Clinical Policy: Phase II Outpatient Cardiac Rehabilitation Programs

Reference Number: WNC.CP.223
Last Review Date:

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Phase II outpatient cardiac rehabilitation is a comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore Members with cardiovascular heart disease to active and productive lives. A cardiac rehabilitation program includes prescribed exercise, cardiac risk factor modification, education, and counseling, which includes diet instruction and disease management. It is used to assist Members in dealing with active heart disease and must be performed in a participating facility that has current certification under the Division of Health Service Regulation in accordance with 10A NCAC 14F.1100 through 14F.2106.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that a medically necessary phase II outpatient cardiac rehabilitation program is covered when it is initiated ideally within **six months** (but is required to be initiated within 12 months) for any of the following conditions:

- **A.** Acute myocardial infarction (MI);
- **B.** Coronary artery bypass grafting (CABG);
- **C.** Percutaneous transluminal coronary angioplasty or coronary artery stenting;
- **D.** Heart or heart–lung transplant;
- **E.** Heart valve repair or replacement;
- **F.** Diagnosis of stable angina pectoris;
- **G.** Surgery to palliate a congenital heart defect;
- **H.** Repaired or unrepaired congenital heart disease with functional limitations;
- **I.** Diagnosis of cardiomyopathy with stable ventricular function;
- **J.** Members are deemed an appropriate candidate by their treating physician; **and:**
- **K.** The Member meets the criteria in **one** of the following risk categories:
    1. **High-risk patients** are defined as having any **one** of the following:
        a. Exercise capacity limited to less than or equal to 5 METs;

b. Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more ST depression by ECG, or symptoms such as shortness of breath related to cardiac ischemia;
c. Severely depressed left ventricular function, such as an ejection fraction less than or equal to 30%;
d. Resting complex ventricular arrhythmia;
e. Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing;
f. Decrease in systolic blood pressure of 15 to 20 mmHg or more with exercise;
g. Recent (within the last six months) MI that was complicated by serious ventricular arrhythmia;
h. Recent sudden cardiac arrest;
i. Shock or congestive heart failure (CHF) during an MI occurring less than three months previously.

Up to **36 sessions** (three times per week for 12 weeks) of supervised exercise with continuous telemetry monitoring are covered.

2. **Intermediate-risk** patients are defined as having any **one** of the following:
   a. Exercise capacity limited to 6 to 9 METs;
   b. Ischemic ECG response to exercise of less than 2 mm of ST depression;
   c. Uncomplicated MI, CABG, or angioplasty and a post–cardiac event maximal functional capacity of 8 METs or less on ECG exercise test;
   d. Congenital heart disease with palliated biventricular physiology;
   e. Congenital heart disease assessed as intermediate risk by Member 's cardiologist.

   Up to **24 sessions** (three times per week for eight weeks) of supervised exercise with continuous telemetry monitoring available, if needed, are covered.

3. **Low-risk** patients are defined as having any **one** of the following:
   a. Exercise capacity of greater than 9 METs;
   b. Biventricular congenital heart disease that has been successfully repaired;
   c. Congenital heart disease assessed as low risk by Member 's cardiologist.

   A program of up to **six 1-hour sessions** (three times per week for two weeks) involving risk factor reduction education and the creation of a self-administered exercise program for home use is covered.

II. It is the policy of WellCare of North Carolina® that a phase II outpatient cardiac rehabilitation program is **not covered** when continuous ECG monitoring is not performed for high-risk Members . Contraindications to an outpatient cardiac rehabilitation program include, but are not limited to, the following:
A. Marked progressive worsening of exercise tolerance, suggesting an acute pathologic process;
B. Worsening of dyspnea during exercise over the previous three to five days;
C. Acute systemic illness or fever;
D. Acute pericarditis;

E. Moderate to severe aortic stenosis;
F. New onset of atrial fibrillation;
G. Recent embolism;
H. Acute thrombophlebitis;
I. Unstable ischemia;
J. Uncontrolled arrhythmias;
K. Decompensated congestive heart failure;
L. Uncontrolled diabetes;
M. MI within two weeks.

Background[1]

Risk stratification is usually documented as high risk, intermediate risk, or low risk and is used to identify Members at risk for death by infarction or re-infarction to provide guidelines for the rehabilitative process. Risk stratification includes the degree of limitation of exercise during a treadmill electrocardiogram (ECG) stress test performed within three weeks of the program's initiation. Measurement of risk stratification is determined by applying the metabolic equivalents (METs) achieved in the qualifying formal treadmill exercise test or the cycle ergometer exercise test that was performed prior to the patient's participation. A MET or work metabolic rate/resting metabolic rate is a multiple of the resting rate of oxygen consumption during physical activity. One MET represents the approximate rate of oxygen consumption of a seated adult at rest or 3.5 ml of oxygen consumed each minute per kilogram of body weight. For Members under 18 years of age with congenital heart defects, risk stratification may include baseline oxygen saturation, state of palliated physiology, the specific nature of the defect, and history of associated arrhythmias. Measurement of risk stratification may be determined by applying the METs in Members 8 years of age and older who have undergone treadmill or cycle ergometer testing, or may also include a statement by the Member 's cardiologist that takes into account the current hemodynamic status, the specific nature of the defect, and the expected response to exercise.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)

CPT®* Codes	Description
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	06/21
Reviewed CPT codes.	10/21	02/22
Annual Review. Reviewed CPT codes and references updated.	11/22	11/22
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual review. CPT codes reviewed.	08/23	08/23
Annual Review. Changed 'beneficiary' to 'member' Removed HCPCS/ICD-10 code boxes. Removed "Medicaid and health choice' from References.	08/24	08/24
Annual Review. CPT codes reviewed. Under NC Guidance/Claims related information, updated state web address.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1R-1 Phase II Outpatient Cardiac Rehabilitation Programs. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published June 1, 2023. Accessed April 10, 2025.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.