



Harmony Behavioral Health, Inc.

Harmony Behavioral Health of Florida, Inc.

Harmony Health Plan of Illinois, Inc.

HealthEase of Florida, Inc.

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Cardiac Rehabilitation

Policy Number: HS-091

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DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

BACKGROUND

Over 60 million Americans have one or more forms of cardiovascular disease, and cardiovascular disease is the leading cause of morbidity and mortality in the United States for both men and women, accounting for > 50% of all deaths. Coronary artery disease (CAD), with its clinical manifestations of stable angina pectoris, unstable angina, acute myocardial infarction (MI), and sudden cardiac death, affects 12.9 million Americans. The morbidity and subsequent disability associated with CAD alone have far-reaching medical and socioeconomic implications. Nearly 519,000 coronary revascularization procedures are performed each year. These procedures, together with the associated hospital stays, medications, medical personnel, and healthcare facility charges, resulted in an estimated cost in 1994 of more than \$56 billion. CAD is also the leading cause of premature, permanent disability in the U.S. labor force, and approximately two thirds of patients who suffer MI do not make a full recovery. Patients who survive the acute stage of an MI have a 1.5 to 15 times higher risk of illness and death than that of the general population (Hayes, 2003).

Cardiac rehabilitation (CR) programs have been introduced as a way to enhance recovery from MI or coronary angioplasty (coronary artery bypass grafting or percutaneous transluminal coronary angioplasty), to minimize the disability associated with CAD, and to reduce the risk of subsequent cardiac events. Cardiac rehabilitation has been defined in different ways but generally refers to comprehensive, long-term programs involving medical evaluation, exercise, cardiac risk factor modification, education, and counseling for patients with chronic or post-acute cardiovascular disease.

Phases of Cardiac Rehabilitation

CR programs are generally administered as a three-part process: phase I, inpatient or recovery phase; phase II, outpatient or intermediate phase; and phase III, community-based or home long-term phase.

Phase I – Inpatient Rehabilitation: The objectives in phase I (the first 14 to 21 postoperative or postevent days) are intended to provide surveillance for optimal patient management. In addition to providing a structured progressive ambulation program, specially trained healthcare personnel teach the patient how to recognize cardiac symptoms and respond appropriately; explain the doses, effects, and side effects of the medications; educate patients on stress management; and discuss cardiovascular disease risk factors.

Phase II – Outpatient Rehabilitation: A symptom-limited exercise test is administered, establishing the patient's MET capacity and identifying high-risk characteristics that require further evaluation or intervention. Risk stratification is used to identify patients at risk for death or reinfarction and to provide guidelines for the rehabilitative process. Patients may meet with a physical therapist and a dietician during this phase of rehabilitation. Rehabilitation is supervised by specially trained personnel. Most exercise programs consist of 3 sessions per week for 4 to 12 weeks for approximately an hour, with continuous ECG monitoring. The patient warms up for 10 to 15 minutes with various callisthenic exercises, then performs exercises using the following modes: stationary bicycle ergometry (with leg only, arm only, or arm-leg combinations), treadmill walking, arm ergometry, and rowing. These exercises are followed by a 10- to 15-minute cool-down period.

Phase III – Long-Term Rehabilitation: The patient continues exercise and modified behaviors related to risk factors at home or in a community-based facility. The patient performs an adequate warm-up session before exercises, which may include walking, bicycling, jogging, swimming, calisthenics, weight training, and endurance sports, depending upon the maximum exercise capacity and the personal preferences of the patient. Group support and counseling are critical for ongoing reinforcement.

Determination of Frequency and Duration of Rehabilitation

The medically necessary frequency and duration of cardiac rehabilitation is determined by the member's level of

cardiac risk stratification. Risk stratification is divided into low, intermediate and high.

High Risk

High risk members have **ANY** of the following:

- Exercise test limited to less than or equal to 5 metabolic equivalents (METS); OR,
- Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more ST depression by ECG; OR,
- Severely depressed left ventricular function (ejection fraction less than 30%); OR,
- Resting complex ventricular arrhythmia; OR,
- Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing; OR,
- Decrease in systolic blood pressure of 15 mm Hg or more with exercise; OR,
- Recent myocardial infarction (less than six months) which was complicated by serious ventricular arrhythmia, cardiogenic shock or congestive heart failure; OR,
- Survivor of sudden cardiac arrest (SCA)

A cardiac rehabilitation program for high risk members should have the following features. The program should consist of 36 sessions (e.g. 3 sessions a week for 12 weeks) of supervised exercise with continuous telemetry monitoring, as well as contain an educational program for risk factor/stress reduction. Also, the program should create an individual out-patient exercise program that can be self-monitored and maintained. If no clinically significant arrhythmia is documented during the first three weeks of the program, the provider can have the member complete the remaining portion without telemetry monitoring.

