

MVP/Preferred Care BENEFIT INTERPRETATION
Cardiac Rehabilitation Phase II

Type of Policy

Medical

Codes

CPT Codes: 93798, 93797

Evidence Basis for Policy

Standard of Care. The procedure, device, or drug is accepted medical practice as evidenced by an abundance of scientific literature and well-designed clinical trials.

Description

Cardiac rehabilitation is a comprehensive program designed to optimize the physical, psychological and social abilities of a cardiac disease patient. This is accomplished through diet, exercise, knowledge of risk factors, education and reinforcement of a healthy lifestyle.

Cardiac rehabilitation consists of three phases:

Phase I – An inpatient cardiac rehabilitation program that delivers preventive and rehabilitative services is covered while the member is hospitalized for one of the diagnoses listed below. Inpatient cardiac rehabilitation is subject to concurrent review.

Phase II – An outpatient cardiac rehabilitation service that is physician supervised and includes electrocardiographic monitoring during exercise is covered. The program is intended to improve cardiac function and exercise tolerance. The program must be based at a participating facility or participating freestanding outpatient program.

See grid for risk stratification for cardiac rehabilitation as indicated by the American Association of Cardiovascular and Pulmonary Rehabilitation. AACVPR (2007).

Phase III – A long term outpatient program which physical fitness and risk factor reduction are accomplished in a minimally supervised or unsupervised setting. A Phase III cardiac rehabilitation program is not considered to be medically necessary and therefore will not be covered.

Indications/Criteria

Documentation Requirements:

- documentation in the medical record substantiating medical necessity (indications) and appropriateness (contraindications) must be submitted upon request;
- request for “monitored” Phase II Cardiac Rehabilitation services requires submission of high-risk indicators; and

All Phase II Cardiac Rehabilitation (monitored or unmonitored) services must be ordered by the member’s PCP or treating in-plan cardiologist; and all Phase II Cardiac Rehabilitation (monitored or unmonitored) referrals are limited to approved and participating programs.

The following diagnoses are covered:

- post-myocardial infarction within the preceding 12 months (ICD 9 Code 412);
- post-coronary artery bypass surgery within the preceding 6 months (ICD 9 Code V45.81);
- post-percutaneous transluminal coronary angioplasty (PTCA) (ICD 9 code V42.82);
- post-cardiac transplant or post heart-lung transplant (ICD 9 code V42.1);
- valvular disease (Class IV for one year), pre- and post-operatively (pre) (ICD 9 code 424.0-424.91), (post) (V43.3); or
- coronary artery disease with class III or class IV angina (ICD 9 codes 413.0, 413.1, 413.9).

Coverage for Phase II will be based on the risk categories set forth in the Guidelines for Cardiac Rehabilitation Programs from the American Association of Cardiovascular and Pulmonary Rehabilitation.

Risk level	Characteristics
Low (limited to 12 sessions or 4 weeks)	No significant left ventricular dysfunction (i.e., ejection fraction greater than or equal to 50%).
	No resting or exercise-induced myocardial ischemia manifested as angina and/or ST-segment displacement.
	No resting or exercise-induced complex arrhythmias.
	Uncomplicated myocardial infarction, coronary artery bypass surgery, angioplasty, or atherectomy.
	Functional capacity greater than or equal to 6 METs on graded exercise test 3 or more weeks after clinical event.
Intermediate (limited to 24 sessions or 8 weeks, may require intermittent ECG monitoring)	Mild to moderately depressed left ventricular function (ejection fraction 31-49%).
	Functional capacity < 5-6 METs on graded exercise test 3 or more weeks after clinical event.
	Failure to comply with exercise intensity prescription.
	Exercise induced myocardial ischemia (1-2 mm ST-segment depression) or reversible ischemic defects (echocardiographic or nuclear radiography).
High (limited to 36 sessions or 12 weeks, requires continuous ECG telemetry monitoring during exercise)	Severely depressed left ventricular function (ejection fraction less than or equal to 30%).
	Complex ventricular arrhythmias at rest or appearing or increasing with exercise.
	Decrease in systolic blood pressure of > 15 mmHg during exercise or failure to rise with increasing exercise workloads.
	Survivor of sudden cardiac death.
	Myocardial infarction complicated by congestive heart failure, cardiogenic shock, and/or complex ventricular arrhythmias.
	Severe coronary artery disease and marked exercise-induced myocardial ischemia (> 2 mm ST-segment depression).
<p><i>Note: MET = metabolic equivalent units. From Guidelines for Rehabilitation Programs (p. 14) by the American Association of Cardiovascular and Pulmonary Rehabilitation, Champaign, IL: Human Kinetics Books. Copyright 1995 by American Association of Cardiovascular and Pulmonary Rehabilitation. Reprinted by permission.</i></p>	

