Cardiac Rehabilitation (Outpatient Phase II)  
Corporate Medical Policy

File name: Cardiac Rehabilitation (Outpatient Phase II)  
File code: UM.REHAB.04  
Origination: 08/1994  
Last Review: 08/2011  
Next Review: 07/2012  
Effective Date: 02/01/2012

**Document Precedence**

BCBSVT Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with all terms, conditions and limitations of the subscriber contract. Benefit determinations are based in all cases on the applicable contract language. To the extent that there may be any conflict between Medical Policy and contract language, the contract language takes precedence.

**Medical Policy**

**Description**

This medical policy addresses Phase II cardiac rehabilitation programs.

Cardiac rehabilitation (CR) is a program of multidisciplinary interventions, designed to assist clinically suitable cardiac patients to attain and maintain their optimal level of functioning, as defined by the United States Public Health Service (1):

“Cardiac rehabilitation services are comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. These programs are designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or re-infarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients” This USPHS guideline recommends cardiac rehabilitation services for patients with coronary heart disease (CHD) and with heart failure, including those awaiting or following cardiac transplantation.

A 2010 definition of cardiac rehabilitation by the Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation is as follows: “Cardiac rehabilitation can be viewed as the clinical application of preventive care by means of a professional multi-disciplinary integrated approach for comprehensive risk reduction and global long-term care of cardiac patients.” (2)

Note: This policy does not address programs considered to be “Intensive Cardiac Rehabilitation Programs,” such as the Dean Ornish Program for Reversing Heart Disease and the Pritikin Program.

Definitions (Goroll and Mulley; 2009; Thompson, 2007):
• **Phase I (Inpatient):** Inpatient rehabilitation, usually lasting for the duration of hospitalization for an acute coronary event or surgery. It emphasizes a gradual, progressive approach to exercise and an education program that helps the patient understand the disease process, the rehabilitation process, and initial preventive efforts to slow the progression of disease.

• **Phase II (Outpatient Electrocardiographically-Monitored):** Multifaceted outpatient rehabilitation, lasting from hospital discharge to 1–12 weeks later. Phase II CR emphasizes safe physical activity to improve conditioning with continued behavior modification aimed at smoking cessation, weight loss, healthy eating, and other factors to reduce disease risk (see below).

• **Phase III (Supervised):** Supervised rehabilitation, lasting 6–12 months. Establishes a prescription for safe exercise that can be performed at home or in a community service facility, such as a senior center, and continues to emphasize risk-factor reduction.

• **Phase IV (Maintenance/Follow-Up):** This is usually an indefinite program. The goal is to encourage lifelong adherence to the healthy habits established during Phase III. Follow-up visits can occur at 6–12 month intervals. Blood pressure and pulse measurement, serum lipid levels, and even repeat maximal exercise tolerance tests can provide useful feedback to the patient and indicate areas that may require lifestyle changes to minimize coronary.

**Policy**

**Phase II cardiac rehabilitation** is considered medically necessary when individually prescribed by a physician in circumstances where there is the expectation of clear and measurable progress toward a rehabilitative goal, a less restrictive setting or other medically necessary goal, and all the following criteria are met:

1. Cardiac rehabilitation is initiated within 90 days and completed within 180 days of ANY of the following:
   - Acute myocardial infarction (MI); or
   - Coronary artery bypass grafting (CABG); or
   - Heart/lung transplantation; or
   - Percutaneous coronary vessel remodeling (i.e., atherectomy, angioplasty, stenting); or
   - Survivor of sudden cardiac death; or
   - Survivor of sustained ventricular tachycardia or fibrillation; or
   - Valve replacement or repair; or
   - Class III or IV congestive heart failure (CHF) that has failed to respond to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living; or
   - Coronary artery disease (CAD) with chronic stable angina pectoris that has failed to respond to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living.

   **AND**

2. The patient has no absolute contraindications to cardiac rehabilitation (Ades and Hambrecht 2007) as indicated by absence of the following:
   - Marked progressive worsening of exercise tolerance suggesting an acute pathologic process;
   - Worsening of dyspnea during exercise over the previous three to five days;
- uncontrolled diabetes;
- Acute systemic illness or fever;
- Recent systemic or pulmonary embolism;
- acute myocarditis or pericarditis;
- Moderate to severe aortic stenosis or severe outflow obstruction of the left ventricular outflow tract;
- MI within one weeks;
- New onset of atrial fibrillation;
- Ventricular dysfunction, with a history of previous heart illness prior to a recent cardiac event;
- Acute thrombophlebitis;
- Unstable angina pectoris;
- Uncontrolled arrhythmias;
- Decompensated congestive heart failure (CHF);
- Dissecting aneurysm;
- Severe hypertension;
- Exertional hypotension or syncope;
- Severe orthopedic limitations;

AND

3. Prior to initiating CR, it is recommended there be documentation that the patient underwent exercise stress testing and did not experience ANY of the following:
   - Severe dyspnea at low exercise workload (< 5 METS)
   - Angina at low exercise workload (< 5 METS)
   - Heart rate > 120 beats per minute
   - Malignant ventricular arrhythmias
   - ST segmental changes at low exercise workload (< 5 METS)
   - Significant ischemia at low work rates (< 5 METS)
   - Decreased systolic blood pressure during exercise
   - Combination of findings that add up to Duke Treadmill Score of –5 or worse).

