

MLN Matters Number: MM4401

Related Change Request (CR) #: 4401

Related CR Release Date: April 21, 2006

Effective Date: March 22, 2006

Related CR Transmittal #: R909CP and R52NCD

Implementation Date: June 21, 2006

Cardiac Rehabilitation Programs

Provider Types Affected

All providers who bill Medicare for cardiac rehabilitation services

Provider Action Needed



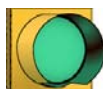
STOP – Impact to You

Effective on and after March 22, 2006, Medicare has expanded coverage for cardiac rehabilitation programs to include three new indications, and has extended the time frame for performing the services to include up to 36 sessions.



CAUTION – What You Need to Know

CR4401 updates the *National Coverage Determination (NCD) Manual*, Publication 100-03, Section 20.10, Cardiac Rehabilitation Programs (March 22, 2006), to include three newly covered indications: 1) heart valve repair/replacement; 2) percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; and 3) heart or heart-lung transplant. It also extends the program's possible duration to a total of 36 sessions (generally, two to three sessions per week for 12 to 18 weeks) and lists the services required to provide a comprehensive program. CR4401 also updates the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 32, Section 140 to include billing requirements and language regarding physician supervision.



GO – What You Need to Do

Make sure that your billing staffs are aware of these coverage changes in the Cardiac Rehabilitation Program.

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Background

Phase II cardiac rehabilitation, as described by the U.S. Public Health Service, is a comprehensive, long-term program including medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Phase II refers to outpatient, medically supervised programs that are typically initiated 1-3 weeks after hospital discharge and provide appropriate electrocardiographic monitoring.

CR4401 updates *National Coverage Determinations (NCD) Manual* (100-03), Section 20.10 (effective for cardiac rehabilitation services provided on or after March 22, 2006) to:

- Expand the clinical indications for coverage;
- Extend the program's possible duration;
- Simplify the language regarding physician supervision;
- List the services required to provide a comprehensive program; and
- Update the relevant billing and claims related instructions found in the *Medicare Claims Processing Manual* (Publication 100.04).

CMS has historically covered cardiac rehabilitation services for patients who have: (1) a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) coronary artery bypass surgery; and /or (3) stable angina pectoris. The updated NCD now provides coverage for these three indications and adds three additional ones.

Expanded Coverage

Effective for services performed on or after March 22, 2006, Medicare covers cardiac rehabilitation exercise programs for patients who meet the following criteria:

- Have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or
- Have had coronary bypass surgery; or
- Have stable angina pectoris; or
- Have had heart valve repair/replacement; or
- Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- Have had a heart or heart lung transplant.

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Further, the updated policy also now allows up to 18 weeks for a beneficiary to receive their maximum of 36 cardiac rehabilitation services (Patients generally receive two to three sessions per week for 12 to 18 weeks).

Please note that additional services may be covered at the discretion of the local Medicare contractor, but may not exceed 72 sessions within a 36-week period.

Clarification of Physician and Facility Requirements

The updated policy also clarifies language regarding physician supervision and facility requirements and the physician's physical location during the rehabilitation services. Specifically the NCD requires that:

- The program must be staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease; and
- The facility must have available for immediate use the necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator.

The *Medicare Claims Processing Manual* instructs that:

- Cardiac rehabilitation programs shall be performed incident to physician's services in outpatient hospitals, or outpatient settings such as clinics or offices. Follow the policies for services incident to the services of a physician as they apply in each setting. For example, see Pub. 100-02, chapter 6, section 2.4.1, and Pub. 100-02, chapter 15, section 60.1.

Coding Requirements

This CR also changes the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 32, Section 140, to update the relevant billing and claims related instructions, and points out the following applicable HCPCS codes:

- **93797** - Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session); and
- **93798** - Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session).

You should note that your carriers and FIs will apply current payment methodologies, rates, and payments policies for cardiac rehabilitation services when these services are performed according to the new policy stated in this CR. However, they will not search and adjust claims that have already been processed unless brought to their attention.

Additional Information

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The revision of Section 20.10 of the *Medicare National Coverage Determinations Manual* (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. Remember that:

- NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR 405.1064, effective May 1, 2005);
- An NCD that expands coverage is also binding on a Medicare advantage organization; and
- In addition, an administrative law judge may not review an NCD. (See 1869(f)(1)(A)(i) of the Social Security Act.

You may view CR4401, Transmittal 52, the revised *Medicare National Coverage Determinations Manual*, Chapter 1 - Coverage Determinations, Part 1, Section 20.10 (Cardiac Rehabilitation Programs – effective March 22, 2006), at <http://www.cms.hhs.gov/Transmittals/downloads/R52NCD.pdf> on the CMS website.

You may view CR4401, Transmittal 909, the revised *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 140 (Cardiac Rehabilitation Programs) and 140.1 (Coding Requirements), at <http://www.cms.hhs.gov/Transmittals/downloads/R909CP.pdf> on the CMS website.

If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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