

Medical Policy and InterQual® Criteria

Cardiac Rehabilitation, Outpatient

Policy Number: OCA 3.61

Version Number: 23

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Product Applicability		<input checked="" type="checkbox"/> All Plan⁺ Products
WellSense Health Plan		Boston Medical Center HealthNet Plan
<input checked="" type="checkbox"/> NH Medicaid		<input checked="" type="checkbox"/> MassHealth ACO
<input checked="" type="checkbox"/> NH Medicare Advantage		<input checked="" type="checkbox"/> MassHealth MCO
		<input checked="" type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct
		<input checked="" type="checkbox"/> Senior Care Options

⁺ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers outpatient, medically-supervised phase II cardiac rehabilitation **medically necessary** when criteria are met. Prior authorization is NOT required for waived diagnoses noted in the Applicable Coding section of this policy for a member age 18 or older on the date of service. Prior authorization is required for phase II cardiac rehabilitation for all other diagnoses using applicable InterQual® criteria for members age 18 or older on the date of service to determine medical necessity. Plan Medical Director review is required for individual consideration of requests for outpatient, medically-supervised phase II cardiac rehabilitation for members age 17 or younger on the date of service until InterQual® criteria are available for the Plan’s pediatric members.

Prior authorization requests for intensive cardiac rehabilitation (ICR) will be evaluated by a Plan Medical Director using the Plan’s *Medically Necessary* medical policy, policy number OCA 3.14. According to the Centers for Medicare & Medicaid Services (CMS), “intensive cardiac rehabilitation (ICR) refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner. An additional Plan prior authorization is NOT

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required for phase I patient cardiac rehabilitation during an approved inpatient admission. Phase III and phase IV cardiac rehabilitation programs are considered maintenance programs and therefore are NOT considered medically necessary by the Plan after the completion of outpatient and medically-supervised, phase II cardiac rehabilitation.

A cardiac rehabilitation program must be medically supervised by a physician, physician assistant, nurse practitioner, or clinical nurse specialist to be considered medically necessary. Prior authorization requests for a cardiac rehabilitation program that do not meet this guideline will be evaluated by a Plan Medical Director for all Plan members using the Plan's *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12. The applicable code for this service is NOT payable for any Plan product.

Clinical Criteria

The Plan considers outpatient and medically-supervised, phase II cardiac rehabilitation programs to be medically necessary when applicable InterQual® criteria are met for an adult member (age 18 or older on the date of service).

Limitations and Exclusions

1. Cardiac rehabilitation for a pediatric member (under the age of 18 on the date of service) requires Medical Director review and approval until InterQual® criteria are established for the Plan's pediatric members.
2. The use of a mobile medical application (software that can be executed on a mobile platform or web-based) for cardiac rehabilitation is considered experimental and investigational or NOT medically necessary due to insufficient published evidence to assess the safety and/or impact on health outcomes related to cardiac rehabilitation.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, the following NCDs are applicable for cardiac rehabilitation: NCD 20.10 for Cardiac Rehabilitation Programs, NCD 20.10.1 for Cardiac Rehabilitation Programs for Chronic Heart Failure, NCD 20.31 for Intensive Cardiac Rehabilitation (ICR) Programs, NCD 20.31.1 for the Pritikin Program, NCD 20.31.2 for the Ornish Program for Reversing Heart Disease, and NCD 20.31.3 for the Benson-Henry Institute Cardiac Wellness Program. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

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Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria and Limitations and Exclusions sections of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

ICD-10 Diagnosis Codes Δ	Description: Prior authorization is NOT required for ANY of the following waived, primary diagnosis codes for outpatient, phase II cardiac rehabilitation when the service is billed with a covered CPT code listed below. Δ
I05.0-I08.9	Rheumatic valve diseases
I09.1	Rheumatic diseases of endocardium, valve unspecified
I11.0	Hypertensive heart disease with heart failure Plan note: Excludes heart failure with decompensation, as specified in InterQual® criteria.
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.2	Hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease, or end stage renal disease Plan note: Excludes heart failure with decompensation, as specified in InterQual® criteria.
I20.1	Angina pectoris with documented spasm

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	Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I20.8	Other forms of angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I20.9	Angina pectoris, unspecified Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I21.01-I21.4	ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
I22.0-I22.9	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
I23.7	Postinfarction angina Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I24.0-I24.9	Other acute ischemic heart disease
I25.10	Atherosclerotic heart disease of native coronary artery
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.2	Old myocardial infarction
I25.3	Aneurysm of heart
I25.41-I25.42	Coronary artery aneurysm or dissection
I25.6	Silent myocardial ischemia

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I25.701	Atherosclerosis with coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.708	Atherosclerosis with coronary artery bypass graft(s), unspecified, with other forms of angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.709	Atherosclerosis with coronary artery bypass graft(s), unspecified, with angina pectoris with unspecified angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.711	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.718	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with other forms of angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with unspecified angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.721	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.728	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with other forms of angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.729	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with unspecified angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.731	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm Plan note: Excludes unstable angina, as specified in InterQual® criteria.

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I25.738	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with other forms of angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.739	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with unspecified angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.751	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.758	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with other forms of angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.759	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with unspecified angina pectoris Plan note: Excludes unstable angina, as specified in InterQual® criteria.
I25.81-I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified
I34.0-I37.9	Nonrheumatic valve disorders
I46.2-I46.9	Cardiac arrest
I50.1-I50.9	Heart failure Plan note: Excludes heart failure with decompensation, as specified in InterQual® criteria.
I97.0	Postcardiotomy syndrome
I97.110	Postprocedural cardiac insufficiency following cardiac surgery
I97.120	Postprocedural cardiac arrest following cardiac surgery
I97.130	Postprocedural heart failure following cardiac surgery
Z94.1	Heart transplant status
Z94.3	Heart and lungs transplant status
Z95.0-Z95.5	Presence of cardiac implants and grafts
Z95.811- Z95.818	Presence of other cardiac implants and grafts
Z98.61	Coronary angioplasty status

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CPT Codes Δ	<p>Description: Codes covered for outpatient and medically-supervised, phase II cardiac rehabilitation services billed no more than one (1) unit per day when medically necessary and applicable InterQual® criteria are met, as documented in the member’s medical record.</p> <ul style="list-style-type: none"> • Prior authorization is NOT required for outpatient and medically-supervised, phase II cardiac rehabilitation services when the service is billed with one of these CPT codes and a waived, primary diagnosis code specified above. Δ • All other primary diagnosis codes REQUIRE Plan prior authorization and services must meet applicable InterQual® criteria, as documented in the member’s medical record.
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Δ Note: Applicable InterQual® criteria must still be met when Plan prior authorization is waived for outpatient and medically-supervised, phase II cardiac rehabilitation services provided to an adult member (age 18 or older on the date of service). Documentation in the member’s medical record must include clinical information supporting that applicable InterQual® criteria are met, that the member’s diagnosis is consistent with a diagnosis code waived for Plan prior authorization, and that outpatient and medically-supervised, phase II cardiac rehabilitation services was provided to the Plan member. To waive the prior authorization requirement, outpatient and medically-supervised, phase II cardiac rehabilitation services must also be billed with an applicable covered and medically necessary CPT code specified above (and excludes the experimental and investigational HCPCS code listed above). The waived, primary diagnosis code must be accurately documented on the claim form with the covered procedure code.

HCPCS Codes	<p>Description: Codes covered for CMS-certified intensive cardiac rehabilitation (ICR) programs. Prior authorization with Plan Medical Director review is required for ALL diagnosis codes for ICR services.</p>
G0422	<p>Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session</p> <p>Plan note: Plan Medical Director review is required for ICR. Prior authorization requests will be evaluated using the Plan’s <i>Medically Necessary</i> medical policy, policy number OCA 3.14.</p>
G0423	<p>Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session</p> <p>Plan note: Plan Medical Director review is required for ICR. Prior authorization requests will be evaluated using the Plan’s <i>Medically Necessary</i> medical policy, policy number OCA 3.14.</p>

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A	12/03/06 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)
Internal Approval: 10/03/06			

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12

*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13

*Effective Date for the Senior Care Options Product(s): 01/01/13

*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy Revisions History

Cardiac Rehabilitation, Outpatient

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Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
09/11/07	Updated template and added coding.	Version 2	09/11/07: MPCTAC 09/25/07: Utilization Management Committee (UMC) 10/15/07: Quality Improvement Committee (QIC)
09/09/08	No changes.	Version 3	09/09/08: MPCTAC 09/30/08: UMC 10/22/08: QIC
08/25/09	No changes to the criteria, updated coding (removed S0340 and S0341 from the policy because these codes are not applicable).	Version 4	08/25/09: MPCTAC 08/25/09: UMC 09/23/09: QIC
09/01/10	Minor formatting changes, removed visit limitation, updated references and coding.	Version 5	09/15/10: MPCTAC 10/27/10: QIC
05/05/11	Added select ICD-9 V codes into the code table as diagnoses that are appropriate for cardiac rehab and are prior authorization exempt. These V codes were approved by the UMC on 05/04/11.	Version 6	05/04/11: UMC
09/01/11	Updated criteria to indicate that cardiac rehabilitation is considered medically necessary within 26 weeks after a cardiac event or diagnosis, updated references and coding.	Version 7	09/21/11: MPCTAC 11/29/11: QIC
08/01/12	Off cycle review for Well Sense Health Plan, revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introduction, revised Limitations.	Version 8	08/17/12: MPCTAC 09/06/12: QIC
09/01/12	Updated all sections of the policy (including Description of Service, Clinical Guideline Statement, Definitions, Applicable Coding, Limitations, and Clinical Background Information). Clinical criteria and applicable code list updated. Deleted 'Phase II' from the policy title.	Version 9	09/19/12: MPCTAC 10/24/12: QIC

