FUTURE DRAFT Local Coverage Determination (LCD) for Cardiac Rehabilitation (DL32872)

Please note: This is a Draft policy.
Draft LCDs are works in progress that are available on the Medicare Coverage Database site for public review.
Draft LCDs are not necessarily a reflection of the current policies or practices of the contractor.

Please note: Future Effective Date.

Contractor Information

Contractor Name	Contractor Number	Contractor Type
Palmetto GBA opens in new window	11401	MAC - Part A

Back to Top

LCD Information

Document Information

Primary Geographic Jurisdiction opens in new window
West Virginia

Oversight Region
Region IV

Original Determination Effective Date
For services performed on or after 01/28/2013

LCD ID Number
DL32872

Original Determination Ending Date
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LCD Title
Cardiac Rehabilitation

Revision Effective Date
For services performed on or after 01/28/2013

Contractor's Determination Number
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Revision Ending Date

AMA CPT/ADA CDT Copyright Statement

CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determination(s) or payment policy rules and regulations for cardiac and intensive cardiac rehabilitation services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for cardiac and intensive cardiac rehabilitation services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding cardiac and intensive cardiac rehabilitation services are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

Title XVIII of the Social Security Act, §1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, §1862(a)(1)(D) items and services related to research and experimentation

Title XVIII of the Social Security Act, §1862 (a)(D) Personal Comfort items

Title XVIII of the Social Security Act, §1862(a)(7) excludes routine physical examinations

Title XVIII of the Social Security Act, §1833 (e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

42 CFR 410.26 Services incident to a physisican's professional services

42 CFR 410.27 Therapeutic outpatient hospital or CAH services and supplies incident to a physician's or non-physician practitioner's service

42 CFR 410.49 Cardiac rehabilitation program and intensive cardiac rehabilitation program: conditions of coverage.

CMS Internet-only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §60.1.B and 232.

CMS Internet-only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 32, §140.1-140.3.

CMS Internet-only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 13, §13.5.1.

Indications and Limitations of Coverage and/or Medical Necessity

Cardiac Rehabilitation (CR) means a comprehensive, physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. The purpose of the program is to restore individual patients with certain cardiac conditions to active and productive lives as demonstrated in the outcomes assessment.

The medical literature divides CR into three phases: Phase I is the immediate in-hospital, post-cardiac event phase; Phase II is the outpatient immediate post-hospitalization recuperation phase; and Phases III and IV are the long-term maintenance phases and are not payable under Medicare. This LCD encompasses Phase II or outpatient post-hospital CR. Phase II programs are typically initiated one to three weeks after hospital discharge and consist of a series of medically supervised exercise sessions with Continuous Electrocardiograph Monitoring (CEM). Clinically optimal results are obtained if these sessions are conducted two to three times per week over a 12–18-week period, generally for a total of 36 sessions.

Phases of Cardiac Rehabilitation

- Phase I: Acute in-hospital phase of CR. This is included in the hospital care for the acute illness and is not included under the CR benefit.
- Phase II: For the purposes of this LCD, Phase II is divided into
    - Phase IIA and Phase IIB.
    - Phase IIA is the initial outpatient CR, consisting of 36 or fewer sessions, occurring up to two sessions per day.
    - Phase IIB consists of up to an additional 36 sessions and will only be allowed if determined medically necessary. Phase IIB benefits must meet additional medical necessity criteria. Specifically, there must be clear demonstration that the patient is benefiting from CR and that the exit criteria below from phase IIA have not been met. The maximum total of allowable sessions under Phase IIA and IIB is 72.

- Phase III: CR programs that are self-directed or self-controlled/monitored exercise programs.
- Phase IV: CR programs or maintenance therapy that may be safely carried out without medical supervision.

NOTE: Phase III CR programs do not meet the supervisory requirements of the benefit and are not covered under Medicare.

Individualized treatment plan is a written plan tailored to each individual patient that includes all of the following:

- A description of the individual's diagnosis.
- The type, amount, frequency and duration of the items and services furnished under the plan.
- Must be reviewed and signed by a physician every 30 days.
- The goals set for the individual under the plan.

Intensive Cardiac Rehabilitation (ICR) services must include the comprehensive program components of a CR program. In addition ICR services must demonstrate that the program improves patients' cardiovascular disease through specific outcome measurements. See CMS National Coverage Policy section of this LCD.

CR and ICR are covered for the following patients:

- Patients who begin the program within 12 months of an acute Myocardial Infarction (MI).
- Patients who have had Coronary Artery Bypass Graft (CABG) surgery.
- Patients with current, stable angina pectoris.
- Patients who have had heart valve repair/replacement.
- Patients who have had Percutaneous Transluminal Coronary Angioplasty (PTCA) or coronary stenting.
- Patients who have had a heart or heart-lung transplant.

Limitations

ICR services **must** be provided in a program approved through the NCD process:

- ICR programs must be approved by CMS.
- For ICR programs that are approved by CMS, sites wishing to furnish ICR services via an approved ICR program may begin to enroll as ICR program suppliers using the CMS-855A for the fiscal intermediary or Part A Medicare Administrative Contractor (MAC).
- Contractors and MACs will ensure that claims submitted from individual ICR sites are submitted by enrolled ICR program sites.

A. Facilities for Both CR and ICR

For CR programs provided in the outpatient department of a hospital, coverage is subject to the following conditions:

- The facility is a hospital outpatient department or a physician's office.
- The facility has available for immediate use all the necessary cardiopulmonary emergency diagnostic and therapeutic life-saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment or defibrillator.
- The program is staffed by personnel necessary to conduct the program safely and effectively and who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease.

Physician responsibility

There are two categories of responsibility that require a physician (MD or DO). One is that of medical director the physician(s) with directorial responsibility for the CR or ICR program. The medical director in consultation with staff is involved in directing the progress of individuals in the program. This individual must possess all of the following (1) expertize in the management of individuals with cardiac pathophysiology; (2) cardiopulmonary training in basic life support or advanced cardiac life support; and (3) a license to practice medicine in the state in which the CR or ICR program is offered. The other physician responsibility is that of supervising physician. This could be the same individual as the medical director, but that is not required. An identified supervising physician must also possess the same three specific characteristics listed for the medical director. The supervising physician must be immediately available at all times while cardiac rehabilitation services are being rendered. This does not require that a physician be physically present in the exercise room itself but **must be immediately available and accessible** at all times. It should also be noted that non-physician practitioners may not serve in the medical director role or supervisory role for Cardiac rehabilitation.

B. Diagnoses for Both CR and ICR

- For MI, the date of entry into the program must be within 12 months of the date of infarction. **(ICD -9-CM diagnosis codes: 410.XX (see "ICD-9-CM Codes That Support Medical Necessity" section below for complete list); or 412** if the Acute Myocardial Infarction (AMI) occurred more than eight weeks and less than 12 months before the first CR or ICR session).

C. Frequency and Duration for CR and ICR

Once a beneficiary begins CR, he may not switch to ICR, and once a beneficiary begins ICR, he may not switch to CR. Upon completion of a CR or ICR program, beneficiaries must experience another indication in order to be eligible for additional coverage for CR or ICR. Should a beneficiary experience more than one indication simultaneously, he may participate in a single series of CR or ICR sessions (e.g., a patient who had a myocardial infarction within 12 months and currently experiences stable angina is entitled to one series of CR sessions).

- CR Program:
- The frequency and duration of the program is generally a total of 36 sessions over a maximum of 36 weeks.
- A single session must last at least 31 minutes in order to be billable. If two sessions are billed for a single day, then the total combined time must be at least 91 minutes (60 minutes for the first session and at least 31 minutes for the second session) in duration.

