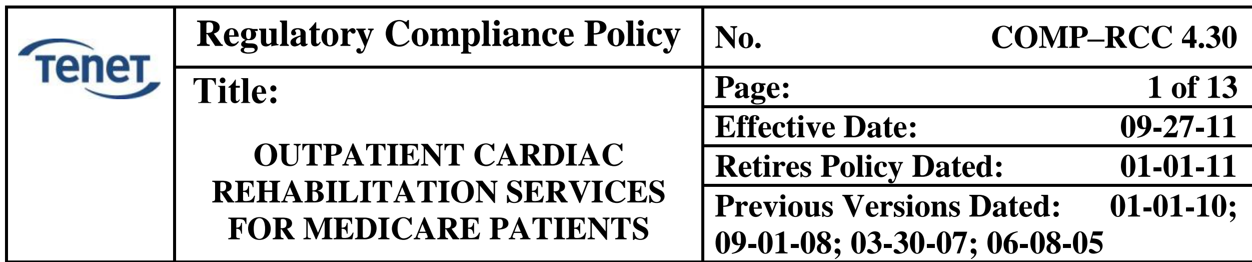


Tenet	Regulatory Compliance Policy	No. COMP–RCC 4.30
	Title:	**Page: 1 of 13**
	OUTPATIENT CARDIAC REHABILITATION SERVICES FOR MEDICARE PATIENTS	**Effective Date: 09-27-11**
		Retires Policy Dated: 01-01-11
		Previous Versions Dated: 01-01-10; 09-01-08; 03-30-07; 06-08-05

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the facility (a "Tenet Facility") (collectively, "Tenet").

II. PURPOSE:

The purpose of this policy is to ensure that outpatient cardiac rehabilitation services provided to Medicare patients are billed to the Medicare program in accordance with applicable regulations and guidance.

III. DEFINITIONS:

A. "**Cardiac Rehabilitation**" means a physician-supervised program that furnishes Physician-prescribed Exercise, cardiac risk factor modification, Psychosocial Assessment, and Outcomes Assessment.

B. "**Individualized Treatment Plan**" means a written plan tailored to each individual patient that includes all of the following:

1. a description of the individual's diagnosis;

2. the type, amount, frequency, and duration of the items and services furnished under the plan; and

3. the goals set for the individual under the plan.

C. "**Intensive Cardiac Rehabilitation Program**" means a physician-supervised program that furnishes Cardiac Rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements.

D. "**Medical Director**" means a physician that oversees or supervises the Cardiac Rehabilitation or Intensive Cardiac Rehabilitation program at a particular site.

E. "**Outcomes Assessment**" means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following:

1. Assessments from the commencement and conclusion of Cardiac Rehabilitation and Intensive Cardiac Rehabilitation, based on patient-centered outcomes which must be measured by the physician immediately at the beginning of the program and at the end of the program; and

2. Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

F. "**Physician-prescribed Exercise**" means aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual patients by a physician.

G. "**Psychosocial Assessment**" means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

IV. POLICY:

Each Tenet Facility shall ensure that its cardiac rehabilitation services for Medicare patients meet the requirements set forth in this policy, which are the minimum requirements applicable to Medicare patients. The Tenet Facility may set forth additional requirements as it sees fit. In addition, the Tenet Facility shall ensure that its cardiac rehabilitation program meets the requirements of any applicable state law, The Joint Commission, or other licensing or accreditation authorities. This policy does not address the requirements set forth, for example, by state law, state Medicaid programs, managed care agreements, workers' compensation programs or other programs which may impose additional medical necessity, documentation, supervision or other requirements, to which the Tenet Facility must adhere if it provides cardiac rehabilitation to those beneficiaries.

