Medical Policy

Cardiac Rehabilitation, Outpatient

Policy Number: OCA 3.61
Version Number: 16
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Product Applicability

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
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<tr>
<td>✗ New Hampshire Medicaid</td>
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<td>✗ NH Health Protection Program</td>
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</tr>
</tbody>
</table>

Notes:

+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers medically-supervised, phase II outpatient cardiac rehabilitation programs to be medically necessary based on the Plan’s medical criteria. See the Medical Policy Statement section and Limitations section of this policy for Plan medical criteria and prior authorization requirements.

Phase II outpatient cardiac rehabilitation does not require Plan prior authorization for a member with a specified diagnosis code listed in the Applicable Coding section when all applicable Plan criteria are met; all other diagnoses REQUIRE prior authorization. Prior authorization is required

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for a member when all applicable Plan criteria are NOT met for phase II outpatient cardiac rehabilitation. Programs that do not include all components of a comprehensive phase II outpatient cardiac rehabilitation program require prior authorization. Review the Plan policy, *Medically Necessary* (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment.

Phase III and phase IV cardiac rehabilitation programs are considered experimental and investigational. (See the Definitions section of this Plan policy for definitions of phase I, phase II, phase III, and phase IV cardiac rehabilitation.) It will be determined during the Plan’s prior authorization process if the service is considered experimental and investigational for the requested indication. See the Plan policy, *Experimental and Investigational Treatment* (policy number OCA 3.12), for the product-specific definitions of experimental or investigational treatment.

**Description of Item or Service**

**Intensive Cardiac Rehabilitation (ICR):** 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. As required by §1861(eee)(4)(A) of the Social Security Act (the Act), an ICR program must show, in peer-reviewed published research, that it accomplished one or more of the following for its patients: (1) positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; and (3) reduced the need for percutaneous coronary interventions. The ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five (5) or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services: (1) low density lipoprotein; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and (6) the need for cholesterol, blood pressure, and diabetes medications. Individual ICR programs must be approved through the national coverage determination process to ensure that they demonstrate these accomplishments.” Program criteria are outlined at: [http://www.ssa.gov/OP_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm). The list of CMS approved facilities are listed at: [http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/](http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/)

**Phase II Cardiac Rehabilitation:** Phase II cardiac rehabilitation, as described by the U.S. Public Health Service, is a comprehensive, long-term program 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. Phase II refers to outpatient, medically-supervised programs that are typically initiated within a few weeks after hospital discharge and provide appropriate electrocardiographic (ECG) monitoring and medically-supervised

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exercise. The frequency and duration of the program generally does not exceed 36 sessions, occurring 2-3 times per week for 12-18 weeks.

**Medical Policy Statement**

The Plan considers outpatient, phase II cardiac rehabilitation services medically necessary when Plan criteria are met and documented in the member’s medical record. See Section A for services that REQUIRE Plan prior authorization and review Section B for cardiac rehabilitation services that do NOT require Plan prior authorization.

A. **Plan Prior Authorization is REQUIRED:**

Plan prior authorization, including Plan Medical Director review, is required for any ONE (1) of the following conditions, as specified below in items 1 through 6:

1. Member is younger than eight (8) years old on the date of service; OR

2. Cardiac rehabilitation begins AFTER 26 weeks of the member’s diagnosis related to cardiac rehabilitation services; OR

3. The member has a medical condition NOT included in the list of diagnoses that do NOT require Plan prior authorization (with the primary diagnosis codes listed in the Applicable Coding section of this policy); OR

4. The cardiac rehabilitation program does NOT meet the Plan’s definition of a comprehensive phase II cardiac rehabilitation program (i.e., program criteria listed in item B5 of this Medical Policy Statement section are not met, the program is not accredited by the American Academy of Cardiovascular and Pulmonary Rehabilitation [AACVPR] as a phase II cardiac rehabilitation program, or the program is not accredited by the Joint Commission Disease-Specific Care Certification for phase II cardiac rehabilitation); OR

5. The requested outpatient cardiac rehabilitation services will be provided as part of an intensive cardiac rehabilitation (ICR) program that is CMS accredited through the national coverage determination process (as specified in the Description of Item or Service Section of this Plan policy and requires Plan Medical Director review as stated in the Limitations section); OR

6. An outpatient cardiac rehabilitation program that includes sessions WITHOUT continuous ECG monitoring as a component of the exercise program must meet ALL of the following criteria, as specified below in items a through d:
a. Before transitioning the member to an exercise program without continuous ECG monitoring, the first three (3) sessions will be conducted WITH continuous ECG monitoring and there is no adverse change in the member’s medical status during these three (3) continuous ECG monitored sessions; AND

b. The treating provider has determined that the member can safely continue the exercise program without continuous ECG monitoring; AND

c. The treating provider will use a graduated approach as part of the exercise program, assess the member’s risk with each session, and promote member self-monitoring of symptoms at each session; AND

d. The treating provider will use continuous ECG monitoring as soon as the member’s medical condition requires continuous monitoring or the member is at risk for an adverse event.

B. Plan Prior Authorization is NOT Required:

Plan prior authorization is NOT required when ALL of the following criteria are met for outpatient, phase II cardiac rehabilitation services (that are NOT a component of a CMS intensive cardiac rehabilitation [ICR] program), as specified below in items 1 through 5:

1. A member is at least eight (8) years of age when cardiac rehabilitation is initiated; AND

2. Cardiac rehabilitation begins WITHIN 26 weeks of the member’s diagnosis related to cardiac rehabilitation services; AND

3. The member has at least ONE (1) of the following conditions listed below in items a through j: (Note: See the Applicable Coding section for the specific, primary diagnosis codes that do NOT require Plan prior authorization when Plan criteria are met.)

   a. Chronic systolic heart failure, stable ≥ 6 weeks post hospital discharge; OR

   b. Coronary artery bypass grafting; OR

   c. Cardiac surgery; OR

   d. Heart failure; OR

   e. Heart or heart/lung transplantation; OR

   f. Hypertensive heart disease with chronic kidney disease; OR

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g. Hypertensive heart disease with heart failure; OR

h. Myocardial infarction; OR

i. Valve disorders, including repair or replacement surgery; OR

j. Percutaneous coronary intervention or angioplasty (PCI/PTCA) with or without stents; AND

4. The cardiac rehabilitation program meets ONE (1) of the following criteria for ECG monitoring, as specified below in item a or item b:

   a. The cardiac rehabilitation program is a physician-supervised exercise program with continuous ECG monitoring; OR

   b. The cardiac rehabilitation program includes an exercise program without continuous ECG monitoring and ALL of the following criteria are met, as specified below in items (1) through (4):

      (1) Before transitioning the member to an exercise program without continuous ECG monitoring, the first three (3) sessions will be conducted WITH continuous ECG monitoring and there is no adverse change in the member’s medical status; AND

      (2) The treating provider has determined that the member can safely continue the exercise program without continuous ECG monitoring; AND

      (3) The treating provider will use a graduated approach as part of the exercise program, assess the member’s risk with each session, and promote member self-monitoring of symptoms at each session; AND

      (4) The treating provider will use continuous ECG monitoring as soon as the member’s medical condition requires continuous monitoring or the member is at risk for an adverse event; AND

5. Program Criteria:

   The phase II cardiac rehabilitation program meets at least ONE (1) of the following criteria, as specified below in items a through c:

   a. Program is accredited by the American Academy of Cardiovascular and Pulmonary Rehabilitation (AACVPR) as a phase II cardiac rehabilitation program; OR

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b. Program is accredited by the Joint Commission Disease-Specific Care Certification for phase II cardiac rehabilitation; OR

c. The services are rendered as part of a comprehensive phase II cardiac rehabilitation program that is certified and includes ALL of the following program components, as specified below in items (1) through (8):

(1) **Prescribed by Physician:**

The phase II cardiac rehabilitation program must be prescribed by a physician, including the medical evaluation, risk factor modification, exercise program, treatment plan, and outcomes assessment. The progressive exercise program is based on the individual’s clinical status and physical capacity; AND

(2) **Medical Evaluation:**

BOTH of the following criteria must be met, as specified below in items (a) and (b):

(a) A medical evaluation must be conducted by the treating physician, and the physician has determined that the member is a candidate for phase II cardiac rehabilitation; AND

(b) The member’s condition does not include any of the contraindications included in the Limitations section of this policy; AND

(3) **Exercise Stress Test:**

ONE (1) of the following criteria are met, as specified below in item (a) or item (b):

(a) The treating provider has determined that the member may benefit from cardiac rehabilitation, but the member cannot safely perform an exercise stress test or a six (6)-minute walk test is used as a replacement; OR

(b) BOTH of the following criteria are met for exercise stress test, as specified below in items (1) and (2):

(1) A member must undergo an exercise stress test prior to entering a phase II cardiac rehabilitation program to determine if the member is an appropriate candidate for cardiac rehabilitation and to determine the type, duration, and frequency of exercise (if the member is determined to be an appropriate candidate for the program). When

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reviewing results of the exercise stress test, the Plan defines a low exercise workload as a metabolic equivalent of less than 5; see this policy’s Definitions section for the definition of exercise workload.

Note: Plan prior authorization is NOT required for the exercise stress test; AND

(2) The member did NOT experience ANY of the following signs and symptoms during the exercise stress test, as specified below in items i through vi:

i. Angina at low exercise workload; OR

ii. Malignant ventricular arrhythmias; OR

iii. Severe dyspnea at low exercise workload; OR

iv. Significant ischemia at low workload; OR

v. ST segmental changes at low exercise workload; OR

vi. Systolic blood pressure decreased during exercise; AND

(4) **Location of Care and Staff:**

ALL of the following criteria are met, as specified below in items (a) through (c):

(a) Cardiac rehabilitation services must be provided in a physician’s office or a hospital outpatient setting; AND

(b) A physician must be immediately available and accessible for medical consultations and emergencies at all times when services are provided to the member; AND

(c) The cardiac rehabilitation must be staffed by personnel trained to conduct the program safely and effectively; this includes staff training in basic and advanced life support and exercise therapy for members with coronary disease; AND

(5) **Risk Factor Assessment and Modification:**

The program includes an assessment of ALL of the member’s cardiac risk factors and a targeted goal with specified intervention(s) for each identified risk factor.
applicable for the member. Interventions will incorporate exercise training, member education, counseling, and behavior modification, as needed. Risk factors targeted for modification include the following when appropriate for the member, as specified below in items (a) through (i):

(a) Tobacco use/smoking cessation program; AND

(b) Blood pressure control; AND

(c) Lipid control; AND

(d) Physical activity habits and tolerance; AND

(e) Weight management; AND

(f) Blood glucose level; AND

(g) Depression and other psychosocial barriers to success; AND

(h) Stress management; AND

(i) Adherence to the prescribed, preventive medication regimen; AND

(6) **Physician-Prescribed Exercise:**

Exercise program includes aerobic exercise combined with other types of physical activity, such as strength training and stretching, as appropriate for the member’s medical condition and treatment goals and prescribed by the treating physician; AND

(7) **Treatment Plan:**

ALL of the following criteria are met, as specified below in items (a) through (c):

(a) A written, individualized treatment plan must be developed for the member based on the member’s diagnosis and medical condition and include the type, amount, frequency, and duration of cardiac rehabilitation services; AND

(b) The individualized treatment plan must include an initial assessment of the member’s condition using objective clinical measures and self-reported member assessment, and specific goals must be developed for the member; AND
(c) The treatment plan is reviewed by the physician as needed, but at least every 30 days; AND

(8) Outcome Assessment:

A written outcome assessment is developed at the conclusion of the program that documents the member’s progress using objective clinical measures and self-reported member assessment to determine the effectiveness of the program, as well as an assessment of the member’s status in relation to the program’s clinical exit criteria. Acceptable exit criteria include ALL of the following, as specified below in items (a) through (d):

(a) Symptoms of angina or dyspnea are stable at the patient’s maximum exercise level; AND

(b) The patient has achieved a stable level of exercise tolerance without ischemia or dysrhythmia; AND

(c) The patient’s resting blood pressure and heart rate are within normal limits; AND

(d) The stress test is not positive during exercise. (A positive stress test in this context implies an ECG with a junctional depression of 2 mm or more associated with slowly rising, horizontal, or down sloping ST segment).

