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Conditions of Coverage for Outpatient Cardiac Rehabilitation Programs

What's Changed?

Extended inclusion of Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) codes allowing physicians to supervise CR and ICR services virtually through the end of Calendar Year (CY) 2023 or the end of the Public Health Emergency (PHE) whichever is later

This fact sheet informs Medicare Part B physicians, providers, and suppliers of the conditions of coverage for CR and ICR programs.

Section 144(a) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for CR and ICR programs and specifies certain conditions of coverage. CMS codified the conditions of coverage for CR and ICR programs consistent with MIPPA in 42 CFR 410.49.

In 2014, we expanded coverage of CR to include chronic heart failure through the National Coverage Determination (NCD) process. The Medicare NCD Manual, Pub. 100-03, Chapter 1, Part 1, section 20.10.1 discusses this expansion. In 2018, section 51004 of the Bipartisan Budget Act (BBA of 2018) expanded coverage of ICR to include chronic heart failure. We updated 42 CFR 410.49 to codify this expansion.

Conditions of Coverage for CR & ICR Programs

CR is a physician-supervised program that provides:

- Physician prescribed exercise
- Cardiac risk factor modification
- Psychosocial assessment
- Outcomes assessment
- Individualized treatment plan

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ICR is a physician-supervised program that includes CR and has been shown to improve patients' cardiovascular disease through specific outcome measures.

Medicare Part B covers CR and ICR for patients who experience 1 or more of the following:

- Acute myocardial infarction within the preceding 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart or heart-lung transplant
- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure medical therapy for at least 6 weeks

CR and ICR programs must include all components listed in Table 1.

Table 1: Required Components for CR & ICR Programs

Required Component	What's Included in the Component?
Physician-prescribed exercise	Aerobic exercise combined with other types of exercise (for example, strengthening and stretching) a physician finds appropriate for individual patients each day you provide CR or ICR services. **Note**: We haven't established the shortest length of time a patient must exercise. The number of minutes each patient exercises is part of the individualized treatment plan (as described below) and is tailored to each patient. If more than 1 CR or ICR session is given in 1 day, only 1 of those sessions must include physician-prescribed exercise.
Cardiac risk factor modification	Education, counseling, and behavioral intervention, tailored to the individual's needs.
Psychosocial assessment	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 • A psychosocial evaluation of the individual's response to and rate of progress under the treatment plan

Table 1: Required Components for CR & ICR Programs (continued)

Required Component	What's Included in the Component?
Outcomes assessment	The physician or program staff must perform an evaluation at the beginning and end of the program. These evaluations are based on patient-centered outcomes as it relates to the individual's rehabilitation. Physicians must consider evaluations conducted by program staff when developing and reviewing individualized treatment plans. When performing evaluations, physicians or program staff must use objective clinical measures of the patient's exercise performance and self-reported measures of exertion and behavior.
Individualized treatment plan	A written plan tailored to each individual patient that includes all the following: • A description of the individual's diagnosis • The type, amount, frequency, and duration of the items and services included under the plan • The goals set for the individual under the plan A physician must establish, review, and sign the individualized treatment plan every 30 days. The individualized treatment plan must detail how each patient uses each CR component.

Program Length for CR & ICR

Medicare limits CR programs to a maximum of 2, 1-hour sessions per day for up to 36 sessions for a period no more than 36 weeks with the option for an additional 36 sessions, over an extended period of time, if the Medicare Administrative Contractor (MAC) approves.

Medicare limits ICR programs to 72, 1-hour sessions for up to 6 sessions per day, for a period no more than 18 weeks.

In order to report 1 session of CR or ICR in a day, the session must be at least 31 minutes. You may only report additional sessions of CR or ICR beyond the first session in the same day if the duration of treatment is 31 minutes or greater beyond the 1-hour increment. In other words, to report 2 sessions of CR in a single day, the first session would account for 60 minutes and the second session would account for at least 31 minutes. To report 6 sessions of ICR in a single day, the first 5 sessions would account for 60 minutes each and the sixth session would account for at least 31 minutes. If several shorter periods of CR or ICR are given in a single day, you must add the minutes of service during those periods together for reporting in 1-hour session increments.

