

**TO: ALL PROVIDERS**

**FROM: CAREFIRST OF MARYLAND INC., MEDICARE PART A**

**DATE: SEPTEMBER 17, 2004**

**SUBJECT: GUIDELINES FOR CARDIAC REHABILITATION COVERAGE IN THE OUTPATIENT HOSPITAL SETTING**

Recent medical record review performed by CareFirst of MD, Inc., Medicare Part A Fiscal Intermediary has shown that there continues to be confusion about Medicare coverage criteria for cardiac rehabilitation services.

### **Definition**

Cardiac rehabilitation is a comprehensive program of medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling designed to restore certain patients with coronary heart disease to active and productive lives. Cardiac rehabilitation, as described in the medical literature, is divided into three phases:

- Phase I - the immediate in-hospital post cardiac event phase
- Phase II - the outpatient post hospitalization recuperation phase
- Phase III - the long-term maintenance phase. **Phase III level programs are considered to be general maintenance programs by Medicare and are not covered**

This bulletin encompasses outpatient, post-hospital cardiac rehabilitation, or Phase II cardiac rehabilitation. The program consists of a series of supervised exercise sessions with continuous ECG monitoring. Clinically optimal results are expected if these sessions are conducted three times per week over a 12-week period.

### **Diagnoses**

Cardiac rehabilitation is only covered for three groups of patients:

- Patients who begin the program within 12 months of an acute myocardial infarction (MI). The date of the MI must be documented in the medical record.
- Patients who are status post coronary artery bypass (CABG) surgery (no time restriction). The date of the CABG should be documented in the medical record.

- Patients with stable angina pectoris

The diagnosis of stable angina should be substantiated with a physician history, hospital discharge summary, or physician statement to confirm the diagnosis of stable angina (413.9). Elements of the history that are supportive of the diagnosis include a description of the patient's chest discomfort, the circumstances under which it occurs, and the methods used to relieve it. When the patient establishes a predictable pattern of chest pain, such that the angina can be reliably anticipated with certain activities, and that pattern has been stable for several months, the patient can be said to have "chronic stable angina". Of course, if the chest pain only occurs with activities that require marked exertion, there is no need for the patient to enlist in a cardiac rehabilitation program. Therefore, the documentation that would be useful would include that the patient has a pattern of symptoms that are likely to be improved by cardiac rehabilitation, and that the patient's status has been stable for over one month. Again, if the patient only develops chest pain with significant exertion, a cardiac rehabilitation program is not needed.

Regardless of the therapeutic or diagnostic interventions that may have occurred, a patient with the diagnosis of stable angina may be considered for cardiac rehabilitation. If a patient's stable angina resolves after undergoing coronary angioplasty and/or coronary artery stenting, then the patient is not eligible for cardiac rehabilitation. Likewise, if a patient's stable angina remains or returns after undergoing coronary artery angioplasty or stenting, then the patient may be considered for cardiac rehabilitation.

Analysis of data over the past several months indicates that ICD-9 diagnosis code 413.9, stable angina, has been used by some physicians to report not only patients who currently experience angina, but also for patients who have had an interventional procedure (angioplasty and/or stent) which has resolved their symptoms. If symptoms are no longer present, then cardiac rehabilitation is not available as a preventive measure.

These are the **only** diagnoses that are covered by Medicare at this time.

A patient with unstable angina does not qualify for cardiac rehabilitation services. In addition, congestive heart failure, post-heart or heart/lung transplant, status post coronary angioplasty, and post non-CABG cardiac surgery are not included as covered conditions for cardiac rehabilitation in CMS Pub 100-3, CH 1, §20.10, and cardiac rehabilitation for these conditions is excluded from coverage.