- No more than two one-hour sessions, utilizing any combination of the CPT codes (93798) will be allowed per day for up to 36 sessions over a maximum of 36 weeks (Phase IIA).
- An additional 36 sessions may be allowed if a significant intercurrent illness or comorbidity occurred during the first 36 sessions **and** the exit criteria have not been met (Phase IIB). Inclusion of the KX modifier on the claim line(s) will be accepted 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 CR coverage requirements. The medical record must reflect the reasons and be available to Medicare upon request.
- An additional series of 36 sessions may be allowed as a new series of CR initiated after an intervening event described as an indication for CR in this LCD. Inclusion of the KX modifier on the claim line(s) will be accepted as an attestation by the provider of the service that documentation is on file verifying that an additional series of CR meets the CR coverage requirements.
- ICR Program:
- The frequency and duration of the program are generally a total of 72 sessions over a maximum of 18 weeks (126 days).
- A single session must last at least 31 minutes in order to be billable. If two or more sessions are billed for a single day, then the total combined time must be at least 91 minutes for two sessions or at least 181 minutes for three sessions, etc. in duration.
- Six sessions may be allowed per day, not to exceed a total of 72 sessions over a period of up to 18 weeks (126 days).
- Additional sessions may be allowed if a significant intercurrent illness or comorbidity occurred beyond 126 days from the date of the first session and the exit criteria have not been met. Inclusion of the KX modifier on the claim line(s) will be accepted as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond the 126 days meets the ICR coverage requirements. That documentation must be available to Medicare upon request.
- An additional series of 72 sessions may be allowed as a new series of ICR initiated after an intervening event described as an indication for ICR in this LCD. Inclusion of the KX modifier on the claim line(s) will be accepted as an attestation by the provider of the service that documentation is on file verifying that an additional series of ICR meets the ICR coverage requirements.

D. Exit Criteria for Both CR and ICR

Outcome assessments should include:

- Minimally, assessments from the commencement and conclusion of CR/ICR, based on patient-centered outcomes, which must be measured by the physician immediately at the beginning and end of the program.
- Objective clinical measures of the effectiveness of the CR/ICR program for the individual patient, including exercise performance and self-reported measures of exertion and behavior.
  Once a patient has reached the following, further CR may not be considered reasonable and necessary unless medical record documentation clearly indicates otherwise:
- Ischemic heart disease: Patient's status following MI, CABG, PTCA or stent, and patients with angina undergoing stress testing without demonstrating significant ischemia or dysrhythmia after completion of six minutes of a Bruce protocol, or equivalent, achieving a stable level of exercise tolerance (7 METS). (See the American Heart Association's functional classification: Class I, or normal function status, begins at 7 metabolic equivalent units (METS).)
- Following valve repair/replacement: Patients achieving a stable level of exercise tolerance (7 METS).
- Heart and heart-lung transplant patients: Issues such as deconditioning and cachexic deterioration may complicate the definition of reasonable exit criteria. Based on the study of long term cardiopulmonary exercise performed after heart transplant (Osada et al), a peak oxygen consumption (VO2) of greater than 90 percent of predicted will be used as the exit criterion for phase IIA. Patients whose peak VO2 is less than 90 percent of predicted may qualify for phase IIB.

In addition to the exercise/physiologic criteria listed above, the patient should also be ready for transition as manifested by progress toward the cognitive and functional goals identified and addressed during the program.

E. Non-Covered Diagnoses for Both CR and ICR

- Use of any ICD-9-CM diagnosis code not in the "ICD-9-CM Diagnosis Codes That Support Medical Necessity" section of this LCD will be cause for denial of claims.

- A patient with unstable angina or a patient status post-non-cardiac surgery will not qualify for CR services.
- Congestive heart failure in the absence of other covered conditions is not included as a covered condition of CR. (See CMS National Coverage Policy section of this LCD)

F. Other Services

- Evaluation and Management (E/M) services, Electrocardiograms (ECGs) and other diagnostic services may be covered on the day of CR if these services are separate and distinct from the CR program and are reasonable and necessary, but would not be covered if provided routinely as part of the CR program.
- Forms of counseling, such as dietary counseling, psychosocial intervention, lipid management and stress management, are components of the CR program and are not separately reimbursed.

