



Overview of the Conditions of Coverage for Medicare Part B Outpatient Cardiac Rehabilitation Services



Introduction

This fact sheet informs Medicare Part B physicians, providers, and suppliers of the conditions of coverage for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) services. The fact sheet gives an overview of the conditions of coverage and contains no policy changes.

Background

[Section 144\(a\) of the Medicare Improvements for Patients and Providers Act \(MIPPA\) of 2008](#) established coverage provisions for CR and ICR services. The statute specifies certain conditions of coverage for these services. CMS codified the conditions of coverage for CR and ICR services 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 [Section 410.49](#) to codify this expansion.

Conditions of Coverage for CR & ICR Services

CR is a physician-supervised program that provides:

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

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 services 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 medical therapy for at least 6 weeks

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

Table 1: Required Services for CR & ICR Programs

REQUIRED SERVICE	WHAT'S INCLUDED IN THE SERVICE?
Physician-prescribed exercise	<p>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</p> <p>Note: CMS hasn'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.</p>
Cardiac risk factor modification	<p>Education, counseling, and behavioral intervention, tailored to the patients' individual needs</p>
Psychosocial assessment	<p>An evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes:</p> <ul style="list-style-type: none"> • An assessment 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
Outcomes assessment	<p>An evaluation of progress as it relates to the individual's rehabilitation which includes the following:</p> <ul style="list-style-type: none"> • Assessments based on patient-centered outcomes measured by the physician at the beginning and end of the program • Objective clinical measures of exercise performance and self-reported measures of exertion and behavior
Individualized treatment plan	<p>A written plan tailored to each individual patient that includes all the following:</p> <ul style="list-style-type: none"> • 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 <p>The individualized treatment plan detailing how components are used for each patient must be established, reviewed, and signed by a physician every 30 days</p>

Program Length for CR & ICR Services

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, if the Medicare Administrative Contractor (MAC) approves.

We limit 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 services in a day, the session must be at least 31 minutes. You may only report additional sessions of CR or ICR services 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 services 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 1-time switch. We don't allow multiple switches.

CR & ICR Settings

A patient must get CR and ICR services 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 as specified in [42 CFR 410.27](#). Review physician roles, responsibilities, and requirements in Table 2.

Table 2: Physician Roles, Responsibilities, & Requirements

PHYSICIAN TYPE	ROLES & RESPONSIBILITIES	REQUIREMENTS
Medical Director	A physician who oversees or supervises 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: <ul style="list-style-type: none"> • 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 is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being provided to patients under CR and ICR programs.	Physicians acting as the supervising physician must have all the following: <ul style="list-style-type: none"> • 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

Standards for an ICR Program

In order for Medicare to approve an ICR program, it must demonstrate, through peer-reviewed published research, that it accomplished 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 demonstrate, through peer-reviewed published research, that it accomplished a statistically significant reduction in 5 or more of the following measures:

- 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 Public Health Emergency (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 is serving as part of the hospital during the COVID-19 pandemic. You must register the patient as a hospital outpatient when the services are given. Other conditions of coverage must continue to be met.

Supervision

A physician must supervise any CR and ICR services. However, we recognize that in some cases, the physical proximity of the physician might present additional exposure risks. On March 31, 2020, CMS 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 December 2, 2020, CMS issued the [CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule](#). The final rule allows physicians to supervise CR and ICR services virtually using audio/video real-time communications technology until the PHE ends or December 31, 2021.

Telehealth

On October 14, CMS added CR and ICR HCPCS codes (93797, 93798, G0422, and G0423) to the Medicare telehealth services list on a temporary basis for the duration of the PHE for the COVID-19 pandemic. 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:

- [Coronavirus Waivers & Flexibilities](#)
- [Current Emergencies](#)
- [Medicare Benefit Policy Manual \(Pub. 100-02\), Chapter 15, Section 232](#)
- [Medicare Claims Processing Manual \(Pub. 100-04\), Chapter 32, Section 140.2.2](#)
- [Medicare NCD Manual, \(Pub. 100-03\), Chapter 1, Part 1, Section 20.10.1](#)
- [Section 144\(a\) of the Medicare Improvements for Patients and Providers Act \(MIPPA\) of 2008](#)
- [Section 51004 of the Bipartisan Budget Act](#)
- [42 CFR 410.49](#)

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