### **'Incident to' and Direct Supervision Requirements for Cardiac Rehabilitation**

The "incident to" policy has several provisions, one of which is the "direct supervision" requirement. In order to be covered under the 'incident-to' benefit in an outpatient hospital department, services must be furnished as an integral, although incidental part of a physician's professional service in the course of diagnosis or treatment of an illness or injury. In order for a hospital or clinic staff to provide "incident to" services, *there must be a physician associated with the facility performing a service to which the staff's services are "incident."* In addition,

“incident to” requires that the designated physician be directly involved in the care of the patient who is receiving the “incident to” services and that this physician, or another, directly supervises the service. The benefit does not require that a physician perform a personal professional service on each occasion of service by a non-physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, where necessary, to change the treatment program. The patient’s medical record should reflect that the patient has seen a physician and that this physician has documented that the patient’s treatment regimen and progress are meeting the patient’s goals and plan of treatment for the patient. This documentation should be contained in the patient’s medical record. Also, any alterations to the patient’s program by the physician should be documented in the medical record.

“Direct supervision” requires that a physician, either the “incident to” physician, or another physician who is standing in for that physician, be present in the exercise program area while the exercise portion of Cardiac Rehabilitation is being performed. There can be some discretion as to what constitutes the “exercise program area,” but it is presumed that it does not include the whole hospital. Generally, the Emergency Department is not considered part of the exercise program area. Because the physician must be available at all times, he or she cannot be simultaneously performing invasive procedures or employed in a position where invasive procedures are likely. First hand knowledge of ongoing activity is required

Examples may be helpful:

Scenario One: A community cardiologist performs an evaluation and sends her patient to a hospital Cardiac Rehabilitation Program. The program, which does not have an onsite medical director, uses the cardiologist’s evaluation and orders to initiate the Cardiac Rehabilitation services. The doctor in the emergency room is listed on a bulletin board in the exercise program area as the person to call in the case of an emergency.

Comments: In this instance, the Cardiac Rehabilitation Program cannot bill Medicare for the services provided. The “incident to” provision has not been met, in that, although the program personnel are employed by the hospital, the physician is not, and therefore the services provided cannot be incident to her. In addition, the doctor designated for responding to emergencies is not in the exercise program area.

Scenario Two: The program above hires a medical director.

This doctor is either on site, or is signed out to another doctor who remains in the exercise program area whenever the medical director is absent. The exercise program area is defined as the immediate exercise room, and the adjacent cardiology suite which is across the hall. In this scenario, a community cardiologist sees a patient, does a full workup, and writes out a prescription for cardiac rehabilitation. The patient comes to the facility and is examined and evaluated by the medical director who concurs with the diagnosis and prescribed therapy. He writes a note to that effect, and signs a personalized treatment plan developed for the patient.

Comments: In this instance, the patient has arrived with all the information needed to begin the Cardiac Rehabilitation Program. However, the service is being provided incident to the medical

director of the facility, and therefore he establishes direct personal contact with the patient. Additionally, because this program has a protocol which assures the presence of a physician in the exercise program area, both “incident to” and “direct supervision” requirements have been met.

Note: It is perhaps helpful to understand that the “incident to” and “direct supervision” requirements are not entirely medical safety issues. They are also legal requirements. The Social Security Act requires that Medicare payable services belong to a benefit category. Cardiac Rehabilitation Programs only fall under a benefit category when the services are provided under direct supervision of a physician.

### **Stress Test**

A prospective candidate for a cardiac rehabilitation program must be evaluated for his suitability to participate. A valuable diagnostic test for this purpose is the stress test. A Cardiac Rehabilitation program may include a stress test, or it may accept one performed by the patient’s attending physician.

All patients must have a pre-entry stress test that is positive for exercise-induced ischemia.

### **Nursing Assessment**

For an initial evaluation to be separately billable, it must be performed by a physician. The physician would bill Medicare Part B with the code that best represents the service performed and the facility charge would be billed to Part A in the same manner as any other physician service.

