CARDIAC REHABILITATION
HS-091

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.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). 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 CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

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 and hour, with continuous ECG monitoring. The patient warms up for 10 to 15 minutes with various calisthenic 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 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** 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** 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**

**Applicable To:**
- Medicaid
- Medicare

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; OR
7. Have stable, chronic heart failure defined as an individual with left ventricular ejection fraction of 35% or less and New York Health Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks.4

* Stable members are defined as those who have not had recent (<6 weeks) or planned (<6 months) major cardiovascular hospitalizations or procedures.

**Program Requirements**

1. Services provided in connection with a cardiac rehabilitation exercise program may be considered medically necessary for up to 36 sessions (see Background for detail concerning duration/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.

2. 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.

3. 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).
4. 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® Code**

93798  Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

**HCPCS Level II® Codes**

G0422  Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session

G0423  Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session

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-10-CM Diagnosis Codes**

I20.0-I20.9  Angina pectoris

I21.01-I21.09  ST elevation (STEMI) myocardial infarction of anterior wall

I21.11-I21.19  ST elevation (STEMI) myocardial infarction of inferior wall

I21.21-I21.4  ST elevation (STEMI) myocardial infarction of other sites

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

I24.1  Dressler’s syndrome; postmyocardial infarction syndrome

I25.10  Atherosclerotic heart disease of native coronary artery without angina pectoris

I25.110 - I25.119  Atherosclerotic heart disease of native coronary artery with angina pectoris

I25.2  Old myocardial infarction

I25.700-I25.799  Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with 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

I25.9  Chronic ischemic heart disease, unspecified

I46.2-I46.9  Cardiac arrest

I47.0  Re-entry ventricular arrhythmia

I47.2  Ventricular tachycardia

I50.20-I50.23  Systolic (congestive) heart failure

I50.30-I50.33  Diastolic (congestive) heart failure

I50.40-I50.43  Combined (congestive) heart failure

R57.0  Cardiogenic shock

Z94.1  Heart transplant status

Z94.3  Heart and lung transplant status

Z95.1  Presence of aortocoronary bypass graft

Z95.2  Presence of prosthetic heart valve

Z95.3  Presence of xenogenic heart valve

Z95.4  Presence of other heart-valve replacement

Z95.5  Presence of coronary angioplasty implant and graft

Z95.812  Presence of fully implantable artificial heart

Z98.61  Coronary angioplasty status

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member’s benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.
REFERENCES


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<td>2/1/2018</td>
<td>Approved by MPC. Inclusion of criteria for Members with stable, chronic heart failure.</td>
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<tr>
<td>8/3/2017, 10/6/2016</td>
<td>Approved by MPC. No changes.</td>
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<td>10/15/2015</td>
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<td>3/5/2015</td>
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