

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-08 Medicare Program Integrity</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 339</b>	<b>Date: May 21, 2010</b>
	<b>Change Request 6850</b>

**SUBJECT: Cardiac Rehabilitation and Intensive Cardiac Rehabilitation**

**I. SUMMARY OF CHANGES:** CMS is establishing a new supplier specialty code for intensive cardiac rehabilitation services. The new code will be 31.

**EFFECTIVE DATE: January 1, 2010**

**IMPLEMENTATION DATE: October 4, 2010**

*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

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	10/Table of Contents
<b>N</b>	10/2.2.8/Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR)

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**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.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment – Business Requirements

Pub. 100-08	Transmittal: 339	Date: May 21, 2010	Change Request: 6850
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**SUBJECT: Cardiac Rehabilitation and Intensive Cardiac Rehabilitation**

**Effective Date: January 1, 2010**

**Implementation Date: October 4, 2010**

## I. GENERAL INFORMATION

**A. Background:** The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for cardiac rehabilitation (CR) programs and intensive cardiac rehabilitation (ICR) programs. The Centers for Medicare and Medicaid Services (CMS) decided to implement the statutory provisions through rule making, in the calendar year (CY) 2010 Physician Fee Schedule (PFS). On October 30, 2009, the CY 2010 PFS Final Rule with Comment was finalized and put on display and is available at <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>. The Final Rule was published in the Federal Register on November 25, 2009, and is available on pages 62004 - 62005.

To implement MIPPA CR and ICR coverage provisions CMS added section 410.49, *Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage*, to the Public Health Code of Federal Regulations (42 CFR). The CR and ICR coverage provisions included in new section 42 CF R 410.49 were effective January 1, 2010.

**B. Policy:** Effective January 1, 2010, Medicare Part B covers CR and ICR program services for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty or coronary stenting;
- A heart or heart-lung transplant; or
- Other cardiac conditions as specified through a national coverage determination (NCD) (CR only).

ICR programs must be approved by CMS through the NCD process and must meet certain criteria for approval. Individual sites wishing to provide ICR services via an approved ICR program must enroll with their local Medicare contractor or MAC as an ICR program supplier using CMS 855B. Contractors and MACs must ensure that claims submitted from individual ICR sites are submitted by enrolled ICR program sites.

**NOTE:** Per the NCD process, the coverage analyses of the first ICR programs under evaluation will be completed no later than August 15, 2010. CMS anticipates future analyses of additional ICR programs. ICR programs that are approved through the NCD process will be identified in the NCD manual (Pub. 100-03), on the CMS Web site and in the Federal Register. Once ICR programs are approved through the NCD process, sites wishing to furnish ICR services via an approved ICR program may begin to enroll as ICR program suppliers using CMS 855B.

Regulations at 42 CFR 410.49 include all coverage provisions for CR and ICR items and services, identifies definitions, covered indications, settings, physician supervision requirements and physician standards, required CR and ICR components, limitations to the number of sessions covered, and the period of time over which the sessions may be covered.

CR and ICR programs must include the following components: 1) physician-prescribed exercise each day CR and ICR items and services are furnished; 2) cardiac risk factor modification; 3) psychosocial assessment; 4) outcomes assessment; and 5) an individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed and signed by a physician every 30 days.

CR sessions are limited to a maximum of 2 1-hour sessions per day up to 36 sessions furnished over a period of up to 36 weeks, with the option for an additional 36 sessions at Medicare contractor discretion over an extended period of time. ICR sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

**NOTE:** Once a beneficiary begins CR, he or she may not switch to ICR and once a beneficiary begins ICR, he or she may not switch to CR. Upon completion of a CR or ICR program, beneficiaries must experience another indication in order to be eligible for coverage of more CR or ICR. Should a beneficiary experience more than one indication simultaneously, he or she may participate in a single series of CR or ICR sessions (i.e., a patient who had a myocardial infarction within 12 months and currently experiences stable angina is entitled to one series of CR sessions, up to 36 1-hour sessions with contractor discretion for an additional 36 sessions; or one series of ICR sessions, up to 72 1-hour sessions over a period up to 18 weeks).

Contractors shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond 36 sessions of CR up to a total of 72 sessions meets the requirements of the medical policy or, for ICR, that any further sessions beyond 72 sessions within a 126 day period counting from the date of the first session or for any sessions provided after 126 days from the date of the first session meet the requirements of the medical policy.

