MetroPlus Health Plan

# Policy and Procedure

| Title: CARDIAC REHABILITATION | Division: Medical Management<br>Department: Utilization Management |
|---|---|
| Approval Date: 3/30/18 | LOB: Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP |
| Effective Date: 3/30/18 | Policy Number: UM-MP227 |
| Review Date: 3/30/19 | Cross Reference Number: |
| Retired Date: | Page 1 of 19 |

1. **POLICY:**
   Clinical Policy Cardiac Rehabilitation Guidelines

2. **RESPONSIBLE PARTIES:**
   Medical Management Administration, Utilization Management, Integrated Care Management, Claims Department, Provider Contracting

3. **DEFINITIONS**
   METS – A measure of exercise intensity, formally known as a metabolic equivalent. METS are directly related to the intensity of physical activity and the amount of oxygen consumed. The larger the MET value, the more calories burnt

   CARDIAC REHABILITATION- A comprehensive program of medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling designed to restore certain patients with coronary heart disease to active and productive lives. Cardiac rehabilitation, as described in the medical literature, is divided into 3 phases and consists of a series of supervised exercise sessions with continuous electrocardiograph monitoring. Clinically optimal results are obtained if these sessions are conducted 3-times per week over a 12-to-18 week period.

4. **PROCEDURE:**

   Clinical Criteria
   Cardiac rehabilitation is considered medically necessary when the services are prescribed by the treating physician and initiated within 90 days of the cardiac event and completed with 12 months for any of the following conditions:

   1) Acute myocardial infarction (MI)/Acute coronary syndrome (ACS); OR
   2) Coronary artery bypass grafting (CABG); OR
   3) Heart or heart/lung transplantation; OR
   4) Percutaneous coronary intervention (PTCA, angioplasty, stents, atherectomy); OR
   5) Survivor of sudden cardiac death; OR
   6) Survivor of sustained ventricular tachycardia or fibrillation; OR
   7) Heart valve replacement or repair; OR
   8) Class III or IIV congestive heart failure (CHF) which has failed to respond to pharmacotherapy, and the condition is interfering with the ability to perform age related activities of daily living (ADLS); OR

9) Coronary Artery Disease (CAD) with chronic stable angina pectoris which has failed to respond to pharmacotherapy and is interfering with the ability to perform age-related ADLS; OR
10) Placement of ventricular assist device

Frequency and Duration

The medically necessary frequency and duration of cardiac rehabilitation is determined by the patient's level of cardiac risk stratification:

1) High-risk patients with any of the following:
   a. Decrease in systolic blood pressure by 15 mm Hg or more with exercise; OR
   b. Exercise test limited to less than or equal to 5 METS; OR
   c. Marked exercise-induced ischemia, as indicated by either angina pain or 2 mm or more ST depression by electrocardiography (ECG); OR
   d. Recent myocardial infarction (less than 6 months) which was complicated by serious ventricular arrhythmia, cardiogenic shock, or CHF; OR
   e. Resting complex ventricular arrhythmia; OR
   f. Severely depressed left ventricular function (LVEF less than 30%); OR
   g. Survivor of sudden cardiac arrest; OR
   h. Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing.

Cardiac rehabilitation programs for high-risk patients include:
   a. 18-36 sessions (e.g., 3 times a week for 12 weeks) of supervised exercise with continuous telemetry monitoring
   b. An individual outpatient exercise program that can be self-monitored and maintained
   c. Educational program for risk factor/stress reduction
   d. If no clinically significant arrhythmia is documented during the first 3 weeks of the cardiac rehabilitation program, the provider may have the patient complete the remaining portion without telemetry monitoring.

2) Intermediate-risk patients with any of the following:
   a. Exercise test limited to 6 to 9 METS; or
   b. Ischemic ECG response to exercise of less than 2 mm of ST depression; or

c. Uncomplicated myocardial infarction, coronary artery bypass surgery, or angioplasty and has a post-cardiac event maximal function capacity of 8 METS or less on ECG exercise test.

Cardiac rehabilitation programs for Intermediate-risk patients include:

a. 12-24 sessions or less of exercise training without continuous ECG monitoring
b. The program's goal is to determine an ongoing exercise program that is "self-administered."

3) Low-risk patients Exercise test limited to those with 9 METS or greater .

Cardiac rehabilitation programs for low-risk patients include:

a. 6 1-hour sessions involving risk factor reduction education and supervised exercise to show safety and define a home program (e.g., 3 times per week for a total of 2 weeks or 2 sessions per week for 3 weeks)

Program Components

Cardiac rehabilitation program to include:

a. 18 one-hour sessions involving risk factor reduction education and supervised exercise to show safety.
    i. EXCEPTION FOR MEDICARE - ENTITLED TO 36 SESSIONS
b. Physician-prescribed and physician-supervised exercise each day that cardiac rehabilitation services are provided;
    i. Cardiac risk factors modification (e.g., nutritional counseling, assessing smoking status, history and control of diabetes or hypertension, lipid management, and weight management);
    ii. Psychosocial assessment;
    iii. Quantifiable Outcomes assessment;
    iv. Individualized treatment plan detailing how each of the above components are utilized. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.
c. The program's goal is to define a home program.
d. Medical Director's review is required for requests for greater than the recommended number of sessions above.

e. Another qualifying cardiac event is required to start a new cardiac rehabilitation program. [for example]
   i. Another cardiovascular surgery or angioplasty; or
   ii. Another documented myocardial infarction or extension of initial infarction; or
   iii. New clinically significant coronary lesions documented by cardiac catheterization; or
   iv. New evidence of ischemia on an exercise test, including thallium scan.

   A comprehensive evaluation and cardiac risk assessment should be performed prior to the initiation of cardiac rehabilitation to evaluate the patient and determine an appropriate exercise program. In addition to a medical examination, the evaluation may include an electrocardiogram stress test. Additional stress testing may also be performed at the completion of the program.

Place of Service

1. The place of service for cardiac rehabilitation is ambulatory outpatient, physician office, or hospital outpatient setting.
   a. All settings must have a physician immediately available and accessible for medical consultation and emergencies at all times when services are being furnished under the program.
   b. All medical personnel necessary to conduct cardiac rehabilitation are trained in both basic and advanced life-support techniques.
   c. The facility must have available the necessary cardiopulmonary emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary.

Exclusions

The Plan does not regard outpatient cardiac rehabilitation as medically necessary when any of the following are applicable:

1. Presence of congestive heart failure in the absence of other conditions.
2. Presence of unstable angina.
3. Continuation of > 36 sessions for > 20 weeks.
4. Occupational and/or physical therapy are considered not medically necessary in conjunction with cardiac rehabilitation, unless the services are performed for an unrelated condition.

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## 5. APPLICABLE PROCEDURE CODES

| CPT | Description |
|---|---|
| 93797 | Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session) |
| 93015 | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report |
| 93016 | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report |
| 93017 | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report |
| 93018 | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only |
| 93024 | Ergonovine provocation test |

## 6. APPLICABLE PROCEDURE CODES

| HCPCS CODE | Description |
|---|---|
| S9449 | Weight management classes, nonphysician provider, per session |
| S9451 | Exercise classes, nonphysician provider, per session |

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| S9452 | Nutrition classes, nonphysician provider, per session |
| S9453 | Smoking cessation classes, nonphysician provider, per session |
| S9454 | Stress management classes, nonphysician provider, per session |
| S9470 | Nutritional counseling, dietitian visit |

## 7. APPLICABLE DIAGNOSIS CODES

| ICD 10 | DESCRIPTION |
|---|---|
| I02.0 | Rheumatic chorea with heart involvement |
| I05.0 | Rheumatic mitral stenosis |
| I05.1 | Rheumatic mitral insufficiency |
| I05.2 | Rheumatic mitral stenosis with insufficiency |
| I05.8 | Other rheumatic mitral valve diseases |
| I05.9 | Rheumatic mitral valve disease, unspecified |
| I06.0 | Rheumatic aortic stenosis |
| I06.1 | Rheumatic aortic insufficiency |
| I06.2 | Rheumatic aortic stenosis with insufficiency |
| I06.8 | Other rheumatic aortic valve diseases |
| I06.9 | Rheumatic aortic valve disease, unspecified |
| I08.0 | Rheumatic disorders of both mitral and aortic valves |
| I08.1 | Rheumatic disorders of both mitral and tricuspid valves |
| I08.2 | Rheumatic disorders of both aortic and tricuspid valves |
| I08.3 | Combined rheumatic disorders of mitral, aortic and tricuspid valves |
| I08.8 | Other rheumatic multiple valve diseases |
| I08.9 | Rheumatic multiple valve disease, unspecified |
| I09.81 | Rheumatic heart failure (congestive) |

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|---|---|
| **I11.0** | Hypertensive heart disease with heart failure |
| **I13.0** | Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4, chronic kidney disease, or unspecified chronic kidney disease |
| **I13.2** | Hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease or end stage renal disease |
| **I20.0** | unstable angina |
| **I20.1** | Angina pectoris with documented spasm |
| **I20.8** | Other forms of angina pectoris |
| **I20.9** | Angina pectoris, unspecified |
| **I21.01** | ST elevation (STEMI) myocardial infarction involving left main coronary artery |
| **I21.02** | ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery |
| **I21.09** | ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall |
| **I21.11** | ST elevation (STEMI) myocardial infarction involving right coronary artery |
| **I21.19** | elevation (STEMI) myocardial infarction involving right coronary artery |
| **I21.21** | ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery |
| **I21.29** | ST elevation (STEMI) myocardial infarction involving other sites |
| **I21.3** | ST elevation (STEMI) myocardial infarction of unspecified site |
| **I21.A1** | Myocardial infarction type 2 |
| **I21.A9** | Other myocardial infarction type |
| **I22.0** | Subsequent ST elevation (STEMI) myocardial infarction of anterior wall |
| **I22.1** | Subsequent ST elevation (STEMI) myocardial infarction of inferior wall |
| **I22.2** | Subsequent non-ST elevation (NSTEMI) myocardial infarction |
| **I22.8** | I22.8 Subsequent ST elevation (STEMI) myocardial infarction of other sites |
| **I22.9** | Subsequent ST elevation (STEMI) myocardial infarction of unspecified site |

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|---|---|
| **I24.0** | Acute coronary thrombosis not resulting in myocardial infarction |
| **I24.1** | Dressler's syndrome |
| **I24.8** | Other forms of acute ischemic heart disease |
| **I24.9** | Acute ischemic heart disease, unspecified |
| **I25.10** | Atherosclerotic heart disease of native coronary artery without angina pectoris |
| **I25.110** | Atherosclerotic heart disease of native coronary artery with unstable angina pectoris |
| **I25.111** | Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm |
| **I25.118** | Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris |
| **I25.2** | Old myocardial infarction |
| **I25.3** | Aneurysm of heart |
| **I25.41** | Coronary artery aneurysm |
| **I25.42** | Coronary artery dissection |
| **I25.5** | Ischemic cardiomyopathy |
| **I25.6** | Silent myocardial ischemia |
| **I25.700** | Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris |
| **I25.701** | Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm |
| **I25.708** | Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris |
| **I25.709** | Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris |
| **I25.710** | Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris |
| **I25.718** | Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm |
| **I25.719** | Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm |

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| **I25.720** | Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris |
| **I25.721** | Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm |
| **I25.728** | Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris |
| **I25.729** | Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris |
| **I25.730** | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris |
| **I25.731** | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm |
| **I25.738** | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris |
| **I25.739** | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris |
| **I25.750** | Atherosclerosis of native coronary artery of transplanted heart with unstable angina |
| **I25.751** | Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm |
| **I25.758** | Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris |
| **I25.759** | Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris |
| **I25.760** | Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina |
| **I25.761** | Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm |
| **I25.768** | Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris |
| **I25.769** | Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris |
| **I25.790** | Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris |

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|---|---|
| **I25.791** | Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm |
| **I25.798** | Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris |
| **I25.799** | Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris |
| **I25.810** | Atherosclerosis of coronary artery bypass graft(s) without angina pectoris |
| **I25.811** | Atherosclerosis of native coronary artery of transplanted heart without angina pectoris |
| **I25.812** | Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris |
| **I25.82** | Chronic total occlusion of coronary artery |
| **I25.83** | Coronary atherosclerosis due to lipid rich plaque |
| **I25.84** | Coronary atherosclerosis due to calcified coronary lesion |
| **I25.89** | Other forms of chronic ischemic heart disease |
| **I25.9** | Chronic ischemic heart disease, unspecified |
| **I34.0-I34.9, I36.0-I37.9** | Nonrheumatic mitral, tricuspid and pulmonary valve disorders |
| **I42.3-I42.7** | Cardiomyopathy |
| **I46.2-I46.9** | Cardiac arrest |
| **I47.9** | Paroxysmal tachycardia, unspecified |
| **I49.01** | Ventricular fibrillation |
| **I49.02** | Ventricular flutter |
| **I50.1** | Left ventricular failure, unspecified |
| **I50.20** | Unspecified systolic (congestive) heart failure |
| **I50.21** | Acute systolic (congestive) heart failure |
| **I50.22** | Chronic systolic (congestive) heart failure |
| **I50.30** | Unspecified diastolic (congestive) heart failure |
| **I50.31** | Acute diastolic (congestive) heart failure |
| **I50.32** | Chronic diastolic (congestive) heart failure |
| **I50.33** | Acute on chronic diastolic (congestive) heart failure |

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|---|---|
| **I50.40** | Unspecified combined systolic (congestive) and diastolic (congestive) heart failure |
| **I50.41** | Acute combined systolic (congestive) and diastolic (congestive) heart failure |
| **I50.42** | Acute combined systolic (congestive) and diastolic (congestive) heart failure |
| **I50.43** | Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure |
| **I80.810** | Right heart failure, unspecified |
| **I50.811** | Acute right heart failure |
| **I50.812** | Chronic right heart failure |
| **I50.813** | Acute on chronic right heart failure |
| **I50.814** | Right heart failure due to left heart failure |
| **I50.82** | Biventricular heart failure |
| **I50.83** | High output heart failure |
| **I50.84** | End stage heart failure |
| **I50.89** | Other heart failure |
| **I50.9** | heart failure, unspecified |
| **I97.0** | Postcardiotomy syndrome |
| **I97.110** | Postprocedural cardiac insufficiency following cardiac surgery |
| **I97.111** | Postprocedural cardiac insufficiency following other surgery |
| **I97.120** | Postprocedural cardiac arrest following cardiac surgery |
| **I97.121** | Postprocedural cardiac arrest following other surgery |
| **I97.13.0** | Postprocedural heart failure following cardiac surgery |
| **I97.190** | Postprocedural cardiac functional disturbances |
| **Z51.89** | Encounter for other specified aftercare |
| **Z94.1** | Heart transplant status |
| **Z94.2** | Lung transplant status |
| **Z95.1** | Presence of aortocoronary bypass graft |
| **Z95.2** | Presence of prosthetic heart valve |
| **Z95.3** | Presence of xenogenic heart valve |

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| **Z95.4** | Presence of other heart-valve replacement |
| **Z95.5** | Presence of coronary angioplasty implant and graft |
| **Z95.811** | Presence of heart assist device |
| **Z95.812** | Presence of fully implantable artificial heart |
| **Z95.61** | Coronary angioplasty status |
| **Z98.89** | Other specified postprocedural status [surgery to heart and great vessels] |

## 8. BACKGROUND

Cardiovascular disorders are the leading cause of mortality and morbidity in the industrialized world and account for nearly 50% of all deaths annually. The Centers for Disease Control and Prevention reports that approximately 610,000 people die from heart disease in the United States each year, which is one in every four deaths. Every year, about 735,000 Americans have a heart attack. Of these heart attacks, 525,000 are first instances of heart attack, and 210,000 happen in people who have already had a heart attack.

Programs for cardiac rehabilitation were first introduced in the 1960s for patients who were recovering from an acute myocardial infarction. Concerns about the safety of unsupervised exercise after discharge led to the development of highly structured rehabilitation programs that were supervised by physicians and included electrocardiographic monitoring. Indications for outpatient cardiac rehabilitation were expanded to other cardiac patients, such as those who experience postoperative cardiac surgery and myocardiopathy, and patients in heart failure.

In 1995, the United States Public Health Service defined cardiac rehabilitation as a comprehensive, long-term program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. These programs are designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or re-infarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients.