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Policy Revisions History

12/01/12	Revised Summary section to clarify that phase II cardiac rehabilitation is conducted in the outpatient setting.	Version 10	12/19/12: MPCTAC 01/31/13: QIC
12/01/13	Review for effective date 02/01/14. Updated Summary, References, and Clinical Background Information sections. Added Plan note to the table in Applicable Coding section without revising applicable code list. Added definition (with reference) for Exercise Workload. Revised text in Medical Policy Statement section without changing criteria.	02/01/14 Version 11	12/18/13: MPCTAC 01/22/14: QIC
01/30/14	Off cycle review for effective date 04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.	04/01/14 Version 12	01/27/14: MPCTAC 01/30/14: QIC
07/01/14	Review for effective date 08/01/14. Updated Summary section. Revised language in Applicable Coding section without changing applicable code list. Added Plan note to the codes the Plan considers experimental and investigational, CPT code 93797 and HCPCS code S9472. Clarified that the diagnosis codes included in the policy apply to covered services (and not those services listed as experimental and investigational) when Plan criteria are met.	08/01/14 Version 13	07/21/14: MPCTAC (electronic vote) 07/24/14: QIC (electronic vote)
12/01/14 and 01/01/15	Review for effective date 05/01/15. Revised criteria in the Medical Policy Statement section and Limitations section. Updated Summary, Description of Item or Service, and References sections. Updated language in the Applicable Coding section and added HCPCS codes G0422 and G0423 as applicable codes for intensive cardiac rehabilitation.	05/01/15 Version 14	12/24/14: MPCTAC (electronic vote) 01/21/15: MPCTAC 02/14/15: QIC
10/01/15	Review for effective date 12/01/15. Updated list of applicable products and corresponding notes. Updated References section.	12/01/15 Version 15	10/21/15: MPCTAC 11/11/14: QIC
11/25/15	Review for effective date 01/01/16.	01/01/16	11/25/15: MPCTAC

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Policy Revisions History

	Revised language in the Applicable Coding section.	Version 16	(electronic vote) 12/09/15: QIC
10/01/16	Review for effective date 02/01/17. Removed ICD-9 diagnosis codes. Added Plan notes to the Applicable Coding section. Revised the ICD-10 waived diagnosis code list. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made to the Summary, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	02/01/17 Version 17	10/19/16: MPCTAC 11/09/16: QIC
10/01/17	Review for effective date 11/01/17. Administrative changes made to the Limitations section and Applicable Coding section (with revised Plan notes and headers). Updated the Policy Summary, Clinical Background Information, and References sections.	11/01/17 Version 18	10/18/17: MPCTAC
02/01/18	Review for effective date 03/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, and Applicable Coding sections to be consistent with benefit coverage. Updated the Other Applicable Policies section.	03/01/18 Version 19	02/21/18: MPCTAC
11/01/18	Review for effective date 03/01/19. Medical policy criteria retired and applicable InterQual® criteria adopted for outpatient, phase II cardiac rehabilitation. Revised the Medical Policy Statement and Limitations sections. Administrative changes made to the Policy Summary, Description of Item or Service, Applicable Coding, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	03/01/19 Version 20	11/21/18: MPCTAC
09/01/19	Review for effective date 12/01/19. Updated applicable code list.	12/01/19 Version 21	09/18/19: MPCTAC

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Policy Revisions History

	Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.		
09/01/20	Review for effective date 12/01/20. Administrative changes made to the Medical Policy Statement, References, and Other Applicable Policies sections. Revised criteria in the Limitations section.	12/01/20 Version 22	09/16/20: MPCTAC
10/01/21	Review for effective date 11/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Limitations and Exclusions, Applicable Coding, and References sections.	11/01/21 Version 23	10/20/21: MPCTAC

Next Review Date

09/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other

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government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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