Limitations

A. Requests for outpatient cardiac rehabilitation services provided as part of an intensive cardiac rehabilitation (ICR) program that is Centers for Medicare & Medicaid Services (CMS)-accredited through the national coverage determination process (as specified in the Description of Item or Service Section of this Plan policy) require Plan Medical Director review.

B. Limitations for outpatient, phase II cardiac rehabilitation services (that are not a component of a CMS intensive cardiac rehabilitation [ICR] program) include ANY of the following, as specified below in items 1 through 3:

1. Cardiac rehabilitation sessions extending beyond 18 weeks in duration will be denied as not medically necessary unless additional documentation of medical necessity is provided and authorized by the Plan; OR

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2. Contraindications to cardiac rehabilitation include but are not limited to ANY of the following medical conditions, as specified below in items a through o:

   a. Aortic stenosis, moderate to severe; OR

   b. Arrhythmia, uncontrolled; OR

   c. Atrial fibrillation, new onset; OR

   d. Congestive heart failure (CHF) with decompensation; OR

   e. Diabetes, uncontrolled; OR

   f. Dyspnea at rest; OR

   g. Dyspnea on exertion worsening during exercise over the past three (3) to five (5) days; OR

   h. Embolism that has recently occurred; OR

   i. Exercise tolerance progressively worsening which suggests an acute pathologic process; OR

   j. Fever or acute systemic illness; OR

   k. Ischemia, unstable or significant ischemia with low-level exercise; OR

   l. Myocardial infarction (MI) within the last three weeks; OR

   m. Pericarditis, acute; OR

   n. Third degree heart block without a pacemaker; OR

   o. Thrombophlebitis, acute; OR

3. Members less than eight (8) years old are not eligible for phase II cardiac rehabilitation programs.
Definitions

**Coronary Artery Bypass Graft (CABG) Surgery:** A surgical procedure using native veins or arteries to bypass blockages of coronary arteries to improve blood supply to the myocardium.

**Exercise Workload:** Exercise testing involves the measurement of total body work, including oxygen uptake. The metabolic equivalent of the task (MET) is used to clinically express a rate for the oxygen requirement of the exercise workload during an exercise test on a treadmill or cycle ergometer. Below are clinically meaningful METs for exercise, prognosis, and maximal performance.

<table>
<thead>
<tr>
<th>MET</th>
<th>Metabolic Equivalents for Maximum Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 MET</td>
<td>Resting</td>
</tr>
<tr>
<td>2 METs</td>
<td>Level walking at 2 m.p.h.</td>
</tr>
<tr>
<td>4 METs</td>
<td>Level walking at 4 m.p.h.</td>
</tr>
<tr>
<td>&lt; 5 METs</td>
<td>Poor prognosis; peak cost of basic activities of daily living</td>
</tr>
<tr>
<td>10 METs</td>
<td>Prognosis with medical therapy as good as coronary artery bypass surgery, unlikely to exhibit significant nuclear perfusion defect</td>
</tr>
<tr>
<td>13 METs</td>
<td>Excellent prognosis regardless of other exercise responses</td>
</tr>
<tr>
<td>18 METs</td>
<td>Elite endurance athletes</td>
</tr>
<tr>
<td>20 METs</td>
<td>World-class athletes</td>
</tr>
</tbody>
</table>

**Myocardial Infarction:** A condition caused by partial or complete blockage of one (1) or more of the coronary arteries, also known as a heart attack.

**Percutaneous Coronary Intervention (PCI) or Percutaneous Transluminal Coronary Angioplasty (PTCA):** A procedure where a small balloon tipped catheter is threaded into one (1) or more coronary arteries to reduce the blockage. The balloon is inflated to compress the plaque material against the wall of the artery to increase blood flow. Often, this procedure is accompanied by stent placement to keep the artery open.

**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 Stated 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). Because 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

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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 Medical Policy Statement section and Limitation section 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 the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

| ICD-9 Diagnosis Codes | Description: No prior authorization is required for the following waived, primary diagnosis codes for phase II cardiac rehabilitation that is electrocardiographically monitored when Plan criteria are met (as specified in this policy) and the service is billed with CPT code 93797 or CPT code 93798. The waived, primary diagnosis code must be specified on the claim form with the covered procedure code.