In the HF-ACTION clinical trial, 2331 patients with heart failure classes II-IV were randomized to exercise training (36 supervised sessions) and usual care versus usual care alone. This multicenter trial objective was to test the efficacy and safety of exercise training among patients with heart failure. The main outcome indicated that exercise training resulted

in nonsignificant reduction in the primary end points of all-cause mortality or hospitalization and in key secondary clinical end points. After adjusting for highly prognostic predictors of the primary end point, exercise training was associated with modest significant reductions for both all-cause mortality or hospitalization and cardiovascular mortality or heart failure hospitalization. This trial was pivotal in the CMS decision to expand coverage of cardiac rehabilitation for Class IV heart failure.
[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2916661/]

In 2012, the American College of Physicians, American College of Cardiology Foundation, American Heart Association/American Association of Thoracic Surgery, Preventive Cardiovascular Nurses Association, and Society of Thoracic Surgeons published a joint guideline on management of stable ischemic heart disease. The guideline includes the following statement on cardiac rehabilitation: “Medically supervised exercise programs, i.e., cardiac rehabilitation and physician-directed home based programs, are recommended for at-risk patients at first diagnosis of stable ischemic heart disease.”

In 2013, the American College of Cardiology Foundation and the American Heart Association published updated guidelines on the management of heart failure. These guidelines include the following Class IIa recommendation related to cardiac rehabilitation (Level of Evidence: B): “Cardiac rehabilitation can be useful in clinically stable patients with heart failure to improve functional capacity, exercise duration, HRQOL [health-related quality of life], and mortality.”

**Pediatric Cardiac Rehabilitation**

While the beneficial effects of cardiac rehabilitation programs in adults are well known, there are very few clinical trials regarding the use of cardiac rehabilitation in pediatric patients.

In the Boston Pediatric Cardiac Rehab Study in 2005, a 12 week pediatric cardiac rehab study was conducted with 16 children ages 8 to 17. All 16 children who completed the program had heart surgery or a nonsurgical procedure, and 11 of the 16 had only on functional heart pumping chamber. At the 7 month follow up, it was found that the children who completed a twice weekly hour long sessions had significant sustained improvements in exercise function as well as improvement in behavior, self-esteem and emotional state. In addition, 15 of the 16 children had improved heart function, with the heart pumping more blood with each beat, delivering more oxygen.

Somarriba et al. (2008) reported on the effects of exercise rehabilitation for two children with dilated cardiomyopathy. These children underwent a structure exercise program that showed improvements in cardiovascular fitness and strength without deterioration in ventricular function. The authors recommend a careful and medically supervised approach for exercise in children with cardiomyopathy. It was noted that larger prospective studies are needed on the functional and metabolic responses for these children.

**Patient Symptoms - Classes of Heart Failure New York Heart Association (NYHA) Functional Classification**

1. Class I [mild] - No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
2. Class II [Mild] - Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
3. Class III [Moderate] - Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
4. Class IV [Severe] - Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

*www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.Wo1w8UxFxMU*

**American Heart Association Heart Failure Stages**

1. Stage A: Presence of heart failure risk factors but no heart disease and no symptoms
2. Stage B: Heart disease is present but there are no symptoms (structural changes in heart before symptoms occur)
3. Stage C: Structural heart disease is present AND symptoms have occurred
4. Stage D: Presence of advanced heart disease with continued heart failure symptoms requiring aggressive medical therapy

*Yancy, C. W., et. al. "2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines." Circulation 128.16 (2013): n. pag. Print.*

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## 10. ATTACHMENTS:

| | Title | Attachment |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

## 11. REVISION LOG:

| REVISIONS | DATE |
|---|---|
| | |
| | |

| Approved: | Date: | Approved: | Date: |
|---|---|---|---|
| Bruce Sosler, MD<br>Clinical Medical Director | | Talya Schwartz, MD<br>Chief Medical Officer | |

| Title: CARDIAC REHABILITATION | Division: Medical Management<br>Department: Utilization Management |
|---|---|
| Approval Date: 3/30/18 | LOB: Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP |
| Effective Date: 3/30/18 | Policy Number: UM-MP227 |
| Review Date: 3/30/19 | Cross Reference Number: |
| Retired Date: | Page 19 of 19 |

## Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.