Local Coverage Determination (LCD): Cardiac Rehabilitation (L34412)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
Palmetto GBA	A and B MAC	10111 - MAC A	J - J	Alabama
Palmetto GBA	A and B MAC	10112 - MAC B	J - J	Alabama
Palmetto GBA	A and B MAC	10211 - MAC A	J - J	Georgia
Palmetto GBA	A and B MAC	10212 - MAC B	J - J	Georgia
Palmetto GBA	A and B MAC	10311 - MAC A	J - J	Tennessee
Palmetto GBA	A and B MAC	10312 - MAC B	J - J	Tennessee
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
Palmetto GBA	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

Back to Top

LCD Information

Document Information

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Original ICD-9 LCD ID
L32872

LCD Title
Cardiac Rehabilitation

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

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For services performed on or after 10/01/2015

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N/A

CMS National Coverage Policy
Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be medically 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)(7) states Medicare will not cover any services or procedures associated with routine physical checkups.

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

Title XVIII of the Social Security Act, §1861(eee)(4)(A) describes intensive cardiac rehabilitation programs.

42 CFR §410.26 Services and supplies incident to a physician's professional services: Conditions.

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

42 CFR §410.32 (3)(i)(ii) and (iii) Levels of supervision

42 CFR §410.49 (c) 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 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §20.10.1

CMS Internet-Only Manual, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §§20.31, 20.31.1, 20.31.2, and 20.31.3

CMS Internet-Only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 32, §§140-140.3

CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 15, §15.4.2.8

CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 32, §140.2.2

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Coverage Indications, Limitations and/or Medical Necessity

Cardiac Rehabilitation (CR) means a comprehensive, *physician-supervised program that furnishes 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.* 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.

Intensive cardiac rehabilitation (ICR) refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner.

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 in the case of acute cardiac events such as myocardial infarction (MI) or cardiac surgery; and Phases III and IV are the long-term maintenance phases and are not payable under Medicare. This LCD encompasses Phase II CR. Phase II programs are typically initiated one to three weeks after hospital discharge in the case of acute cardiac events such as MI or cardiac surgery 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 yet been met. The maximum total number of allowable sessions under Phase IIA and IIB combined 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. Phase IV CR programs do require medical supervision and therefore are not covered under Medicare.

Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR)

An 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 established, reviewed and signed by a physician every 30 days.
• The goals set for the individual under the plan.

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

For Cardiac Rehabilitation (CR) Only: *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). Stable patients are defined as patients who have not had recent (=6 weeks) or planned (=6 months) major cardiovascular hospitalizations or procedures.*

Facilities

For CR/ICR 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) expertise 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 (NPP's) may not serve in the medical director role or supervisory role for cardiac rehabilitation programs.

Diagnoses

For myocardial infraction, the date of entry into the program must be within 12 months of the date of infarction.

Frequency and Duration

NOTE*: A beneficiary may switch from an ICR program to a CR program. The beneficiary is limited to a one-time switch, multiple switches are not allowable. Once the beneficiary switches from ICR to CR he or she will be limited to the number of sessions remaining in the program. For example, a beneficiary who switches from ICR to CR after 12 sessions will have 24 sessions of CR remaining, (i.e., 12 sessions of ICR + 24 sessions of CR = total of 36 sessions). 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). Beneficiaries may not switch from CR to ICR. 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.*

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. Beneficiaries who switch from ICR to CR may also be eligible for up to 72 combined sessions with contractor discretion for CR sessions after 36 (to include completed ICR sessions prior to switch). In these cases and consistent with the information above, the KX modifier must be included on the claim should the beneficiary participate in more than 36 CR sessions following the switch.

Exit Criteria

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.

Cardiac Rehabilitation

Non-Covered Diagnoses

• A patient with unstable angina or a patient status post-non-cardiac surgery will not qualify for CR services unless the latter surgical intervention has been documented to exacerbate the underlying cardiac condition.
• Acute congestive heart failure is not included as a covered condition of CR.

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.

Exit Criteria

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; Chronic Heart Failure: 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.

Intensive Cardiac Rehabilitation (ICR)

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.

Nationally Covered and Non-Covered Indications

Effective for claims with dates of service on and after August 12, 2010, the Pritikin Program meets the intensive cardiac rehabilitation (ICR) program requirements set forth by Congress in §1861(eee)(4)(A) of the Social Security Act and in regulations at 42 CFR §410.49(c) and, as such, has been included on the list of approved ICR programs available on the Centers for Medicare & Medicaid Services (CMS) website under Medicare-Medicare Approved Facilities/Trials/Registries- ICR Programs.