V. PROCEDURE:

A. General Requirements

1. Covered Patient Populations. Under Medicare, outpatient cardiac rehabilitation services are covered only for patients with a clear medical need, who are referred by a physician, and have:

a. a documented diagnosis of acute myocardial infarction within the preceding 12 months,

b. have had a coronary artery bypass graft surgery within the preceding 6 months,

c. have current **stable** angina pectoris, as evidenced by a pre-entry stress test positive for exercise-induced ischemia within six months of starting cardiac rehabilitation;

d. have had heart valve repair/replacement within the preceding 6 months;

e. have had percutaneous transluminal coronary angio-plasty (PTCA) or coronary stenting within the preceding 6 months; or

f. have had a heart or heart-lung transplant within the past 12 months.

2. Minimum Components of a Cardiac Rehabilitation Program. Cardiac Rehabilitation programs must include all of the following:

a. Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished;

b. Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to the patients' individual needs;

c. Psychosocial Assessments, as described in Section III.G.;

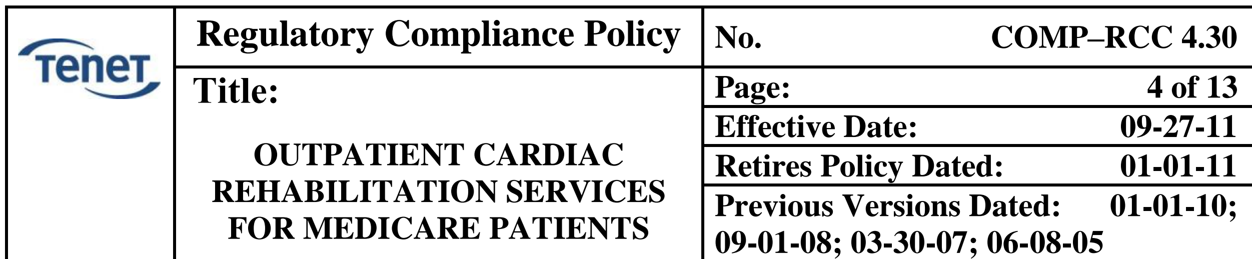
d. Outcomes Assessments, as described in Section III.E.; and

e. An Individualized Treatment Plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

*Intensive Cardiac Rehabilitation programs must include the same components; however, all such programs must be approved by the Centers for Medicare and Medicaid Services (CMS) prior to providing services. To the extent that a Tenet Facility wishes to establish an Intensive Cardiac Rehabilitation program, please contact your Regulatory Counsel for assistance.

3. Physician's Order. The services and supplies must be furnished on a physician's order by hospital personnel who are under a physician's supervision. This does not mean that each occasion of cardiac rehabilitation services provided by non-physician personnel need also be the occasion of the actual rendition of a personal professional service by a physician. However, during any course of treatment rendered by auxiliary personnel,[1] a physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment.

[1] "Auxiliary personnel" means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor or the physician, of the legal entity (hospital) that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee, or independent contractor of the legal entity (hospital) billing and receiving payment for the services or supplies.



4. Phases. Medicare and the U.S. Public Health Service designate cardiac rehabilitation in three phases. These include:

a. Phase I – Acute convalescent period following cardiac event;

(1) considered part of hospital stay; and

(2) covered as part of DRG allowance for hospital stay.

b. Phase II – Outpatient Medically Supervised Program;

(1) a comprehensive long-term program including medical evaluation, physician-prescribed exercise each day cardiac rehabilitation services are provided, modification of cardiac risk factors, a psychosocial assessment, an outcomes assessment, and an individualized treatment plan (see Section V.A.2.);

(2) initiated 1-3 weeks after hospital discharge and provides appropriate electrocardiographic monitoring that is directed by a physician who is on-site; and

(3) may be conducted in specialized freestanding cardiac rehabilitation facility or hospital outpatient department.

(4) TrailBlazer Health Enterprises divides Phase II into Phase IIA and Phase IIB:

(a) Phase IIA is the initial outpatient cardiac rehabilitation, not to exceed a total of 2-3 times per week over 12-18 weeks.

(b) Phase IIB consists of an additional series of 36 sessions, 2-3 time per week for 12-18 weeks and will only be allowed if determined to be medically necessary.

Note: Only Phase II is reimbursed by Medicare and the only phase covered in this policy.

c. Phase III – Begins after completion of Phase II;

(1) is a less intensively monitored aerobic exercise program;

(2) is not covered by Medicare because it is considered maintenance.

B. Tenet Facility Implementation

The Tenet Facility shall ensure that Cardiac Rehabilitation services provided to Medicare patients meet all of the following requirements. If state law imposes additional requirements, the hospital shall ensure that its cardiac rehabilitation program meets those requirements in addition to the following:

1. Medical Director Requirement. All Cardiac Rehabilitation programs must have a Medical Director who meets the following criteria:

   a. Expertise in the management of individuals with cardiac pathophysiology;

   b. Cardiopulmonary training in basic life support or advanced cardiac life support; and

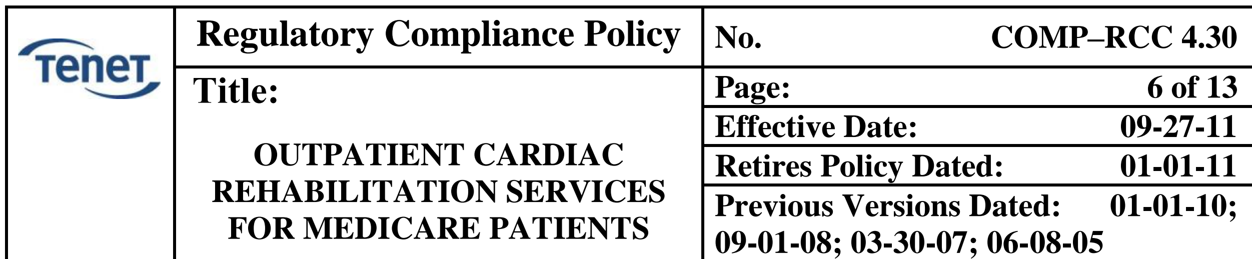
   c. Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

2. Direct Physician Supervision. All Cardiac Rehabilitation services must be provided under direct physician supervision.

   a. For Cardiac Rehabilitation services provided in the hospital, or in a provider based department of the hospital, ‘‘direct supervision’’ means that the physician must be immediately available to furnish assistance and direction throughout the performance of the procedure. CMS has indicated that the physician needs to be physically present, interruptible, and available “without interval of time.” It does not mean that the Supervising Physician must be present in the room or within the provider based department when the procedure is performed.

   b. The Tenet Facility must ensure that there is adequate documentation of physician supervision during the time when Medicare patients are receiving services. This record must be made available to Medicare upon request.

      Because this Supervising Physician will be providing services at the request of the Tenet Facility and on the Tenet Facility’s behalf, the Tenet Facility may choose to employ or contract with the Supervising Physician. To the extent that this relationship creates a financial arrangement with the Supervising Physician, please see Law Department policies L-10 Physician Employment Arrangements or L-5 Personal Service Arrangements.



c. The Supervising Physician may be the Cardiac Rehabilitation Program Medical Director, an employed physician or another physician who has privileges at the Tenet Facility and with whom the Tenet Facility contracts to provide direct physician supervision as required by this policy. Non-physician practitioners cannot fulfill the direct physician supervision requirement for Cardiac Rehabilitation services.

d. In any event, the Supervising Physician must meet the following criteria:

(1) Expertise in the management of individuals with cardiac pathophysiology;

(2) Cardiopulmonary training in basic life support or advanced cardiac life support; and

(3) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

3. Physician Care. The Tenet Facility shall ensure that each Medicare cardiac rehabilitation patient is under the care of a physician who personally sees the patient periodically and sufficiently often to assess the course of treatment. The Tenet Facility shall ensure each patient's record supports the following:

a. Patient's progress notes that document the course of treatment and the patient's progress; and

b. The physician is actively involved in the management of the patient's care. It would not be sufficient if the attending physician merely wrote an order for the services or supplies and referred the patient to the Tenet Facility without being further involved in the management of that course of treatment.

