# Medical Necessity Guideline

| Medical Necessity Guideline (MNG) Title: Cardiac Rehabilitation | | |
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| **MNG #: 52** | **☒SCO ☒One Care** | **Prior Authorization Needed? ☒Yes ☐No** |
| **Clinical: ☒** | **Operational: ☒** | **Informational: ☒** |
| **Medicare Benefit: ☒Yes ☐No** | **Approval Date:** 3/4/2021 | **Effective Date:** 05/22/2021 |
| **Last Revised Date:** | **Next Annual Review Date:** 03/04/2022 | **Retire Date:** |

**OVERVIEW:**

Cardiac rehabilitation is a professionally supervised program to help members recover from heart attacks, heart surgery, and percutaneous coronary interventions such as stenting and angioplasty. Cardiac rehabilitation helps members with heart disease enhance their health and physical abilities. While exercise is an important component of cardiac rehabilitation, education and counseling are additional features of this service. Effective cardiac rehabilitation helps members recover from a cardiac event and learn to successfully manage their heart condition.

Cardiac rehabilitation occurs in four phases:

1. Phase I (Inpatient Rehabilitation) - in the hospital. The goal of Phase I cardiac rehabilitation is to ensure members are physically and mentally able to be discharged
2. Phase II (Outpatient Rehabilitation) - in an outpatient setting with electrocardiographic (ECG) monitoring. The goal of Phase II is to establish exercise practices for members which are safe and effective for their cardiac health. Plans are then made to strengthen their cardiac health beyond supervised rehabilitation
3. Phase III - occurs in an outpatient facility for up to 12 months after a cardiac event. ECG monitoring is not typical during this rehabilitation stage and supervision is less strict than in Phase II.
4. Phase IV - is a long-term change in lifestyle that begins in and then follows the earlier stages of cardiac rehabilitation. Follow-up visits may occur during Phase IV to ensure continued adherence to the program of healthier diet, exercise, and lifestyle choices.

**DECISION GUIDELINES:**

**Clinical Eligibility:**

Phase II Cardiac Rehabilitation is medically necessary for select members when it is initially prescribed by a physician and any of the following have occurred within the preceding 24 months:

- Acute myocardial infarction (MI)
- Coronary artery bypass surgery (CABG)
- Percutaneous coronary vessel remodeling (i.e. angioplasty, atherectomy, stenting)
- Valve replacement or repair
- Heart Transplantation or heart-lung transplantation
- Sustained ventricular tachycardia or fibrillation,

- Survivor of sudden cardiac death
- Diagnosis of inoperative or difficult to manage coronary artery disease with symptoms of angina pectoris, which prevents the patient from functioning adequately to meet home or occupational needs (particularly with modifiable coronary risk factors or poor exercise tolerance)
- Placement of a ventricular assist device
- Major pulmonary surgery; Great vessel surgery; MAZE arrhythmia surgery
- Class III or IV congestive heart failure (CHF)

**Determination of need:**
Additional cardiac rehabilitation services may be considered medically necessary based on the above listed criteria when an individual has a repeat occurrence of any of the covered conditions.

**LIMITATIONS/EXCLUSIONS:**
Cardiac rehabilitation can be authorized for up to a maximum of 36 sessions over a 12-week time period.

Phase III and IV programs are not considered medically necessary because they are self-directed and do not require medical supervision. In other words, our members may complete these programs themselves when they wish. These are not CCA covered services, these services are not paid for, and these do not require prior authorization.

Cardiac rehabilitation programs are not recommended and are considered unsafe or experimental for individuals with coronary artery disease (CAD) who have the following conditions:

- Acute pericarditis or myocarditis; or
- Acute systemic illness or fever; or
- Forced expiratory volume less than 1 liter; or
- Moderate to severe aortic stenosis; or
- New-onset atrial fibrillation; or
- Progressive worsening of exercise tolerance or dyspnea at rest or on exertion within the previous week; or
- Recent embolism or thrombophlebitis; or
- Significant ischemia at low work rates (less than 2 METs, or metabolic equivalents); or
- Third-degree heart block without pacemaker

**KEY CARE PLANNING CONSIDERATIONS:**
Below are criteria for determining when a member is able to leave a cardiac rehabilitation program:

- Patient has achieved a stable level of exercise tolerance without ischemia or dysrhythmia; and
- Symptoms of angina or dyspnea are stable at the patient's maximum exercise level; and
- Patient's resting blood pressure and heart rate are within normal limits; and

- The stress test shows no ischemia during exercise.

**AUTHORIZATION:** Cardiac Rehabilitation requires an authorization with the following codes listed below:

**CPT Codes:**
93797 - Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)

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**HCPCS Codes:**
S9472 - Cardiac rehabilitation program, non-physician provider, per Diem

**REGULATORY NOTES:**
Covered by Medicare

**RELATED REFERENCES:**

This DST guide is not a rigid rule. CCA has the mission to address all of our complicated members' health needs. Care partners can identify members with Behavioral Health and HOPE (*) challenges who may benefit from extending these guidelines to support our at-risk members' unique health challenges. CCA encourages our clinicians to clearly document our members' unique health contexts when requesting care which does not meet this formal DST's conditions and recommendations.
*High Opiate Patient Engagement = members with high doses of opiates whom we hope to help by treating their pain alternatively and reducing their exposure to dangerous opiates.

http://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/Updated_Policies/cms_03_02_cardiac_rehabilitation_mca_2016.pdf

http://www.aetna.com/cpb/medical/data/1_99/0021.html

**ATTACHMENTS:**

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| **EXHIBIT A** | Definitions for the purposes of this DST (from Johns Hopkins):<br>Phase I – Inpatient Rehabilitation: The objectives in phase I (the first 14 to 21 postoperative or post-event days) are intended to provide surveillance for optimal patient management. In addition to providing a structured progressive ambulation program, specially trained healthcare personnel teach |

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| | the member how to recognize cardiac symptoms and respond appropriately; explain the doses, effects, and side effects of the medications; educate member on stress management; and discuss cardiovascular disease risk factors.<br><br>Phase II – Outpatient Rehabilitation: A symptom-limited exercise test is administered, establishing the patient's MET (metabolic equivalents) capacity and identifying high-risk characteristics that require further evaluation or intervention. Risk stratification is used to identify members at risk for death or reinfarction and to provide guidelines for the rehabilitative process. Members may meet with a physical therapist and a dietician during this phase of rehabilitation. Rehabilitation is supervised by specially trained personnel. Most exercise programs consist of 3 sessions per week for 4 to 12 weeks for approximately an hour with continuous ECG monitoring. The member warms up for 10 to 15 minutes with various callisthenic exercises, then performs exercises using the following modes: stationary bicycle ergometry (with leg only, arm only, or arm-leg combinations), treadmill walking, arm ergometry, and rowing. These exercises are followed by a 10- to 15-minute cool-down period.<br><br>Phase III and Phase IV – Long-Term Rehabilitation: The member continues exercise and modified behaviors related to risk factors at home or in a community-based facility. The member performs an adequate warm-up session before exercises, which may include walking, bicycling, jogging, swimming, calisthenics, weight training, and endurance sports, depending upon the maximum exercise capacity and the personal preferences of the patient. Group support and counseling are critical for ongoing reinforcement. |
| **EXHIBIT B** | |

**REVISION LOG:**

| REVISION DATE | DESCRIPTION |
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# Medical Necessity Guideline

**APPROVALS:**

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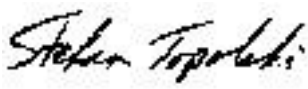
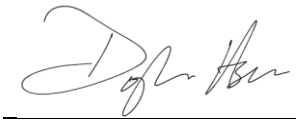
|---|---|
| Stefan Topolski | Medical Director |
| **CCA Senior Clinical Lead [Print]** | **Title [Print]** |
|  | 3/4/2021 |
| **Signature** | **Date** |
| Doug Hsu, MD | VP, Medical Policy & Utilization Review |
| **CCA Senior Operational Lead [Print]** | **Title [Print]** |
|  | 3/4/2021 |
| **Signature** | **Date** |
| Lori Tishler, MD | SVP, Medical Services |
| **CCA CMO or Designee [Print]** | **Title [Print]** |
|  | 3/4/2021 |
| **Signature** | **Date** |