(Plan note: To waive the prior authorization requirement, phase II cardiac rehabilitation with continuous ECG monitoring must be billed with the applicable covered service CPT code specified below [and excludes experimental and investigational CPT codes and HCPCS codes listed below].)

| 394.0-397.9 | Disease of the mitral valve, aortic valve, or other endocardial structures |
| 398.91 | Rheumatic heart failure (congestive type) |
| 402.01 | Hypertensive heart disease, malignant, with heart failure |
| 402.11 | Hypertensive heart disease, benign, with heart failure |
| 402.91 | Hypertensive heart disease, unspecified, with heart failure |
| 404.01 | Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified |
| 404.03 | Hypertensive heart and chronic kidney disease, malignant, with heart failure and chronic kidney disease stage V or end stage renal disease |
| 404.11 | Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified |
| 404.13 | Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage V or end stage renal disease |
| 404.91 | Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified |
| 404.93 | Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage V or end stage renal disease |

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| ICD-10 Diagnosis Codes | Description: No prior authorization is required for the following waived, primary diagnosis codes for phase II cardiac rehabilitation that is electrocardiographically monitored when Plan criteria are met (as specified in this policy) and the service is billed with CPT code 93797 or CPT code 93798. The waived, primary diagnosis code must be specified on the claim form with the covered procedure code. (Plan note: To waive the prior authorization requirement, phase II cardiac rehabilitation with continuous ECG monitoring must be billed with the applicable covered service CPT code specified below [and excludes experimental and investigational CPT codes and HCPCS codes listed below].)

<p>| 410.00-414.9 | Myocardial infarction, angina pectoris, and ischemic heart disease |
| 424.0-424.3 | Valve disorders |
| 427.5 | Cardiac arrest |
| 428.0-428.9 | Heart failure |
| 429.4 | Functional disturbances following cardiac surgery |
| V42.1 | Organ or tissue replaced by transplant, heart |
| V42.2 | Organ or tissue replaced by transplant, heart valve |
| V42.6 | Organ or tissue replaced by transplant, lung |
| V42.89 | Organ or tissue replaced by transplant, other |
| V43.21 | Organ or tissue replaced by other means, heart assist device |
| V43.22 | Organ or tissue replaced by other means, fully implantable artificial heart |
| V43.3 | Organ or tissue replaced by other means, heart valve |
| V45.81 | Postprocedure status, aortocoronary bypass status |
| V45.82 | Postprocedure status, percutaneous transluminal coronary angioplasty status |
| I05.0-I08.9 | Rheumatic valve diseases |
| I09.1 | Rheumatic diseases of endocardium, valve unspecified |
| I11.0 | Hypertensive heart disease with heart failure |
| I13.0 | Hypertensive heart and chronic kidney disease with heart failure |
| I13.2 | Hypertensive heart and chronic kidney disease with heart failure |
| I20.0-I20.9 | Angina pectoris |
| 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 |
| I24.0-I24.9 | Other acute ischemic heart disease |
| I25.10-I25.119 | Atherosclerotic heart disease of native coronary artery |
| I25.2 | Old myocardial infarction |
| I25.3 | Aneurysm of heart |
| I25.41-I25.42 | Coronary artery aneurysm or dissection |</p>
<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>I25.6</td>
<td>Silent myocardial ischemia</td>
</tr>
<tr>
<td>I25.700-I25.799</td>
<td>Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris</td>
</tr>
<tr>
<td>I25.81-I25.89</td>
<td>Other forms of chronic ischemic heart disease</td>
</tr>
<tr>
<td>I25.9</td>
<td>Chronic ischemic heart disease, unspecified</td>
</tr>
<tr>
<td>I34.0-I37.9</td>
<td>Nonrheumatic valve disorders</td>
</tr>
<tr>
<td>I46.2-I46.9</td>
<td>Cardiac arrest</td>
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<tr>
<td>I50.1-I50.9</td>
<td>Heart failure</td>
</tr>
<tr>
<td>I97.0</td>
<td>Postcardiotomy syndrome</td>
</tr>
<tr>
<td>I97.110</td>
<td>Postprocedural cardiac insufficiency following cardiac surgery</td>
</tr>
<tr>
<td>I97.120</td>
<td>Postprocedural cardiac arrest following cardiac surgery</td>
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<tr>
<td>I97.130</td>
<td>Postprocedural heart failure following cardiac surgery</td>
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<tr>
<td>Z94.1</td>
<td>Heart transplant status</td>
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<tr>
<td>Z94.3</td>
<td>Heart and lungs transplant status</td>
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<tr>
<td>Z95.0-Z95.5</td>
<td>Presence of cardiac implants and grafts</td>
</tr>
<tr>
<td>Z95.811-Z95.818</td>
<td>Presence of other cardiac implants and grafts</td>
</tr>
<tr>
<td>Z98.61</td>
<td>Coronary angioplasty status</td>
</tr>
</tbody>
</table>

