SUMMARY OF MEDICARE FINAL NATIONAL COVERAGE DECISION (NCD) FOR CARDIAC REHABILITATION

On Wednesday March 22nd, the Centers for Medicare & Medicaid Services (CMS) posted its new National Coverage Decision (NCD) for cardiac rehabilitation on its website. The entire document can be found at http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=164. This policy is effective immediately, although it may take some time to get the policy updated on the CMS online manual website.

There are numerous changes included in this policy that provide additional flexibility to cardiac rehabilitation programs, and many of those changes are a result of actions taken jointly by AHA, American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) and the American College of Cardiology (ACC) over the past several years.

Summary of Cardiac Rehabilitation National Coverage Decision:

Coverage of expanded diagnoses: CMS expanded the national coverage for cardiac rehabilitation to Medicare beneficiaries who have had: (1) heart valve repair or replacement; (2) percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or (3) heart or combined heart-lung transplant. This decision also reconfirms their existing coverage for beneficiaries who have a documented diagnosis of acute myocardial infarction within the preceding 12 months, have had coronary bypass surgery or have stable angina pectoris. They declined to cover congestive heart failure pending additional evidence that cardiac rehabilitation is reasonable and necessary for this indication.

Physician supervision: CMS again re-affirmed that the standard for physician supervision for cardiac rehabilitation programs is direct physician supervision. However, CMS removed from the coverage manual any unique physician supervision requirements for cardiac rehabilitation and instead directly references existing regulations for direct physician supervision. CMS explains that Medicare covers cardiac rehabilitation services under the benefit category "services incident to a physician's professional services" (Social Security Act 1861(s)(2)(B)). "Incident to" services must be provided under direct physician supervision. The relevant regulatory text, as referenced in the NCD is:

> 42 CFR §410.27 – Outpatient hospital services and supplies incident to a physician service: Conditions.. (f) Services furnished at a location (other than an RHC or an FQHC) that CMS designates as a department of a provider under §413.65 of this chapter must be under the *direct supervision* of a physician. "Direct supervision" means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed."

The discussion in the NCD also references several Medicare manual sections that further describe requirements for "direct supervision". Most importantly for hospitals is the statement in the Medicare Benefit Policy Manual Chapter 6 Section 20.4.1 (Coverage of Outpatient Therapeutic Services) that states, among other things, that "The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises; the hospital medical staff that supervises the services need not be in the same department as the ordering physician." Previous coverage language had included additional and confusing language addressing physician proximity and availability. These statements have been removed from the cardiac rehabilitation coverage policy.

However, because neither the NCD analysis nor the final policy directly defines "hospital premises", it remains unclear how physician supervision requirements apply when the hospital's cardiac rehabilitation service is not located in the main building of the hospital but rather in another location.

In comments to CMS on the draft policy, AHA had recommended that CMS clarify that a hospital's premises are not limited to the main building of the hospital but extend to the hospital's "campus" as defined in 42 CFR 413.65 (a)(2).[1] This would have extended this "general presumption" of compliance with physician supervision requirements beyond the main building. However, CMS declined to take our recommendation, stating that this would result in a particular definition of the term that would only apply to cardiac rehabilitation services. In the absence of a clarification in the NCD, the final decision will fall to each Medicare contractor. Therefore, hospitals with questions about this issue are encouraged to discuss this with their fiscal intermediary.

Finally, the rule notes that supervision by a physical therapist would not satisfy the Medicare direct physician supervision requirements.

Incident to: CMS did not finalize its earlier proposal that identified the "incident to" physician as the ordering physician. Instead, CMS states that satisfying the "incident to" benefit category requirements may differ based on the setting in which the services are provided. The policy analysis section specifically states:

> "The concept of 'incident to' and its rules are clarified across other CMS manuals including the Medicare Benefit Policy Manual (Chapter 6 § 20.4.1 and Chapter 15 § 60.1) and the Code of Federal Regulations depending on the site of service. This NCD does not impose additional requirements on cardiac rehabilitation service beyond what is already stated in other manuals that apply to numerous Medicare services."

[1] 42 CFR 413.65(a)(2) defines "campus" to mean "the physical area immediately adjacent to the provider's main buildings, other areas, and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus".

In comment to CMS, AHA and other organizations indicated that, depending on local medical practices, numerous physicians should be permitted to fulfill the "incident to" requirements, including the patient's primary care physician, the referring cardiologist/cardiac surgeon, or the medical director of the hospital's cardiac rehabilitation program. We believe that CMS's approach will allow this kind of flexibility in determining which physicians is responsible for complying with the "incident to" physician requirements.

Duration: The final NCD lengthens the time over which a course of cardiac rehabilitation therapy may be provided and increases the number of sessions that may be provided over the allowed period. The final policy allows a course of up to 36 sessions over 12-18 weeks without individual review by a Medicare contractor and the contractor has the discretion to cover cardiac rehabilitation services beyond 18 weeks, but coverage must not exceed a total of 72 sessions for 36 weeks.

Components of service: The final NCD states that cardiac rehabilitation programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling.

In AHA's comments to CMS we had noted that several of these components are covered separately under Medicare and sought clarification about whether these services may be separately billed for when they are provided in conjunction with the cardiac rehabilitation service. In the analysis section of the NCD, CMS states that: "The components within a comprehensive cardiac rehabilitation program are not separately billable unless the patient separately qualifies for additional services (e.g., medical nutrition therapy for certain diabetic patients.)"

In response to questions from AHA and other commenters about whether the broadened definition of this service merits an increase in Medicare reimbursement, CMS noted that the reimbursement rate for cardiac rehabilitation is outside the scope of this NCD, but "there are other mechanisms by which the agency reviews the resources associated with certain procedures and it is possible that cardiac rehabilitation would be one of those services reviewed."

Rhythm strip: Also, consistent with recommendations from the AHA, in the final NCD CMS decided to remove language regarding the use of electrocardiogram (ECG) rhythm monitoring strips. In the proposed policy, CMS had said that the appropriate use of these services "may be determined by the clinician and the Medicare local contractor if the contractor determines such a policy is necessary in their geographic area." The AHA had recommended that this language be stricken as Medicare contractors are already well aware of their discretionary authority to implement additional or stricter coverage requirements in their localities.