CMS has not defined "periodically and sufficiently often," nor has it provided clear guidance as to which physician and where, or how often physician encounters are required. The Tenet Facility should establish processes to ensure adequate physician oversight and ensure that the medical record contains documentation that demonstrates the occurrence of and/or the outcomes of physician management.

4. Medical Necessity. Medicare patients must meet medical necessity criteria for participation in the Phase II cardiac rehabilitation program in order for

the hospital to bill and be reimbursed for outpatient cardiac rehabilitation services. Clearance for Medicare patients is established by documenting an initial screening assessment performed by the Supervising Physician and/or the attending or referring physician responsible for prescribing the patient's Phase II cardiac rehabilitation program. If the initial screening examination is performed by the attending or referring physician in his or her office, the Tenet Facility shall obtain a copy of the documentation and place it in the medical record. The initial screening assessment must include the following:

a. clinical exam;

b. medical history review;

c. diagnosis;

d. review of available ancillary information and studies; and

e. the initial exercise plan, goals, and order/prescription.

5. Duration of Cardiac Rehabilitation. Medicare coverage may include:

a. a maximum of 2-3, 1-hour sessions per day for up to 36 sessions over up to 36 weeks.

Note: While Medicare allows for up to 36 sessions, all patients must be evaluated to determine if they benefit from the full program because not all patients may need 36 sessions. The evaluation and assessment of progress or lack there of must be documented by the physician.

b. Additional coverage is allowed only on a case-by-case basis taking into consideration exit criteria. Under no circumstances will coverage be extended beyond an additional 36 sessions.

c. Exit criteria include, but are not restricted to, the following parameters:

(1) patient has achieved stable level of exercise tolerance without ischemia or dysrhythmia;

(2) symptoms of angina or dyspnea are stable at the patient's maximum exercise level;

(3) the patient's resting blood pressure and heart rate are within normal limits;

(4) cardiac stress test is not positive during exercise[2]; Medicare will cover one cardiac stress test, if indicated, after 3 months (usually at the completion of the program);

(5) for patients with valvuloplasty or valve replacement, benefits are available for Phase IIA only;

(6) for post-transplant patients, peak oxygen consumption of greater than 90 percent predicted. Patients whose peak oxygen consumption is less than 90 percent predicted may qualify for the additional Phase IIB.

d. Requests for extensions of Cardiac Rehabilitation services beyond 36 sessions over up to 36 weeks must be submitted to the Medicare Administrative Contractor for consideration and approval. Each request must be submitted in writing by the attending physician and must contain all supporting documentation.

6. CPR Training for Staff. The program shall be staffed by personnel necessary to conduct the program safely and effectively who are trained in basic and advanced life support techniques and in exercise therapy for coronary disease.

7. CPR Team. During the hours of operation of the cardiac rehabilitation program, a cardiopulmonary resuscitation team must be available to respond and to be able to provide ACLS should a complication occur. The facility must explicitly describe, in a written policy, their incident response plan that assures a trained emergency response team (which includes a physician) is available to provide for the availability of intensity of care services that are needed to ensure the patient's safety should a complication occur. The Emergency Department may provide this coverage.

8. Equipment. The Tenet Facility shall ensure that the cardiac rehabilitation program area has available for immediate use all necessary cardiopulmonary emergency diagnostic and therapeutic life-saving equipment and supplies accepted by the medical community as medically necessary, *e.g.,* oxygen, cardiopulmonary resuscitation equipment; or defibrillator.

[2] A positive test in this context implies an EKG with a junctional depression of 2mm or more associated with slowly rising, horizontal or down sloping ST segment.