Nursing assessments are an integral part of assessing and monitoring the patient's cardiovascular status as well as the progress made during the cardiac rehab program. However, nursing assessments are not separately billable. All services provided during cardiac rehab are covered within the cardiac rehab HCPCS code.

### **Physician Orders**

The documentation should include physician's orders or script signed and dated prior to the start of care.

### **ECG Rhythm Strips**

Monitoring ECG rhythm strips constitutes an important and necessary procedure which should be done while the cardiac patient is engaged in the exercise program. Documentation should include the rhythm strips for each session billed.

## Frequency and Duration

CMS Pub 100-3, CH 1, §20.10 defines the usual duration of CR by stating that “services provided in connection with a cardiac rehabilitation exercise program may be considered reasonable and necessary for up to 36 sessions, usually 3 sessions a week in a single 12 week period. Coverage for continued participation in cardiac exercise programs beyond 12 weeks would be allowed only on a case-by-case basis with exit criteria taken into consideration.” In monitoring this, several points should be considered:

1. Coverage is limited, except on a case by case basis, to twelve weeks
  - a) In counting weeks, CareFirst of MD, Inc. would not consider interruptions for reasons of health (e.g., re-hospitalization, episode of illness, etc) to be part of the 12 week span and will automatically allow exception to the 12 week (but not the 36 session) limitation.
  - b) If the cardiac rehab program is interrupted for unforeseen reasons (patient fatigue, necessary travel, etc.), CareFirst of MD, Inc. would not consider the interruption to be part of the 12 week span and will automatically allow exception to the 12 week (but not the 36 session) limitation.
  - c) Holidays, vacations and inclement weather do not impact the 12 week limitation.
2. Coverage is limited, except on a case by case basis, to thirty six sessions regardless of the number of weeks.
3. Interruptions in a cardiac rehab program do not reset the 36 session limitation although they may allow additional sessions on a case by case basis.
  - a) If the beneficiary starts cardiac rehab, is interrupted for reasons of health or any other reason and then restarts the program, the count of sessions should continue where it left off.
  - b) If the beneficiary starts cardiac rehab, is interrupted by a second qualifying event (cardiac surgery or acute MI) and then restarts the program, the count of sessions should continue where it left off.
  - c) If the beneficiary starts cardiac rehab, stops the program for any reason and then restarts the program with a different provider, the count of sessions should continue where it left off. It is therefore incumbent upon cardiac rehabilitation providers to obtain medical records from past cardiac rehabilitation providers.
4. If the beneficiary completes 36 sessions of a cardiac rehab program and then has a second qualifying event (cardiac surgery or acute MI), additional sessions may be appropriate on a case by case basis depending on medical necessity.

## Documentation Requirements

Following is a list of the information that should be maintained and made available to Medicare upon request. All applicable documentation of medical necessity must be provided. This documentation must be legible and should include, but is not limited to:

- Physician orders
- History and physical
- Initial evaluation and reevaluations
- Plan of treatment
- Progress notes
- Attendance records
- Initial stress test
- ECG rhythm strips
- Short delays in the program (e.g., absence due to other medical illnesses) must be clearly documented
- All claims with the diagnosis of stable angina require additional medical documentation to support the diagnosis of stable angina
- Medical necessity for extended programs must be clearly documented
- Ideally, the supervising physician should be listed on each patient's daily exercise note, even if he or she did not see the patient on that day. (A physician's signature is not required, but could be useful to document compliance with the "direct physician supervision" requirement.)

Additionally, each Cardiac Rehabilitation Program should have documentation that assures that "incident to," and "direct supervision" requirements are being met. A standard operating procedure that requires that there is an appropriate facility-based physician involved in the care of every patient, and that guarantees that a designated physician is available each time Cardiac Rehabilitation is performed, would be helpful to reviewers.

If you have any questions you can contact Janice Austin, RN at 410-561-4158.

**THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE AT NO-COST FROM OUR WEBSITE AT [www.marylandmedicare.com](http://www.marylandmedicare.com)**