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 232, Pub. 100-04, Medicare Claims Processing Manual, chapter 26, section 10.8.3, and chapter 32, section 140, and 100-06, Medicare Financial Management, chapter 6, section 420, for detailed information regarding ICR policy and claims processing.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
6850.1	See Pub. 100-04 for detailed Business Requirements	X		X	X						

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6850.2	A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles">http://www.cms.hhs.gov/MLNMattersArticles</a> 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 site 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 your 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	X						

### IV. SUPPORTING INFORMATION

**A. For any recommendations and supporting information associated with listed requirements, use the box below:**

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

**B. For all other recommendations and supporting information, use this space: N/A**

### V. CONTACTS

**Pre-Implementation Contact(s):** Sarah McClain, Coverage, 410-786-2994, [sarah.mcclain@cms.hhs.gov](mailto:sarah.mcclain@cms.hhs.gov), Pat Brocato-Simons, Coverage, 410-786-0261, [patricia.brocatosimons@cms.hhs.gov](mailto:patricia.brocatosimons@cms.hhs.gov), Michelle Atkinson, coverage, 410-786-2881, [michelle.atkinson@cms.hhs.gov](mailto:michelle.atkinson@cms.hhs.gov), Bill Ruiz, Institutional Claims Processing, 410-786-9283, [William.ruiz@cms.hhs.gov](mailto:William.ruiz@cms.hhs.gov), Tom Dorsey, Practitioner Claims Processing, [Thomas.Dorsey@cms.hhs.gov](mailto:Thomas.Dorsey@cms.hhs.gov), 410-786-7434, Alisha Banks, Provider Enrollment, 410-786-0671, [alisha.banks@cms.hhs.gov](mailto:alisha.banks@cms.hhs.gov), Richard Cuchna, CWF Inquiry Screens, 410-786-7239, [richard.cuchna@cms.hhs.gov](mailto:richard.cuchna@cms.hhs.gov)

**Post-Implementation Contact(s):** Appropriate Regional Office

## **VI. FUNDING**

### **A. For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

### **B. 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.

# **Medicare Program Integrity Manual**

## **Chapter 10 - Medicare Provider/Supplier Enrollment**

### **Table of Contents** *(Rev.339, 05-21-10)*

*2.2.8 – Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR)*

## ***2.2.8 – Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR)***

***(Rev.339, Issued: 05-21-10, Effective: 01-01-10, Implementation: 10-04-10)***

### ***A. General Background Information***

*Effective January 1, 2010, Medicare Part B covers Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) program services for beneficiaries who have experienced one or more of the following:*

- An acute myocardial infarction within the preceding 12 months;*
- A coronary artery bypass surgery;*
- Current stable angina pectoris;*
- Heart valve repair or replacement;*
- Percutaneous transluminal coronary angioplasty or coronary stenting;*
- A heart or heart-lung transplant; or,*
- Other cardiac conditions as specified through a national coverage determination (NCD) (CR only).*

*ICR programs must be approved by CMS through the national coverage determination (NCD) process and must meet certain criteria for approval. Individual sites wishing to provide ICR services via an approved ICR program must enroll with their local contractor or MAC as an ICR program supplier.*

### ***B. ICR Enrollment***

*In order to enroll as an ICR site, a supplier must complete a Form CMS-855B, with the supplier type of “Other” selected. Contractors shall verify that the ICR program is approved by CMS through the NCD process. A list of approved ICR programs will be identified through the NCD listings, the CMS Web site and the Federal Register. Contractors shall use one of these options to verify that the ICR program has met CMS approval.*

*ICR suppliers shall be enrolled using specialty code 31. ICR suppliers must separately enroll each of their practice locations. Therefore, each enrolling ICR supplier can only have one practice location on its CMS-855B enrollment application and shall receive its own PTAN.*

*Contractors shall only accept and process reassignments (855R’s) to ICR suppliers for physicians defined in 1861(r)(1) of the Act.*

### ***C. Additional Information***

*For more information on ICR suppliers, refer to:*

- 42 CFR §410.49;*

- *Pub. 100-04, Medicare Claims Processing Manual, chapter 32, sections 140.2.2 – 140.2.2.6; and*
- *Pub. 100-02, Medicare Benefit Policy Manual. chapter 15, section 232.*