Effective for claims with dates of service on and after August 12, 2010, the Ornish Program for Reversing Heart Disease meets the Intensive Cardiac Rehabilitation (ICR) program requirements set forth by Congress in §1861(eee)(4)(A) of the Social Security Act, and in regulations at 42 CFR §410.49(c) and, as such, has been included on the list of approved ICR programs available on the CMS website under Medicare-Medicare Approved Facilities/Trials/Registries- ICR Programs.

Effective August 12, 2010, if a specific ICR program is not included on the list as a Medicare-approved ICR program, it is non-covered.

Effective for claims with dates of service on and after May 6, 2014, the Benson-Henry Institute Cardiac Wellness Program meets the Intensive Cardiac Rehabilitation (ICR) program requirements set forth by Congress in §1861(eee)(4)(A) of the Social Security Act, and in regulations at 42 CFR §410.49(c) and, as such, has been included on the list of approved ICR programs available on the CMS website under Medicare-Medicare Approved Facilities/Trials/Registries- ICR Programs.

Effective May 6, 2014, if a specific ICR program is not included on the above-noted list as a Medicare approved ICR program, it is non-covered.

Limitations

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

• ICR programs must be approved by CMS through the NCD process and must meet certain criteria for approval. A list of approved ICR programs will be identified through the NCD listings, the CMS Web site and the Federal Register. The contractor shall use one of these options to verify that the ICR program has met CMS approval.
• For ICR programs that are approved by CMS, sites wishing to furnish ICR services via an approved ICR program must enroll with their local Medicare Administrative Contractor (MAC) as an ICR program supplier using the CMS-855B form.
• MACs will ensure that claims submitted from individual ICR sites are submitted by enrolled ICR program sites.

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 levels 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.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

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.

N/A

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.

N/A

CPT/HCPCS Codes

Group 1 Paragraph: N/A

Group 1 Codes:

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

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

The CPT codes included in this LCD will be subject to "procedure to diagnosis" editing. The following list includes only those diagnoses for which the identified CPT 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 codes **93797, 93798, G0422, and G0423:**

Group 1 Codes:

ICD-10 Codes	Description
I20.1	Angina pectoris with documented spasm
I20.8	Other forms of angina pectoris
I20.9	Angina pectoris, unspecified
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I21.9	Acute myocardial infarction, unspecified
I21.A1	Myocardial infarction type 2
I21.A9	Other myocardial infarction type
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris

ICD-10 Codes	Description
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
I25.2*	Old myocardial infarction
I25.5	Ischemic cardiomyopathy
I25.6	Silent myocardial ischemia
I25.701	Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm
I25.708	Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris
I25.709	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris
I25.711	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.718	Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris
I25.721	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.728	Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris
I25.729	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris
I25.731	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.738	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris
I25.739	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris
I25.751	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm
I25.758	Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris
I25.759	Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris
I25.761	Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm
I25.768	Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris
I25.769	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris
I25.790	Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris
I25.791	Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.798	Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris
I25.799	Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris
I25.810	Atherosclerosis of coronary artery bypass graft(s) without angina pectoris
I25.811	Atherosclerosis of native coronary artery of transplanted heart without angina pectoris
I25.812	Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris
I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified
I50.22	Chronic systolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.812	Chronic right heart failure
I50.814	Right heart failure due to left heart failure
I50.82	Biventricular heart failure
I50.84	End stage heart failure
I50.89	Other heart failure
Z48.21	Encounter for aftercare following heart transplant
Z48.280	Encounter for aftercare following heart-lung transplant
Z94.1	Heart transplant status
Z94.3	Heart and lungs transplant status
Z95.1	Presence of aortocoronary bypass graft
Z95.2	Presence of prosthetic heart valve

ICD-10 Codes	Description
Z95.3	Presence of xenogenic heart valve
Z95.4	Presence of other heart-valve replacement
Z95.5	Presence of coronary angioplasty implant and graft
Z98.61	Coronary angioplasty status
Z98.890	Other specified postprocedural states

Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation:
Note: ICD-10 code I25.2 (old myocardial infarction) refers to a MI that has occurred more than eight weeks prior to cardiac rehabilitation services.

