Cardiac Rehab FAQ’s (Abstracted from AACVPR site)

1) Q. Is the 36 session CR program once in a lifetime or per calendar year or per event?

Answer: Patients are eligible for CR if their diagnosis meets the criteria listed in the CMS or MAC coverage information. So, for example, if a patient completes a CR program after having a PTCA and has CABG some months later, he/she is eligible for another course of CR.

2) Q: If the patient comes to CR, but is unable to exercise due to a medical situation (high BP, high glucose, symptoms that contraindicate exercise that day, etc!), how do we bill for the time spent with that patient?

Answer: A patient must exercise during each day that CR session(s) are received. If there is no exercise provided, it would be inappropriate and fraudulent to bill the patient for CR services that day.

3) Q: What are the 2011-12 changes to physician supervision for cardiac rehab?

Answer: Per the 2011 Final Hospital Outpatient Prospective Payment System (HOPPS) regulation, whether on or off campus, the supervising physician must be "immediately available" without differentiation between on and off-campus hospital-based CR and PR programs. CMS decided to remove the 2010 requirement for off-campus hospital-based programs that required a physician "in the provider-based department". This is discussed in greater detail in the Federal Register, 11-24-10, pgs 71998-72013.

4) Q: Does documenting the supervising physician need to be on each patient chart or only daily dept. document?

Answer: CMS is silent on how to document this information. The degree of documentation is subject to local Medicare contractor requirements. CGS our MAC-J15 provider has been silent on how to document this information. Keeping a daily record in the department of who is the physician in the supervisory role is recommended.

5) Q: Can CR and PR patients exercise in the same class?

Answer: Although not ideal from a clinical perspective, there is no Medicare regulation that disallows this practice. Always check CR or PR local policy on “exclusive use”, however, most local Medicare contractors have followed federal rules and removed this archaic language. Unfortunately, in some circumstances, staff, space, and financial restrictions require mixing these two patient populations in order to provide the service to our patients.
6) **Q: Can Phase III and Phase II patients be mixed in same session?**

**Answer:** There is neither current CMS restriction nor a MAC J-15 determination disallowing this.

7) **Q: Can 93797 be billed for education without exercise?**

**Answer:** The definition of CPT 93797 in the AMA CPT Code Book is outpatient cardiac rehab without continuous ECG monitoring. Therefore, this code is appropriate to use for the CMS-required education/counseling components of CR services. It is also appropriate to use this code for non-ECG-monitored exercise, per the definition. (Keep in mind that exercise is required every day the patient comes to cardiac rehab, but not required every session. And, that each single session must be documented as ≥31 minutes in duration; dual sessions must be documented as ≥91 minutes.

8) **Q: If a patient completes 24 sessions, then has another qualifying event, can s/he restart at sessions #1?**

**Answer:** That would depend on the “event”. For example, Transmittal 170 (Change request 6850) states, “Should a beneficiary experience more than one indication simultaneously, he or she may participate in a single series of CR or ICR sessions...” An example would be a patient admitted for NSTEMI and subsequently during the same serial hospital stay had a CABG. A different example might be a patient who enters post CR post NSTEMI and does not complete the program due to CABG intervention on session #20. That patient would be discharged from the CR program and would re-enter with a new diagnosis post-CABG.

9) **Q: Can you explain billing for orientation for cardiac rehab?**

**Answer:** Exercise is required every day the patient attends CR. The first session would consist of exercise orientation (some exercise) and ITP development (i.e., initial assessment) with the patient. If that takes > 90 minutes, it would be appropriate to use one 93798 code and one 93797 code for CR services provided that day.

10) **Q: Can nurse practitioners and PAs be used to refer pts? And can they sign off on orders?**

**Answer:** CMS defers to local Medicare contractors because NPPs (non-physician practitioners) are regulated by state scope of practice laws. In J-15 Ohio’s laws allow NPP referral. Kentucky J-15 committee members are researching their statutes.
11) Q: Could you clarify the non-monitored CR charge? What would be the difference between non-monitored and Phase 3 or maintenance CR?

Answer: Difference is the level of surveillance and outcome monitoring required. Phase II provides a much higher level than just monitoring ECG rhythms and exercise variables.

12) Q: If a cardiac rehab patient only attends an education session - not able to exercise can we bill for that education session using 93797?

Answer: No, because exercise was not provided that day.

13) Q: Does CMS reimburse a different amount for the ECG monitored cardiac rehab and the unmonitored program?

Answer: In hospital-based CR programs, reimbursement is the same for HCPCS 93798 and 93797 because both codes fall under APC 0095. Medicare reimbursement rates are different for the two codes in the physician-based setting.

14) Q: We have heard that some Cardiac Rehab programs have received denials from commercial payers for the CPT 93797 code. We are concerned about the patients ending up with a large bill before we use this. Ideas?

Answer: The recommendation is to pre-certifying patients who have a non-Medicare insurance plan to determine 1. Amount of reimbursement, 2. Entry and exit criteria (stress test needed? Etc), 3. Amount of co-payment, 4. Clarification of recognition and payment of CPT 93797 for non-ECG exercise OR education/counseling.

15) Q: Please clarify supervising MD and Medical director responsibility for CR.

Answer: Supervising MD must be immediately available and accessible for medical consultations and medical emergencies at all times the service is being provided. Medical director must meet the criteria listed in the CMS regulation 42 CFR 410.49(4)(d). (Both may be the same person)

16) Q: How is medical necessity determined--is a letter from the physician adequate?

Answer: Recommended that you have concrete test results, discharge summary, office notes, etc. (or access to that information) to document medical necessity in the case of an audit.
17) Q: If a physician recommends a patient to stay over for additional care for cardiac rehab exceeding 36 sessions; what should be the process?

Answer: If there is well-documented medical necessity. It is often helpful that the referring physician write a letter documenting the circumstances requiring additional sessions as well as the expected medical/physiologic benefits resulting thereof. The MAC has the authority to retroactively deny coverage if they determine there is a lack of medical necessity. (Remember to use a KX modifier attached to the code when billing for any aggregate number of sessions $\geq 36$.)

18) Q: Does cardiac rehab also have a lifetime benefit?

Answer: No, that only applies to pulmonary rehab.

19) Q: For an off-campus hospital satellite cardiac rehab program, in order to comply with the physician supervision regulation, does the physician have to be in the dept or just in the building?

Answer: CMS no longer refers to a specific location or a specific response time, other than “immediately available”. This is true for both on-campus and off-campus settings.

20) Q: Is a modifier “59” necessary when two cardiac rehabilitation sessions are provided in one day?

Answer: Yes, whenever any combination of CPT/HCPCS 93798 and 93797 are used in a day, the modifier must be attached. This is discussed in the CMS publication, MLN Matters # SE 0715.