ICR claims for POS:

Claim Adjustment Reason Code (CARC) 171 – Payment is denied when performed/billed by this type of provider in this type of facility.

NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.

Remittance Advice Remark Code (RARC) N428 - Service/procedure not covered when performed in this place of service.

Medicare Summary Notice (MSN) 21.25 - This service was denied because Medicare only covers this service in certain settings.

Group Code PR (Patient Responsibility) - Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

140.2.2.2 – Requirements for CR and ICR Services on Institutional Claims

(Rev.3058, Issued: 08-29-14, Effective: 02-18-14, Implementation: 08- 18-14)

Effective for claims with dates of service on and after January 1, 2010, contractors shall pay for CR and ICR services when submitted on Types of Bill (TOBs) 13X and 85X only. All other TOBs shall be denied.

The following messages shall be used when contractors deny CR and ICR claims for TOBs 13X and 85X:

Claim Adjustment Reason Code (CARC) 171 – Payment is denied when performed/billed by this type of provider in this type of facility.

Remittance Advice Remark Code (RARC) N428 - Service/procedure not covered when performed in this place of service.

Medicare Summary Notice (MSN) 21.25 - This service was denied because Medicare only covers this service in certain settings.

Group Code PR (Patient Responsibility) – Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

140.2.2.4 – Edits for CR Services Exceeding 36 Sessions

(Rev.3058, Issued: 08-29-14, Effective: 02-18-14, Implementation: 08- 18-14)

Effective for claims with dates of service on or after January 1, 2010, contractors shall deny all claims with HCPCS 93797 and 93798 (both professional and institutional claims) that exceed 36 CR sessions when a KX modifier is not included on the claim line.

The following messages shall be used when contractors deny CR claims that exceed 36 sessions, when a KX modifier is not included on the claim line:

Claim Adjustment Reason Code (CARC) 119 – Benefit maximum for this period or occurrence has been reached.

RARC N435 - Exceeds number/frequency approved/allowed within time period without support documentation.

MSN 23.17- Medicare won't cover these services because they are not considered medically necessary.

Spanish Version - Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas.

Group Code PR (Patient Responsibility) – Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

Contractors shall not research and adjust CR claims paid for more than 36 sessions processed prior to the implementation of CWF edits. However, contractors may adjust claims brought to their attention.

140.3 – Intensive Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010

(Rev.3058, Issued: 08-29-14, Effective: 02-18-14, Implementation: 08- 18-14)

As specified at 42 CFR 410.49, Medicare covers intensive cardiac rehabilitation items and services for patients who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months; or
- A coronary artery bypass surgery; or
- Current stable angina pectoris; or
- Heart valve repair or replacement; or
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or,
- A heart or heart-lung transplant.

Intensive cardiac rehabilitation programs must include the following components:

- Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished;
- Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to patients' individual needs;
- Psychosocial assessment;
- Outcomes assessment; and
- An individualized treatment plan detailing how components are utilized for each patient.

Intensive cardiac rehabilitation programs must be approved by Medicare. In order to be approved, a program must demonstrate through peer-reviewed published research that it has accomplished one or more of the following for its patients:

- Positively affected the progression of coronary heart disease;
- Reduced the need for coronary bypass surgery; and
- Reduced the need for percutaneous coronary interventions.

An intensive cardiac rehabilitation program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

- Low density lipoprotein;
- Triglycerides;
- Body mass index;
- Systolic blood pressure;
- Diastolic blood pressure; and
- The need for cholesterol, blood pressure, and diabetes medications.

Intensive cardiac rehabilitation items and services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all *times* items and services are being furnished under the program. This

provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26 and for hospital outpatient therapeutic services as specified at 42 CFR 410.27.

As specified at 42 CFR 410.49(f)(2), intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.