C. Billing Requirements

1. Documentation. For all Medicare patients participating in the Cardiac Rehabilitation program the following must be appropriately and legibly documented in the patient's medical record:

    a. Physician's prescription or order for the Cardiac Rehabilitation program must;

        (1) be dated;

        (2) be timed (when required by law);

        (3) be signed by the ordering physician;

        (4) include physician's diagnosis;

        (5) include date of onset or event; and

        (6) have documentation to support the diagnosis.

    b. Physician's evaluation of patient's clinical status indicating the qualifying event for cardiac rehabilitation, and a statement that it is safe for the patient to participate in a progressive exercise program;

    c. Outcomes Assessments performed by the physician, as defined in Section III.E;

    d. Individualized Treatment Plan that is established, reviewed, and signed by the physician every 30 days.

    e. Physician's progress notes;

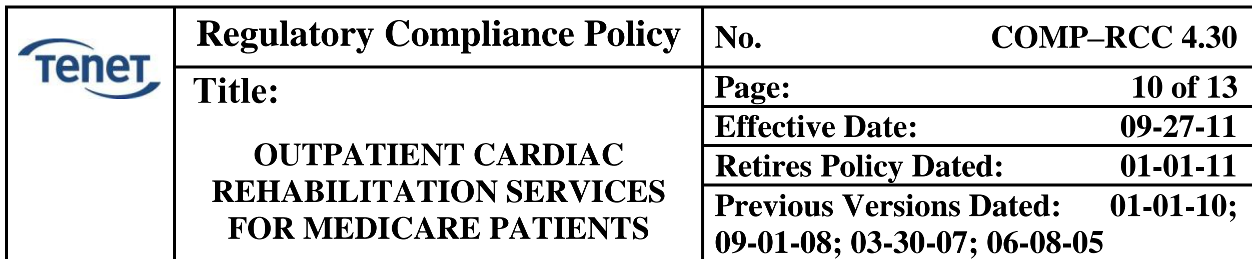
    f. Cardiac risk factor modifications, as described in Section V.A.2.b., indicating the physician's personal involvement in ongoing treatment and assessment of the patient's progress, or lack thereof, and the need for ongoing sessions;

    g. Psychosocial Assessment, as described in Section III.G;

    h. Start of care date;

    i. Most recent history and physical;

    j. EKG strips, or if billing CPT Code 93798 documentation that indicates the patient is receiving continuous EKG monitoring;



k. Number of sessions to date;

l. Individual session notes for each day of service provided;

m. Documentation to support date of occurrence of myocardial infarction (within last 12 months) when billing ICD-9 code 412.

2. Covered Diagnoses. Medicare limits its coverage of cardiac rehabilitation to certain diagnoses. Any diagnosis that does not appear on this list does not support Medicare's medical necessity for cardiac rehabilitation. The ICD-9 codes that support Medicare's medical necessity for cardiac rehabilitation include:

a. 410.00-410.92 Myocardial Infarction;

b. 412 Old Myocardial Infarction (NOTE: ICD-9-CM code 412 refers to an MI that has occurred more than eight weeks prior to cardiac rehabilitation services, but within the past 12 months);

c. 413.00-413.9 Angina Pectoris;

d. V42.1 Heart Replaced By Transplant;

e. V42.2 Heart Valve Replaced By Transplant;

f. V42.89 Organ or tissue replaced by transplant (NOTE: Use for heart-lung transplant);

g. V43.3 Heart Valve Replaced By Other Means;

h. V45.81 Coronary Artery Bypass Surgery (CABG);

i. V45.82 Percutaneous Transluminal Coronary Angioplasty; and

j. V58.73 Aftercare following surgery of the circulatory system not elsewhere classified.

The medical records must contain documentation in support of the diagnostic code.

For angina, all patients must have a pre-entry stress test that is positive for exercise-induced ischemia within six months of starting cardiac rehabilitation (see "Group II Services" below). A positive stress test in this context implies a junctional depression of 2 mm or more with associated slowly rising ST segment, or 1 mm horizontal or downsloping ST segment depressions. Over the

years, nuclear perfusion studies have supplanted standard Electrocardiogram (ECG) treadmill tests as a means of evaluating ischemic heart disease, especially for patients who have abnormal rest ECGs. Therefore, the positive stress test also includes perfusion studies that demonstrate ischemia.