**CPT Code**

**Description:** Covered service for phase II cardiac rehabilitation services billed no more than one (1) unit per day. See the list of diagnosis codes that do NOT require prior authorization when billed with this procedure code (and Plan medical criteria are met).

- **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)

**HCPCS Code**

**Description:** Covered service for CMS-certified intensive cardiac rehabilitation (ICR) programs. Prior authorization is required for ALL diagnosis codes for ICR services.

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

  *(Plan note: Plan Medical Director review is required for this service.)*

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

  *(Plan note: Plan Medical Director review is required for this service.)*
Clinical Background Information

Cardiac rehabilitation is a comprehensive, long-term program that involves medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Cardiac rehabilitation programs have been introduced as a means of recovery from MI, PCI/PTCA, CABG, heart valve surgery, heart and heart-lung transplant surgery, and in patients with stable angina and stable heart failure. The goals of cardiac rehabilitation programs are to improve exercise tolerance, cardiac symptoms, blood lipid levels, and psychosocial well-being, and to reduce cardiovascular risk and associated mortality. The frequency and duration of the program generally does not exceed 36 sessions, occurring 2-3 times per week for 12-18 weeks. Cardiac rehabilitation is generally a safe program with a few associated complications that can include exercise induced ventricular arrhythmia, dyspnea, cardiac arrest, and MI. There are four (4) phases of cardiac rehabilitation.

1. Phase I: The inpatient program that typically begins as soon as the patient is medically stable following a cardiac event or procedure that involves a progressive exercise program, risk factor modification, and education.

2. Phase II: A hospital-based, outpatient program that is usually initiated within a few weeks following hospital discharge that consists of ECG monitoring, supervised exercise, risk factor modification, and education.

3. Phase III: A community or home-based, outpatient program that continues after discharge from phase II that provides a long-term program of unsupervised exercise and risk factor modification.

4. Phase IV: A home-based, life-long outpatient maintenance program that consists of routine exercise and risk factor modification.

References


American Heart Association (AHA) and American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) Scientific Statement. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs. Accessed at: http://circ.ahajournals.org/content/102/9/1069.full

Balady GJ et al.; American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; American Heart Association Council on Cardiovascular Nursing; American Heart Association Council on Epidemiology and Prevention; American Heart Association Council on Nutrition, Physical Activity, and Metabolism; American Association of Cardiovascular and Pulmonary Rehabilitation. 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 on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. Circulation. 2007 May 22; 115(20):2675-82.


Cardiac Rehabilitation, Outpatient

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Thomas RJ, King M, Lui K, Oldridge N, Piña IL, Spertus J. AACVPR/ACCF/AHA 2010 Update: Performance Measures on Cardiac Rehabilitation for Referral to Cardiac Rehabilitation/Secondary Prevention Services Endorsed by the American College of Chest Physicians, the American College of Sports Medicine, the American Physical Therapy Association, the Canadian Association of Cardiac Rehabilitation, the Clinical Exercise Physiology Association, the European Association for Cardiovascular Prevention and Rehabilitation, the Inter-American Heart Foundation, the National Association of Clinical Nurse Specialists, the Preventive Cardiovascular Nurses Association, and the Society of Thoracic Surgeons. J Am Coll Cardiol. 2010 Sep 28; 56(14):1159-67.


West RR, Jones DA, Henderson AH. Rehabilitation after myocardial infarction trial (RAMIT): multicenter randomised controlled trial of comprehensive cardiac rehabilitation in patients following acute myocardial infarction. Heart 2012; 98(8):637-44.


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<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>12/03/06 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>Quality and Clinical Management Committee (Q&amp;CMC)</td>
</tr>
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<td>Internal Approval: 10/03/06</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13

**Policy Revisions History**

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/11/07</td>
<td>Updated template, added coding.</td>
<td>Version 2</td>
<td>09/11/07: MPCTAC 09/25/07: Utilization Management Committee (UMC) 10/15/07: QIC</td>
</tr>
<tr>
<td>09/09/08</td>
<td>No changes.</td>
<td>Version 3</td>
<td>09/09/08: MPCTAC 09/30/08: UMC 10/22/08: QIC</td>
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<tr>
<td>08/25/09</td>
<td>No changes to the criteria, updated coding (removed S0340 and S0341 from the policy because these codes are not applicable).</td>
<td>Version 4</td>
<td>08/25/09: MPCTAC 08/25/09: UMC 09/23/09: QIC</td>
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<tr>
<td>09/01/10</td>
<td>Minor formatting changes, removed visit limitation, updated references and coding.</td>
<td>Version 5</td>
<td>09/15/10: MPCTAC 10/27/10: QIC</td>
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<tr>
<td>05/05/11</td>
<td>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.</td>
<td>Version 6</td>
<td>05/04/11: UMC</td>
</tr>
<tr>
<td>09/01/11</td>
<td>Updated criteria to indicate that cardiac rehabilitation is considered medically necessary within 26 weeks</td>
<td>Version 7</td>
<td>09/21/11: MPCTAC 11/29/11: QIC</td>
</tr>
</tbody>
</table>

Cardiac Rehabilitation, Outpatient

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<th>Reviewing Committee(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/01/12</td>
<td>Off cycle review for Well Sense Health Plan, revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introduction, revised Limitations.</td>
<td>Version 8</td>
<td>08/17/12: MPCTAC 09/06/12: QIC</td>
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<tr>
<td>09/01/12</td>
<td>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.</td>
<td>Version 9</td>
<td>09/19/12: MPCTAC 10/24/12: QIC</td>
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<tr>
<td>12/01/12</td>
<td>Revised Summary section to clarify that phase II cardiac rehabilitation is conducted in the outpatient setting.</td>
<td>Version 10</td>
<td>12/19/12: MPCTAC 01/31/13: QIC</td>
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<tr>
<td>12/01/13</td>
<td>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.</td>
<td>02/01/14 Version 11</td>
<td>12/18/13: MPCTAC 01/22/14: QIC</td>
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<tr>
<td>01/30/14</td>
<td>Off cycle review for effective date 04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.</td>
<td>04/01/14 Version 12</td>
<td>01/27/14: MPCTAC 01/30/14: QIC</td>
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<tr>
<td>07/01/14</td>
<td>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</td>
<td>08/01/14 Version 13</td>
<td>07/21/14: MPCTAC (electronic vote) 07/24/14: QIC (electronic vote)</td>
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<tr>
<td>12/01/14 and 01/01/15</td>
<td>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.</td>
<td>05/01/15 Version 14</td>
<td>12/24/14: MPCTAC (electronic vote) 01/21/15: MPCTAC 02/14/15: QIC</td>
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<tr>
<td>10/01/15</td>
<td>Review for effective date 12/01/15. Updated list of applicable products and corresponding notes. Updated References section.</td>
<td>12/01/15 Version 15</td>
<td>10/21/15: MPCTAC 11/11/14: QIC</td>
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<tr>
<td>11/25/15</td>
<td>Review for effective date 01/01/16. Revised language in the Applicable Coding section.</td>
<td>01/01/16 Version 16</td>
<td>11/25/15: MPCTAC (electronic vote) 12/09/15: QIC</td>
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### Last Review Date

11/25/15

### Next Review Date

10/01/16

### Authorizing Entity

QIC

### Other Applicable Policies

- Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
- Medical Policy - *Medically Necessary*, policy number OCA 3.14
- Reimbursement Guidelines - *General Billing and Coding Guidelines*, policy number SCO 4.31
- Reimbursement Guidelines - *Outpatient Hospital*, policy number SCO 4.17
Reference to Applicable Laws and Regulations


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 accreditating 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 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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