Back to Top

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

013x Hospital Outpatient
085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Note: Palmetto GBA J11 Part A MAC has identified the Bill Types and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes.
0943 Other Therapeutic Services - Cardiac Rehabilitation

CPT/HCPCS Codes
93797 Cardiac rehab
93798 Cardiac rehab/monitor
G0422 Intens cardiac rehab w/exerc
G0423 Intens cardiac rehab no exer

ICD-9 Codes that Support Medical Necessity
The CPT/HCPCS codes included in this LCD will be subjected to "procedure to diagnosis" editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for CPT/HCPCS codes 93797, 93798, G0422 and G0423:

410.00 - 410.02 opens in new window	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL SUBSEQUENT EPISODE OF CARE
410.10 - 410.12 opens in new window	ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL SUBSEQUENT EPISODE OF CARE
410.20 - 410.22 opens in new window	ACUTE MYOCARDIAL INFARCTION OF INFEROLATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF INFEROLATERAL WALL SUBSEQUENT EPISODE OF CARE
410.30 - 410.32 opens in new window	ACUTE MYOCARDIAL INFARCTION OF INFEROPOSTERIOR WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF INFEROPOSTERIOR WALL SUBSEQUENT EPISODE OF CARE
410.40 - 410.42 opens in new window	ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL SUBSEQUENT EPISODE OF CARE
410.50 - 410.52 opens in new window	ACUTE MYOCARDIAL INFARCTION OF OTHER LATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF OTHER LATERAL WALL SUBSEQUENT EPISODE OF CARE
410.60 - 410.62 opens in new window	TRUE POSTERIOR WALL INFARCTION EPISODE OF CARE UNSPECIFIED - TRUE POSTERIOR WALL INFARCTION SUBSEQUENT EPISODE OF CARE
410.70 - 410.72 opens in new window	SUBENDOCARDIAL INFARCTION EPISODE OF CARE UNSPECIFIED - SUBENDOCARDIAL INFARCTION SUBSEQUENT EPISODE OF CARE
410.80 - 410.82 opens in new window	ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES SUBSEQUENT EPISODE OF CARE
410.90 - 410.92 opens in new window	ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE
412*	OLD MYOCARDIAL INFARCTION
413.0 - 413.9 opens in new window	ANGINA DECUBITUS - OTHER AND UNSPECIFIED ANGINA PECTORIS
414.01 - 414.07 opens in new window	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY ARTERY - CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART
414.8	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE
V15.1	PERSONAL HISTORY OF SURGERY TO HEART AND GREAT VESSELS PRESENTING HAZARDS TO HEALTH
V42.1	HEART REPLACED BY TRANSPLANT
V42.2	HEART VALVE REPLACED BY TRANSPLANT
V42.89*	OTHER SPECIFIED ORGAN OR TISSUE REPLACED BY TRANSPLANT
V43.3	HEART VALVE REPLACED BY OTHER MEANS
V45.81	POSTSURGICAL AORTOCORONARY BYPASS STATUS
V45.82	PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY STATUS

Note: ICD-9-CM code 412* (old myocardial infarction) refers to an MI that has occurred more than eight weeks prior to cardiac rehabilitation services.

Note: Use V42.89* for heart-lung transplant.

Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
All diagnoses not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this LCD.

A patient with unstable angina or a patient status post-non-cardiac surgery does not qualify for CR services.

Congestive heart failure in the absence of other covered conditions is not included as a covered condition of CR. (see CMS National Coverage Policy section of this LCD)
Back to Top

General Information

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Documentations Requirements
Documentation supporting medical necessity should be legible, maintained in the patient's medical record and made available to the A/B MAC upon request.

ICD-9-CM diagnosis codes supporting medical necessity must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.

Any diagnosis submitted must have documentation in the patient's record to support coverage and medical necessity.

All CR providers must have documentation of the qualifying event in the patient's medical record. This information may include copies of the referring physician's records or reports. A prescription for CR from the referring physician must be maintained in the patient's medical record by the provider of the CR service.

When billing HCPCS/CPT codes 93797, 93798, G0422 or G0423, the documentation must clearly indicate the patient is receiving continuous ECG monitoring.