4. Routine visits must include one or more of the following “Group I Services:”

   a. Continuous EKG telemetric monitoring during exercise;

   b. EKG rhythm strip with interpretation and physician’s revision of exercise prescription; or

   c. Limited examination for physician follow-up to adjust medication or other treatment changes.

5. “Group II Services”

   a. One comprehensive evaluation is allowed and separately payable at the beginning of the program if not already performed by the patient’s attending physician, or if the evaluation performed by the patient’s attending physician is not acceptable to the program’s director. An assessment performed by a nurse or other personnel does not meet this requirement. Such services are considered routine and are not billable to Medicare.

   b. ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report. One will be allowed at the beginning of the program and one after three months (usually the completion of the program).

   c. Other physician services, as needed.

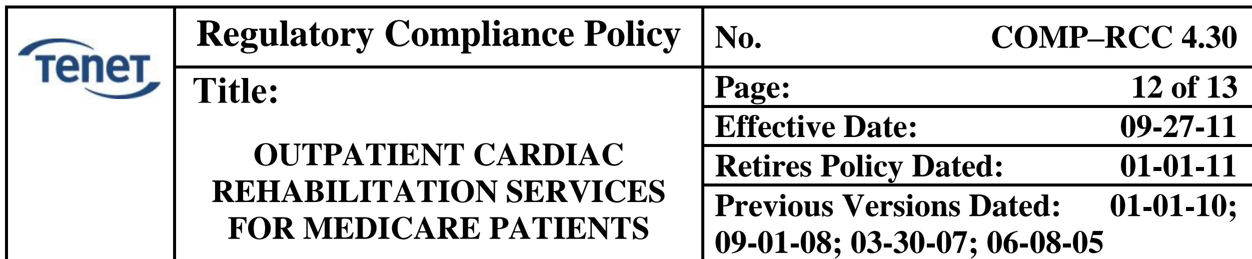
6. Phase III Services are not covered.

7. All bill types (13X, 85X) must indicate the number of units billed. Each cardiac rehabilitation session is considered one unit of service.

8. Utilize CPT Codes 93797 or 93798.

9. Coders must follow all applicable Coding Clinic guidelines when assigning ICD-9 Codes to the encounters.

10. The revenue code for cardiac rehabilitation is 943.



11. If the services are provided in an off-site location and are being billed as hospital services, the off-site location must meet the requirements under Tenet's policy for provider-based entities (see Regulatory Compliance policy COMP-RCC 4.29 Provider-Based Status Determination).

D. Responsible Person

Each Tenet Facility's Rehabilitation Services Director shall be responsible for assuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Facility, and that instances of noncompliance with this policy are reported to the Hospital Compliance Officer.

E. Auditing and Monitoring

Tenet's Audit Services Department shall audit adherence to this policy during its routine audits. Tenet's Quality Management Department shall monitor compliance with this policy during the Comprehensive Clinical Audit process.

G. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- 42 CFR § 410.27

- 42 CFR § 410.26(a) (2)

- 42 CFR § 410.32 (b) (3) (ii)

- 42 CFR § 410.49

- CMS Publication 100-03 Medicare National Coverage Determinations Manual, Chapter 1, § 20.10

- CMS Publication 100-04 Medicare Claims Processing Manual, chapter 32, § 140

- TrailBlazer Health Enterprises, LLC Local Coverage Decision L26504

- CMS Publication 100-002 Medicare Beneficiary Policy Manual Chapter 6, section 20.5.

- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) §144(a)

- 2011 Medicare Physician Fee Schedule; 75 FR 73170 (November 29, 2010)

- Law Department policy L-5 Personal Service Arrangements

- Law Department policy L-10 Physician Employment Arrangements

- Regulatory Compliance policy COMP-RCC 4.29 Provider-Based Status Determination

- Regulatory Compliance policy COMP-RCC 4.36 Supervision of Outpatient Diagnostic and Therapeutic Services