Priority Health	BILLING POLICY No. 062
CARDIAC REHABILITATION	
Date of origin: Dec. 30, 2024	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Cardiac rehabilitation is a physician supervised program which provides physician prescribed exercise, cardiac risk factor modification, psychosocial assessment and outcomes assessment.

Intensive cardiac rehabilitation (ICR) is a physician supervised program that provides cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements.

There are three approved programs of ICR:

- Dr. Ornish's Program for Reversing Heart Disease
- Pritikin Program
- Benson-Henry Institute Cardiac Wellness Program

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD in our Provider Manual.

MEDICAL POLICY

Rehabilitative & Habilitative Medicine Services (#91318)

POLICY SPECIFIC INFORMATION

Coding specifics

Note for commercial plans: Phase II or Outpatient cardiac rehabilitation is subject to therapy limits as outlined in the member's schedule of benefits.

Cardiac Rehabilitation (CR)

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

93798 - Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

These services must have a physician or non-physician practitioner immediately available with accessibility for medical consultations and emergencies at all times.

- Practitioners and Hospitals may report a MAXIMUM of 2 one-hour sessions per day.

- A limit of 36 sessions over up to 36 weeks. Additional sessions over an extended period will require approval.
- The duration of the session must be at least 31 minutes to report an hour. CR should not be reported for sessions less than 31 minutes.
- 2 sessions may be reported in the same day if the duration of treatment is at least 91 minutes.
- If shorter sessions are done in the same day, the minutes of services for those sessions may be added together to meet the needed timeframes.

Intensive Cardiac Rehabilitation (ICR)

G0422- Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session

G0423 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session

These services must have a physician or non-physician practitioner immediately available with accessibility for medical consultations and emergencies at all times.

- Must be an approved ICR program (see NCD for details)
- Specialty code 31
- A MAXIMUM of 6 one-hour sessions may be reported by Practitioners and Hospitals per day.
- A limit of 72 one-hour sessions over a period of up to 18 weeks.
- The treatment duration must be at least 31 minutes.
- Same day sessions may be added together but MAY NOT exceed the 6 one-hour session allowance.

Place of service

- 11 – Office
- 22 – On Campus Outpatient Hospital

Documentation requirements

- Physician prescribed exercise each day the services are provided
- Cardiac risk factor modification, which includes education, counseling and behavioral intervention tailored to the individual's needs.
- Psychosocial assessment
- Outcomes assessment
- Individualized treatment plan detailing how the components are used for each patient. This treatment plan must be established, reviewed and signed by a physician every 30 days.

Revenue code

- 943 – Other Therapeutic Services

Types of bill

- 013 – Hospital Outpatient
- 085 – Critical Access Hospital

Modifiers

- KX – Requirements specified in the medical policy have been met. (Use this modifier when frequency has been exceeded and all criteria in policy have been met)
- 59, XU, XE – Distinct services. Review our provider manual for information on the requirements for these modifiers in our Provider Manual.

For Medicare:

- GA – Pre-service notice of non-coverage was provided by the plan
- GY – No pre-service determination was made

Get more information on the GA and GY modifiers in our Provider Manual.

RESOURCES

- Medicare Claims Processing Manual – Chapter 32 – Billing Requirements for Special Services (CMS)
- NCD – Intensive Cardiac Rehabilitation (ICR) Programs (20.31) (CMS)
- CMS Manual System – Pub 100-04 Medicare Claims Processing – Section 140 (CMS)
- Intensive Cardiac Rehabilitation (ICR) Programs (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added “Disclaimer” section