ICD-10 Codes that DO NOT Support Medical Necessity N/A
ICD-10 Additional Information Back to Top

General Information

Associated Information
Documentation 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-10-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 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:

- *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 the identified psychosocial issues 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(s) 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 the program and if a supervising physician is also involved, that physician should be identified as well.

Utilization Guidelines

Refer to ***Coverage Indications, Limitations and/or Medical Necessity- 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 July 9, 2007, 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
N/A

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Back to Top

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
03/08/2018	R17		

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		Revisions were made to Cardiac Rehabilitation Local Coverage Determination (LCD) L34412. Under ***CMS National Coverage Policy*** Change Request 10199, Transmittal 3848 was deleted as this was manualized and is now found in the following manual citation: CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 32, §140.2.2. *At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Provider Education/Guidance
02/26/2018	R16	The Jurisdiction "J" Part B Contracts for Alabama (10112), Georgia (10212) and Tennessee (10312) are now being serviced by Palmetto GBA. The notice period for this LCD begins on 12/14/17 and ends on 02/25/18. Effective 02/26/18, these three contract numbers are being added to this LCD. No coverage, coding or other substantive changes (beyond the addition of the 3 Part B contract numbers) have been completed in this revision.	• Change in Affiliated Contract Numbers
01/29/2018	R15	The Jurisdiction "J" Part A Contracts for Alabama (10111), Georgia (10211) and Tennessee (10311) are now being serviced by Palmetto GBA. The notice period for this LCD begins on 12/14/17 and ends on 01/28/18. Effective 01/29/18, these three contract numbers are being added to this LCD. No coverage, coding or other substantive changes (beyond the addition of the 3 Part A contract numbers) have been completed in this revision.	• Change in Affiliated Contract Numbers
10/01/2017	R14	Under ***CMS National Coverage Policy*** added the following: CMS Manual System, Pub 100-04, Medicare Claims Processing, Transmittal 3848, dated August 25, 2017, Change Request 10199. Under ***Coverage Indications, Limitations and/or Medical Necessity-Frequency and Duration*** deleted the verbiage in the entire section and replaced it with verbiage as found in Change Request 10199 effective on 09/26/2017. Under ***ICD-10 Codes that Support Medical Necessity Group1: Codes*** added ICD-10 codes I21.9, I21.A1, I21.A9, I50.82, I50.84, I50.89, I50.812 and I50.814. This revision is due to the 2017 Annual ICD-10 Code Updates and becomes effective on 10/01/17.	• Provider Education/Guidance • Other (Change Request 10199, Transmittal 3848)
10/01/2017	R13	*At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Revisions Due To ICD-10-CM Code Changes
01/19/2017	R12	Under ***CMS National Coverage Policy*** revised Title XVIII of the Social Security Act, §1862(a)(7) to read "states Medicare will not cover any services or procedures associated with routine physical checkups" and revised 42 CFR §410.26 to read "Services and supplies incident to a physician's professional services: Conditions". Under ***Sources of Information and Basis for Decision*** deleted a duplicate source.	• Provider Education/Guidance • Typographical Error • Other (Annual Validation)
01/09/2017	R11		• Provider Education/Guidance

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		Under ***ICD-10 Codes That Support Medical Necessity Group 1: Codes*** added Z98.890 to describe a patient with a history of valve repair (not replacement). This ICD-10 code is covered retroactive to 10/01/2016.	• Reconsideration Request
10/01/2016	R10	Under ***ICD-10 Codes That Support Medical Necessity: Group 1*** deleted Z98.89. This revision is due to the Annual ICD-10 Code Update and becomes effective October 1, 2016.	• Provider Education/Guidance • Revisions Due To ICD-10-CM Code Changes
01/22/2016	R9	The LCD was reformatted to categorize the information in a more concise fashion. Throughout the LCD language quoted from the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized. Under ***Coverage Indications, Limitations and/or Medical Necessity – Phases of Cardiac Rehabilitation*** under Phase IIB deleted "…see Section D" in the last sentence. Under **Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR)** added "Is" to the first bullet. Under ***Facilities*** added ICR in the first sentence. Under ***Frequency and Duration*** in the second bullet revised "are" to now read "is". Under ***Cardiac Rehabilitation-Non-Covered Diagnoses*** in the second bullet deleted the sentence "See CMS National Coverage Policy Section of the LCD". Under ***Intensive Cardiac Rehabilitation (ICR)*** deleted the sentence "See CMS National Coverage Policy Section of the LCD". Under ***ICD-10 Codes That Support Medical Necessity*** deleted the paragraph related to "Claims for services provided on and after 02/18/2014…" and in the second paragraph added G0422 and G0423 as these were inadvertently omitted. Under ***Associated Information-Utilization Guidelines*** in the first sentence deleted the reference to Section C. Under bullet 2 corrected the date in the first sentence to be consistent with the NCD. Under ***Sources of Information and Basis for Decision*** corrected several titles of cited journals. The spelling of myocardial was corrected in the third citation. Supplement number (6) was added to the ninth citation. The author name BK Nallamothu was added to the tenth citation. The access date was revised for the last citation listed.	• Provider Education/Guidance • Typographical Error • Other
10/01/2015	R8	Per CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 13, §13.1.3 LCDs consist of only "reasonable and necessary" information. All bill type and revenue codes have been removed.	• Other (Bill type and/or revenue code removal)
10/01/2015	R7	Under ***Coverage Indications, Limitations and/or Medical Necessity-Limitations*** in the third sentence of the first bullet changed the verbiage "MACs" to now read "The contractor…" Under ***Coverage Indications, Limitations and/or Medical Necessity-E. Non-Covered Diagnoses for Both CR and ICR*** deleted "Both" and "…and ICR" from the title. Under ***Coverage Indications, Limitations and/or Medical Necessity-E. Non-Covered Diagnoses for Both CR and ICR*** deleted "ICD-9" from the first bullet to now read "ICD-10". Under ***ICD-10 Codes That Support Medical Necessity*** deleted "HCPCS" from the first sentence of the first paragraph. Under ***Associated Information-Documentation Requirements*** in the second sentence revised "ICD-9" to now read "ICD-10".	• Provider Education/Guidance • Reconsideration Request • Other
10/01/2015	R6	Under ***Coverage Indications, Limitations and/or Medical Necessity*** in section **E. Non-Covered Diagnoses for Both CR and ICR**, added statement to "A patient with unstable angina or a patient status post-non-cardiac surgery will not qualify for CR services" to now read "A patient with unstable angina or a patient status post non-cardiac surgery will not qualify for CR services unless the latter surgical intervention has been documented to exacerbate the underlying cardiac condition." This revision is made based on a reconsideration request.	• Reconsideration Request

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10/01/2015	R5	Under ***ICD-10 Codes That Support Medical Necessity*** deleted "HCPCS" from the second sentence of the first paragraph and revised the sentence to now read, "The following list includes only those diagnoses for which the identified CPT procedures are covered." The word "HCPCS" was deleted and the following HCPCS G0422 and G0423 were deleted from the following statement, "Medicare is establishing the following limited coverage for CPT/HCPCS codes 93797, 93798, G0422 and G0423."	• Other (Due to Change Request 8197 related to implementation of the local shared system NCD edits (20.31, 20.31.1, and 20.31.2))
10/01/2015	R4	This LCD was made identical to the new A/B MAC ICD-9 LCD that was published for notice.	• Provider Education/Guidance • Creation of Uniform LCDs Within a MAC Jurisdiction
10/01/2015	R3	Under ***CMS National Coverage Policy*** added CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 15, §15.4.2.8. and deleted Change Request 8758, Transmittals 191, 2989, and 530 as this information was manualized. Under ***Coverage Indications, Limitations and/or Medical Necessity*** the following verbiage was deleted from the bullets listed under "CR and ICR are covered for the following patients: Patients with a *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 six weeks (effective February 18, 2014)"*and *"Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures."* A new sentence was added to now read, "**For Cardiac Rehabilitation Only:** *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). Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures."* Under ***Coverage Indications, Limitations and/or Medical Necessity-Limitations*** the following verbiage was added to bullet #1: *"...through the NCD process and must meet certain criteria for approval. A list of approved ICR programs will be identified through the NCD listings, the CMS Web site and the Federal Register. MACs shall use one of these options to verify that the ICR program has met CMS approval."* The following verbiage was added to bullet #2: *"...with their local Medicare Administrative Contractor (MAC) as an ICR program supplier..."* The revision to LCD L32872 becomes effective 09/18/2014. The revision to the future LCD L34412 becomes effective 10/01/2015.	• Provider Education/Guidance • Other (Revisions due to Change Request 8758, Transmittals 193, 3058, and 539)
10/01/2015	R2	In **ICD-9 Codes that Support Medical Necessity** added the clarification "Claims for services provided on or after 2/18/2014 for chronic congestive heart failure will be processed when submitted on or after 8/18/2014".	• Reconsideration Request
10/01/2015	R1		• Typographical Error

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		Under ***CMS National Coverage Policy*** the following manual citations and Change Requests were added: CMS Internet-Only Manual, Pub 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §20.10.1; CMS Internet-Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Transmittal 191, dated July 18, 2014, Change Request 8758; CMS Internet-Only Manual, Pub 100-04, Medicare Claims Processing Manual, Transmittal 2989, dated July 18, 2014, Change Request 8758; and CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Transmittal 530, dated July 18, 2014, Change Request 8758. Under ***Coverage Indications, Limitations and/or Medical Necessity*** and ***Associated Information*** language quoted from the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals was italicized throughout this section of the LCD. Under ***Coverage Indications, Limitations and/or Medical Necessity*** in the second paragraph added the following verbiage X2 "… in the case of acute cardiac events such as myocardial infarction (MI) or cardiac surgery" and deleted, "… or outpatient post-hospital…." Under ***Phases of Cardiac Rehabilitation-Phase II*** added "yet" and "(see section D)" to the last bullet. Under the paragraph regarding the individualized treatment plan added "established" to the third bullet. The seventh bullet was added to the list of conditions covered for patients requiring CR (cardiac rehabilitation) and ICR (intensive cardiac rehabilitation). Under ***Limitations*** corrected the cited ICR enrollment form to now read CMS-855B and deleted the following verbiage, "…for the fiscal intermediary or Part A Medicare Administrative Contractor (MAC)." Outcome measures were added for ICR programs. Under ***Diagnoses for Both CR and ICR*** under the first bullet deleted the ICD-9/ICD-10 diagnosis codes. Billing information located under ***C. Frequency and Duration for CR and ICR*** was removed and added as a supplemental article to the LCDs. Under ***Exit Criteria for Both CR and ICR*** added a new heading labeled ***Exit Criteria***. In the first bullet under Exit Criteria, added the exit criteria for chronic heart failure. Under ***E. Non-Covered Diagnoses for Both CR and ICR*** added "Acute" to the third bullet and deleted "…in the absence of other covered conditions…." Under ***Revenue Codes*** deleted the first paragraph and added revenue codes 096X, 0973 or 0982 for type of bill 85X. Under ***ICD-9/ICD-10 Codes That Support Medical Necessity*** diagnosis codes for chronic heart failure were added to each respective LCD. Under ***Associated Information-Documentation Requirements*** under the third bullet added the verbiage, "…the identified psychosocial issues…." The second sentence was deleted from bullet #7 and the following verbiage was added to the first sentence: "…for the program and if a supervising physician is also involved, that physician should be identified as well." The eighth bullet was deleted. Under ***Associated Information-Utilization Guidelines*** corrected the cited LCD section in the first paragraph. Under ***Sources of Information and Basis for Decision*** author names and supplement numbers were added to several references and the citations were placed in the AMA format. The following sources were added: International Classification of Functioning, Disability and Health (ICF). Geneva: World Health Organization; 2001; and New York Heart Association (NYHA) Functional Classification-Classes of Heart Failure. Accessed on 08/06/2014. Under ***ICD-10 Codes That Support Medical Necessity*** deleted the "Note regarding use of Z94.89 for heart-lung transplant as there is a specific ICD-10 code for heart and lung transplant status. This LCD revision becomes effective October 1, 2014.	

Back to Top

Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) A53775 - Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Supplemental Instruction Article

Related National Coverage Documents N/A

Public Version(s) Updated on 03/02/2018 with effective dates 03/08/2018 - N/A Updated on 12/07/2017 with effective dates 02/26/2018 - 03/07/2018 Updated on 12/07/2017 with effective dates 01/29/2018 - 02/25/2018 Updated on 09/15/2017 with effective dates 10/01/2017 - 01/28/2018 Updated on 09/01/2017 with effective dates 10/01/2017 - N/A Updated on 01/13/2017 with effective dates 01/19/2017 - 09/30/2017 Some older versions have been archived. Please visit the MCD Archive Site to retrieve them. Back to Top

Keywords

- Cardiac Rehabilitation
- Intensive Cardiac Rehabilitation

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