A CR record must be maintained. The CR record must show that the five required components of a CR or ICR as applicable including all of the following:

> li> Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished. This does not mean a physician must write a prescription each day, but a physician must write a prescription for each day and each component of rehabilitation that is furnished. In addition there should be a record of the intervention. If ECG monitoring is provided, for example, a representative strip should be provided. There should be a description notation of the exercise provided.

- Cardiac risk factor modification is provided including education, counseling, and behavioral intervention, tailored to the patient's individual needs. The record should document the needs that are identified, the interventions planned to address them and the interventions undertaken.

- Psychosocial Assessment identifying what needs the patient has, the intervention planned to address them and evidence of that intervention. If an assessment is done and no needs are identified, that circumstance should be documented in the patient's record.

- Outcomes assessment showing the results of each of the interventions identified and addressed above.

- An individualized treatment plan detailing how components are utilized for each patient must be present. The individualized treatment plan must be established, reviewed and signed by a physician every 30 days. Particular attention should be given to explaining the progress toward cognitive and functional goals as well as the physiologic exercise goals.

- The presence of a physician or physicians providing the roles of medical director and direct supervision are a condition for coverage of CR and ICR. These roles may be supplied by one or more individual and it is not necessary for the medical director to provide the supervision. In the case of programs provided in hospitals, the role of supervision is presumed.

- The medical record should identify the medical director. For example the prescription for the program elements will be signed by this individual and for example be progress notes and the individualized treatment plan signed every 30 days.

- One method of identifying the supervising physician is to make note of it in the entry of each session by a statement identifying the physician, and signed by the individual making the entry into the record. Other methods of providing reliable evidence would be accepted.

Appendices N/A

Utilization Guidelines Refer to "Indications and Limitations of Coverage and/or Medical Necessity," Section C – "Frequency and Duration," above.

Notice: This LCD imposes utilization guideline limitations. Although Medicare allows up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

Notice: This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

For services to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary. Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD, are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
    - Furnished in a setting appropriate to the patient's medical needs and condition.
    - Ordered and furnished by qualified personnel.
    - One that meets, but does not exceed, the patient's medical needs.
    - At least as beneficial as an existing and available medically appropriate alternative.

Sources of Information and Basis for Decision
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King et al. Medical Director Responsibilities for Outpatient Cardiac Rehabilitation/Secondary Prevention Programs: A Scientific Statement From the American Heart Association/American Association for Cardiovascular and Pulmonary Rehabilitation. Circulation 2005; 112; 3354-3360.

Chan PS, Krumholz HM, Nichol G, et al. Delayed time to defibrillation after in-hospital cardiac arrest. NEJM, 2008, (1):9-17.

OIG Report: Review of Medicare Outpatient Cardiac Rehabilitation Provided by Hospitals (A-05-03-00102), 2005.

Trailblazers "Cardiac Rehabilitation and Intensive Cardiac Rehabilitation" LCD

Advisory Committee Meeting Notes This LCD does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this LCD was developed in cooperation with advisory groups, which include representatives from various specialists consulted.

Contractor Advisory Commitee meeting dates:
North Carolina-10/2/2012
South Carolina-10/2/2012
Virginia-10/2/20/12
West Virginia-10/2/2012

Start Date of Comment Period 10/02/2012

End Date of Comment Period 11/16/2012

Start Date of Notice Period 12/13/2013

Revision History Number Revision #2, 01/28/2013

Revision History Explanation Revision #2, 01/28/2013
This LCD is being moved from a draft to final. The notice period starts 12/13/2012-01/28/2013. Also CPT code 93797 and 93798 have description changes that are effective 01/01/2013. The LCD will become final on 01/28/2013.

Revision #1
Added CPT code 93797 for physician supervision during cardiac rehabilitation exercise without continuous EKG monitoring, this LCD is out for comment 10/02/2012-11/16/2012.

Reason for Change Other

Related Documents
This LCD has no Related Documents.

LCD Attachments
Cardiac Rehabilitation opens in new window (a comment and response document) (PDF - 18 KB)

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Back to Top

All Versions

Updated on 12/08/2012 with effective dates 01/28/2013 - N/A
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Updated on 09/11/2012 with effective dates N/A
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Back to Top