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Minimizing Insurance Delays to Starting Cardiac Rehabilitation

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Disclosures

None

Outline

1. Describe the Ideal Enrollment Pathway
2. Discuss Orders and (Pre) Authorizations
3. Describe Phase 1 Facilitated Referral
4. Describe Best Practice Scheduling

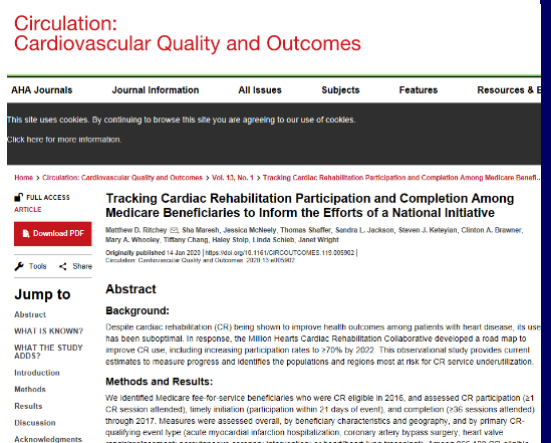
The Current Cardiac Rehabilitation Care Pathway*:
- Too Few Patients are Participating (24%)
- Too Few Patients are Completing 36 visits (27%)

366,103
CR eligible beneficiaries

24.4%*
of eligible beneficiaries

26.9%*
of CR participants

* Medicare beneficiaries, 2016. All values vary across age, gender, race-ethnicity, and event/procedure type. Ritchey M, et al, Circ Cardiovasc Qual Outcomes. 2020;13:e005902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Home > Circulation: Cardiovascular Quality and Outcomes > Vol. 13, No. 1 > Tracking Cardiac Rehabilitation Participation and Completion Among Medicare Benefi...

FULL ACCESS
ARTICLE

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Tools Share

Jump to
Abstract
WHAT IS KNOWN?
WHAT THE STUDY ADDS?
Introduction
Methods
Results
Discussion
Acknowledgments

Tracking Cardiac Rehabilitation Participation and Completion Among Medicare Beneficiaries to Inform the Efforts of a National Initiative

Matthew D. Ritchey, Sha Maresh, Jessica McNeely, Thomas Shaffer, Sandra L. Jackson, Steven J. Keteyian, Clinton A. Brawner, Mary A. Whooley, Tiffany Chang, Haley Stolp, Linda Schieb, Janet Wright

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Abstract

Background:

Despite cardiac rehabilitation (CR) being shown to improve health outcomes among patients with heart disease, its use has been suboptimal. In response, the Million Hearts Cardiac Rehabilitation Collaborative developed a road map to improve CR use, including increasing participation rates to >70% by 2022. This observational study provides current estimates to measure progress and identifies the populations and regions most at risk for CR service underutilization.

Methods and Results:

We identified Medicare fee-for-service beneficiaries who were CR eligible in 2016, and assessed CR participation (≥1 CR session attended), timely initiation (participation within 21 days of event), and completion (≥36 sessions attended) through 2017. Measures were assessed overall, by beneficiary characteristics and geography, and by primary CR-qualifying event type (acute myocardial infarction hospitalization, coronary artery bypass surgery, heart valve

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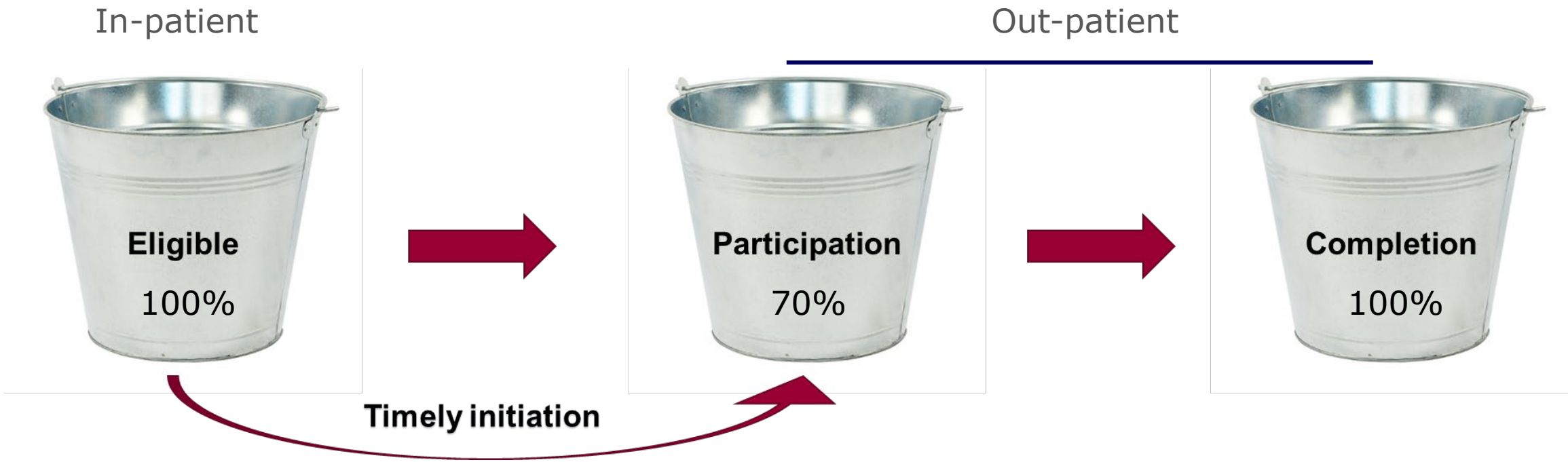
The Ideal Cardiac Rehabilitation Care Pathway*:

- Nearly all Eligible Patients are Referred
- ≥ 70% of Eligible Patients are Enrolled
- All of Those Enrolled Receive 36 CR sessions



*Adapted from Ritchey M, et al, ACC Scientific Sessions, New Orleans, March 18, 2019
**≥ 70% target by 2022, Ades et al, Mayo Clin Proc. 2017;92:234-242

Orders and (Pre) Authorizations

Cardiac Rehabilitation (CR) is a physician ordered service; "as of January 2022, 42 CFR 410.49 and 42 CFR 410.47 require that an MD or DO must order CR, ICR, and PR, respectively. Nonphysician practitioners may not independently order these physician services. It will take an act of Congress to change the statutory language (Section 1861 of the SSA)." [1]

Scheduled to change to allow NPPs order and supervise CR beginning 01 Jan 2024

Consider automatic orders for eligible diagnoses.

- Should be preselected on discharge order sets
- Work with physician partners to maximize use
- Allow CR staff to enter orders (on behalf of physician) when missing

[1] https://central.aacvpr.org/resources/faqs. Accessed 04 Oct 2022

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Orders and (Pre) Authorizations

(Pre) Authorization – "A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost."[1]

Common payers that require a (pre) authorization in Michigan:

Aetna, Blue Care Network, some out of state BCBS, some Medicare replacement plans

If in doubt call the payer to determine their requirements

May take up to two weeks or more to obtain. Having a Central Authorization team is preferred.

[1] https://www.healthcare.gov/glossary/preauthorization/. Accessed 04 Oct 2022

Phase 1 Facilitated Referral

Dedicated CR staff visits patient in the hospital to schedule outpatient CR Orientation (CRO)
Advantages:

- Patient has appointment for CRO prior to discharge
- Emphasizes that participation in CR is next step in recovery. Have appointment info printed on Discharge Instructions
- CR staff are the best ambassadors
- May depend on local hospital policy

Henry Ford Hospital saw ~ 30% increase in scheduled CRO after implementation

Cost effectiveness? An additional 14 patients per year supports a $35K investment in facilitated referral assuming 28 visits completed per patient at ~ $95 each.

Best Practice Scheduling

Scheduling sooner rather than later (< 2 weeks after event) is positively associated with increased participation and has no effect on adverse events. [1,2]

- Approximately 1% loss in enrollment for each day entry to CR is delayed
- No difference in major event rates between CABG, MI, or Valve surgery
  Sternal instability and wound infection rates similar

CMS requires 6 weeks on optimal medical therapy before patients with HF_rEF can *start* CR (first billable session). Can still schedule CRO and have patients attend educational lectures to maintain engagement (if not billed).

Start (pre) authorization process, if required, as soon as possible. May take 2 weeks or more to obtain.

1. Pack QR, Mansour M, Barboza JS, Hibner BA, Mahan MG, Ehrman JK, Vanzant MA, Schairer JR, Keteyian SJ. An early appointment to outpatient cardiac rehabilitation at hospital discharge improves attendance at orientation: a randomized, single-blind, controlled trial. Circulation. 2013 Jan 22;127(3):349-55. doi: 10.1161/CIRCULATIONAHA.112.121996. Epub 2012 Dec 18. PMID: 23250992.
2. Pack QR, Dudycha KJ, Roschen KP, Thomas RJ, Squires RW. Safety of early enrollment into outpatient cardiac rehabilitation after open heart surgery. Am J Cardiol. 2015 Feb 15;115(4):548-52. doi: 10.1016/j.amjcard.2014.11.040. Epub 2014 Nov 29. PMID: 25543236.

Summary

1. There is ~ 1% decrease in CR enrollment rates for each day starting CR is delayed
2. Know the regulations and policies that guide CR and work within them to minimize delays in entry
3. Make connections to eligible patients as early as possible (Phase 1)
4. Aim to schedule patients into CRO sooner rather than later
5. Maximize the use of time between discharge and program entry

Thank you