Exclusions/Limitations

Phase II Cardiac Rehabilitation services (monitored or unmonitored) is limited to a maximum of twelve (12) weeks or a total of thirty-six (36) sessions. Coverage for continued participation in cardiac exercise programs beyond twelve (12) weeks would be considered on a case-by-case basis.

In general, members with the following clinical conditions are considered contraindications for Phase II Cardiac Rehabilitation Services (*regardless of monitoring status*):

- unstable angina pectoris;
- resting systolic hypertension > 200mmHg;
- resting diastolic hypertension > 100mmHg;
- severe aortic stenosis;
- active pericarditis and myocarditis;
- symptomatic hypotension;
- uncontrolled atrial or ventricular arrhythmias;
- uncontrolled tachycardia (>100/min.);
- untreated third-degree heart block;
- recent pulmonary embolism;
- acute thrombophlebitis; or
- resting ST-segment displacement (>3mm).

Acknowledging that the primary outcome of Phase II rehabilitation (based on reports in the scientific literature) is improvement in exercise tolerance. Due to the inability of chemical stress testing (e.g., Persantine/Adenosine Test) to determine a METS level, such testing will not be permitted as a substitute for an exercise stress test in determining Phase II eligibility.

In the presence of severe orthopedic or other impediments to exercise, admission to a Cardiac Phase II program is contingent on Medical Director's review.

Phase I Cardiac Rehabilitation services are considered a part of inpatient services and are not reimbursed as a separate benefit.

Phase III Cardiac Rehabilitation services are not considered to be medically necessary therefore, will not be covered.

Variation for Medicare Procducts

Members are eligible for "monitored" Phase II Cardiac Rehabilitation services when they meet entrance criteria for Phase II Cardiac Rehabilitation.

Duration/Frequency: Cardiac rehabilitation exercise program services are covered up to 36 sessions. Members usually receive 2 to 3 sessions per week for 12 to 18 weeks. Coverage for continued participation in cardiac exercise programs beyond 18 weeks would be considered on a case-by-case basis.

Cardiac rehabilitation services is not to exceed a total of 72 sessions for 36 weeks.

References

1. HAYES Medical Technology Directory™. Cardiac Rehabilitation Programs. Lansdale, PA: HAYES, Inc.; ©Winifred S. Hayes, Inc. March 26, 2003. Available:www.hayesinc.com/.
2. HAYES Update™. Cardiac Rehabilitation Programs. Lansdale, PA: HAYES, Inc.; ©Winifred S. Hayes, Inc. March, 2005. Available:www.hayesinc.com/.
3. Minimal Guidelines for Risk Stratification from the American Association of Cardiovascular and Pulmonary Rehabilitation (1995), accessed within the public domain information from the National Library of Medicine (NLM), 9/05.
4. Centers for Medicare and Medicaid Services; Decision Memo for Cardiac Rehabilitation Programs (CAG-00089R). March, 2006. Available On-Line: www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=164.

Review and Approval

Medical:

Review:

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Approval:

Quality Improvement Committee: 6/9/08

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Note: For Preferred Care authorization requirements refer to Appendix A and Appendix B in the Referral/Prior Authorization/Notification Administrative Policy. You may also refer to the "Prior Authorization of Certain Prescription Drugs" for information on drugs that require prior authorization. Both policies are available on the *easyLink* for Providers at www.preferredcare.org.