Coverage of these services is limited to ECG monitored cardiac rehabilitation programs. Cardiac rehabilitation programs that are not electrocardiographically monitored are considered not medically necessary and therefore are not covered.

In addition, the following are considered not medically necessary:

1. Phase III cardiac rehabilitation programs, or self-directed, self-controlled/monitored exercise programs.
2. Phase IV cardiac rehabilitation programs or maintenance therapy that may be safely carried out without medical supervision.
3. Cardiac rehabilitation when used in a preventive or prophylactic way such as for angina, hypertension, or diabetes.
4. Physical and/or occupational therapy are not medically necessary in conjunction with cardiac rehabilitation unless performed for an unrelated diagnosis.

Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational.
Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Benefits for FEP members may vary. Please consult the FEP Service Plan Brochure.

For New England Health Plan (NEHP) members an approved referral authorization is required.

For Blue Card/ National Account members cardiac rehabilitation must be performed in a participating facility. A single initial visit with the physician for referral to a program may be allowed.

Benefits will be provided for outpatient cardiac rehabilitation when the cardiac event is of a level of severity that it has required acute care and with a frequency of up to three (3) supervised exercise sessions per week, up to a maximum of 36 sessions for each new acute cardiac event.

Services that are educational in nature, e.g., lectures or counseling, which are performed as part of the cardiac rehabilitation program, are not eligible for coverage, even when occurring on a different date of service, unless specifically specified in the contract or certificate of coverage.

Psychological testing and psychotherapy are not a usual component of cardiac rehabilitation. Such services for patients who have a psychiatric diagnosis must be considered under the Mental Health benefits of the contract.

The ongoing maintenance program that follows the 12-week cardiac rehabilitation program is not eligible for coverage.

Some contracts have an exclusion for cardiac rehabilitation, as this is considered “self-care” or “self-help” training. In these cases, any related diagnostic testing must also be excluded.

Cardiac rehabilitation services must be obtained from a contracted or preferred provider.

Eligible Providers

Rehabilitation Providers
Facilities

Related Policies

None

Policy Implementation/Update information

8/1994 original policy issued
9/2000. 11/2002 no changes made
6/2003 added definitions, specific criteria
12/2004 reviewed
2/2005 reviewed definitions removed to match new certificate language
3/2006 annual review, language update to match certificate language and medical necessity criteria expanded
3/2007 minor word changes to match current certificate language. To be reviewed by the CAC 05/2007
3/2008 annual review. Benefit limitation changes from 18 sessions to 36 session per cardiac event.
8/2011 New format. Expanded language on what is considered medically necessary and what is
considered not medically necessary or investigational. Included language on contraindications.
Updated references. Coding is appropriate per Medical/Clinical Coder (SAR).

Scientific Background and Reference Resources

References:


Approved by BCBSVT Medical Directors Date Approved

Antonietta Sculimbrene MD
Chair, Medical Policy Committee
## ATTACHMENT I
Cardiac Rehabilitation

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<thead>
<tr>
<th>Covered Codes</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT</td>
<td>93798</td>
<td>outpatient cardiac rehabilitation with continuous ECG monitoring</td>
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<tr>
<td>HCPCS</td>
<td>S9472</td>
<td>Cardiac rehabilitation program, non-physician provider, per Diem</td>
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<tr>
<td>Revenue</td>
<td>0943</td>
<td>Cardiac Rehabilitation</td>
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<thead>
<tr>
<th>Non Covered Codes</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT</td>
<td>93797</td>
<td>Physician services for outpatient cardiac rehabilitation without continuous ECG monitoring</td>
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</tbody>
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### Codes that suspend for clinical documentation

<table>
<thead>
<tr>
<th>HCPcs</th>
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<tbody>
<tr>
<td>Since the code description indicates that this code can be used for both monitored and non-monitored cardiac rehabilitation, it will suspend for medical review and notes indicating that the cardiac rehabilitation was monitored must be submitted with the claim for reimbursement consideration.</td>
<td>G0422</td>
<td>Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session</td>
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