Intermediate Risk

Intermediate risk members have **ANY** of the following:

- Exercise limited to 6-9 METS; OR,
- Ischemic ECG response to exercise of less than 2 mm of ST depression; OR,
- Uncomplicated myocardial infarction, coronary artery bypass surgery, or angioplasty and has a post-cardiac event maximal functional capacity of 8 METS or less on ECG exercise test.

The program for intermediate risk members should include 24 sessions or less of exercise training without ECG monitoring and should be geared toward an ongoing self-administered exercise program.

Low Risk

Low risk members have the following:

- Exercise test limited to greater than 9 METS.

The program for low risk members should consist of 6 one-hour sessions involving risk factor reduction education and supervised exercise to show safety and definition of a home program.

POSITION STATEMENT

Phase II cardiac rehabilitation services **are considered medically necessary** for members who:

- 1) Have a documented diagnosis of acute myocardial infarction within the preceding 12 months; **OR**,
- 2) Have had coronary bypass surgery; **OR**,
- 3) Have stable angina pectoris; **OR**,
- 4) Have had heart valve repair/replacement; **OR**,
- 5) Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; **OR**,
- 6) Have had a heart or heart-lung transplant.

Program Requirements

- I. Services provided in connection with a cardiac rehabilitation exercise program may be considered medically necessary for up to 36 sessions (see background section for more detail concerning duration and frequency determination). Patients generally receive 2-3 sessions per week for 12-18 weeks. WellCare has the discretion to cover rehabilitation beyond 18 weeks but coverage may not exceed a total of 72 sessions for 36 weeks.
- II. Cardiac rehabilitation programs must be comprehensive and, thus, must include:
 - A medical evaluation; **AND**,
 - A program to modify cardiac risk factors, such as nutritional counseling; **AND**,
 - Prescribed exercise, education and counseling.
- III. The facility at which cardiac rehabilitation occurs must use the necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (e.g. defibrillator, oxygen, resuscitation equipment).
- IV. The program must be staffed by personnel necessary to conduct the program in a safe and effective manner. Personnel must have training in A) both basic and advanced life support techniques and B) exercise therapy for coronary disease.

CODING**Covered CPT® Codes**

- 93797** Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798 Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

ICD-9-CM Procedure Codes - No applicable Codes

HCPCS Level II® Codes

- S9472*** Cardiac rehabilitation program, non-physician provider, per diem
*S- Codes are **NON COVERED FOR MEDICARE – Refer to HCPCS Level II Temporary National Codes**

Covered ICD-9-CM Diagnosis Codes

- 410.00-410.92** Acute myocardial infarction
411.0 Postmyocardial Infarction Syndrome
412 Old Myocardial Infarction
413.9 Stable Angina Pectoris, Other and unspecified
414.00-414.07 Coronary atherosclerosis
428.9 Unspecified heart failure
V42.1* Heart replaced by transplant
V42.2* Heart Valve replaced by transplant
V43.3* Heart valve replaced by other means
V45.81* Postprocedural aortocoronary bypass status
V45.82* Postprocedural percutaneous transluminal coronary angioplasty status

* Per ICD-9-CM Coding Guidelines, diagnosis codes V42.1, V42.2, V43.3, V45.81 and V45.82 are secondary diagnosis codes and should not be billed as a primary diagnosis.

***Current Procedural Terminology (CPT) 2010 American Medical Association: Chicago, IL.®©**

REFERENCES**Peer Reviewed**

1. Balady, GJ, Willaims, MA, Ades, PA, Bittner, V, Comoss, Patricia, Foody, JM, Franklin, B, Sanderson, B, and Southard, D. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update: A Scientific Statement From the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils of Cardiovascular Nursing, Epidemiology, and Prevention; and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. *Circulation*; 115; 2675-2682; 2007.
2. Hayes Directory. Cardiac Rehabilitation Programs, March 26, 2003.
3. Leon, AS, Franklin, BA, Costa, F, Balady, GJ, Berra, KA, Stewart, KJ, Thompson, PD, Williams, MA, and Lauer, MS. Cardiac Rehabilitation and Secondary Prevention of Coronary Heart Disease: An American Heart Association Scientific Statement From the Council on Clinical Cardiology (Subcommittee on Exercise, Cardiac Rehabilitation, and Prevention) and the Council on Nutrition, Physical Activity, and Metabolism (Subcommittee on Physical Activity), in Collaboration With the American Association of Cardiovascular and Pulmonary Rehabilitation. *Circulation*; 111; 369-376; 2005.

Government Agencies, Professional and Medical Organizations

1. Cardiac Rehabilitation Programs. CMS Manual System. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2006.

Other

1. AHRQ Technical Reviews and Summaries, AHCPR Supported Clinical Practice Guidelines, Cardiac Rehabilitation. May, 2003.

HISTORY AND REVISIONS

Date	Action
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
3/31/2011	<ul style="list-style-type: none">• Approved by MPC.