Note: As described in Pub. 100-04, Chapter 32, section 140.2.2, a Medicare patient may switch from an ICR program to a CR program. The patient is limited to a one-time switch. We don't allow multiple switches.

CR & ICR Settings

A patient must get CR and ICR in a physician's office or a hospital outpatient setting. Both settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when you provide items and services under the program. The physician satisfies this provision if the physician meets the requirements for direct supervision for physician office services as we specify in 42 CFR 410.26, and for hospital outpatient services specified in 42 CFR 410.27. Review physician roles, responsibilities, and standards in Table 2.

Table 2: Physician Roles, Responsibilities, & Standards

Physician Type	Roles & Responsibilities	Standards
Medical Director	The physician who oversees the CR or ICR program at a particular site. The medical director, in consultation with staff, is involved in directing the progress of individuals in the program.	The medical director must have all the following: • Expertise in the management of individuals with cardiac pathophysiology • Cardiopulmonary training in basic life support or advanced cardiac life support • License to practice medicine in the state in which the CR or ICR program is offered
Supervising Physician	A physician who's immediately available and accessible for medical consultations and medical emergencies at all times that items and services are provided to individuals under CR and ICR programs.	Physicians acting as the supervising physician must meet the same 3 standards as the Medical Director (listed above).

ICR Program Standards

For Medicare to approve an ICR program, it must show, through peer-reviewed published research, that it did 1 or more of the following for its patients:

- Positively affected the progression of coronary heart disease
- Reduced the need for coronary bypass surgery
- Reduced the need for percutaneous coronary interventions

An ICR program must also show, through peer-reviewed published research, that it accomplished a statistically significant reduction in 5 or more of the following measures for its patients:

- Low density lipoprotein
- Triglycerides
- Body mass index
- Systolic blood pressure
- Diastolic blood pressure
- The need for cholesterol, blood pressure, and diabetes medications

Medicare approves ICR programs through the NCD process. A list of approved ICR programs is available on the ICR Programs webpage.

All prospective ICR sites must apply to enroll in Medicare as an ICR Program site and report specialty code 31 using the designated forms we specify in 42 CFR 424.510. For purposes of appealing an adverse determination concerning site approval, Medicare considers an ICR site a supplier (or prospective supplier) as 42 CFR 498.2 defines.

COVID-19 Public Health Emergency Information

Hospitals Without Walls

Under the CMS Hospitals Without Walls Initiative, hospitals can relocate certain provider-based departments during the PHE for the COVID-19 pandemic, including to a patient's home. You may provide CR and ICR services in the patient's home that's serving as part of the hospital during the COVID-19 pandemic. You must register the patient as a hospital outpatient when you give these services. Make sure you continue to meet other conditions of coverage as well.

Supervision

A physician must supervise any CR and ICR service. However, we recognize that in some cases, the physical proximity of the physician might present additional exposure risks. On March 31, 2020, we announced in an interim final rule with comment period that direct supervision for these services can include the virtual presence of the physician through two-way, audio-video communications technology. We amended our regulation at 42 CFR 410.27(a)(1)(iv)(D) to reflect that change for the duration of the PHE for the COVID-19 pandemic.

On November 2, 2021, we issued the CY 2022 Medicare Physician Fee Schedule final rule. We'll extend, through the end of CY 2023, the inclusion on the Medicare telehealth services list of certain services added temporarily to the telehealth services list due to the PHE. We've extended inclusion of CR and ICR codes allowing physicians to supervise CR and ICR services virtually using audio-video real-time communications technology through the end of CY 2023 or the end of the PHE whichever is later.

Telehealth

CR and ICR HCPCS codes (93797, 93798, G0422, and G0423) are on the Medicare Telehealth Services list as Category 3. They'll be available through the end of the year the PHE ends or December 31, 2023, whichever is later. This means that providers can perform these services in accord with the telehealth flexibilities available during the PHE using audio and video equipment permitting two-way, real-time interactive communication.

Resources:

- Current Emergencies
- Coronavirus Waivers & Flexibilities
- Medicare NCD Manual, Pub. 100-03, Chapter 1, Part 1, section 20.10.1

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement