1. **Question**: Where do we document whether we are a hospital or nonhospital-based setting?
   **Answer**: If the name of your facility does not clearly identify you as hospital-based, indicate this somewhere on the documentation you submit (e.g., letterhead, medical record, ADR response, etc.).

2. **Question**: We are a hospital-based facility. Each day, the name of the supervising physician is documented in the session notes which are electronically signed by staff. Does this meet the direct physician supervision requirements?
   **Answer**: Yes, the direct physician supervision requirements are assumed to be met in a hospital-based facility. Therefore, the process you described is more than sufficient.

3. **Question**: Our physicians often do not document the date and time when writing an order for cardiac rehab services. Is it acceptable for the nursing staff to document the date and time when the order is received?
   **Answer**: No, the physician’s order should be signed and dated by the physician at the time the order is written. The time of the order is not required.

4. **Question**: Our patients complete the Center for Epidemiological Studies Depression (CES-D) screening and it is scored with universal scoring by the RN. It is reviewed, signed, and dated by the medical director on the initial assessment and at discharge. If needed, we refer the patient to a physician. Is this sufficient for the psychosocial assessment requirement?
   **Answer**: It is acceptable for the patient to complete the screening tool and the nurse to score it. However, the key to the psychosocial assessment is not necessarily a number/range or the presence of a physician’s signature. The interpretation of the results and the action taken (even if there is none) should be clearly documented and carried over to the care plan.

   Example: Ms. Smith underwent CES-D screening and the interpretation was high risk of depression. The patient was referred to her primary care doctor for assessment and care of this problem. Signed and dated by the attending physician.

5. **Question**: Is the physician required to write a progress note for each session, or is the review of the IPP every 30 days sufficient?
   **Answer**: CGS does not require a progress note to be entered by the physician for each date. There should be documentation in the chart that the physician prescribed a specific exercise for each day (a note or order from the physician, signed and dated) and a record showing the patient did the exercise. This does not mean a physician must write an order every day, but the physician must write an order for what is done, prior to it being done. CGS expects that the cardiac rehab professional will use this prescription as a dynamic blueprint and will continuously monitor and record the patient’s objective and subjective responses to exercise therapy. While the supervising physician may not personally orchestrate each change in the exercise program, he or she will certainly rely on recorded data and observation based on the exercise sessions in his or her periodic reviews of the patient’s progress.

6. **Question**: We are a hospital-based facility and received denials for direct physician supervision. Are we able to re-bill those accounts?
   **Answer**: Yes, the direct physician supervision requirements are considered to meet the covered diagnosis requirement.

7. **Question**: Is the physician’s documentation of the patient’s diagnosis on the order sufficient to establish a covered condition?
   **Answer**: Yes, if a covered diagnosis on the order substantiates the primary diagnosis on the claim, that documentation would be considered to meet the covered diagnosis requirement.

8. **Question**: If the covered diagnosis is not indicated on the order, is it sufficient if the covered diagnosis is substantiated in the electronic medical record?
   **Answer**: Yes, however, there is the potential of a denial if our reviewers are left to sort through a potentially very long problem list. Our recommendation when using a problem list is to prioritize based on the particular case (i.e., a referral to a cardiac rehab program and it should be easily understood that the problem list is substantiating the reason for the referral).

9. **Question**: Do you recommend highlighting information in the medical record that we feel addresses the coverage requirements?
   **Answer**: Yes, if you are sending a large volume of documentation and/or if the coverage requirements are not clearly documented, it is helpful to point the reviewer to the information (e.g., highlight).

10. **Question**: I have exercise prescriptions signed at the beginning of treatment and use these prescriptions throughout the 36 visits. Sometimes, we make minor changes to the exercise program based on the patient’s responses. Does the prescription need to be updated in these situations?
    **Answer**: Yes, we believe the exercise prescription is an overarching dynamic blueprint of the exercise program for the patient, and we expect the person managing the exercise will need to make minor adjustments. Therefore, we recommend a range of METS and minutes to direct the person managing the exercise to manage the patient. If there is a significant deviation from that blueprint, then that needs to be signed off by a physician.

11. **Question**: We have a cardiac rehab department that is a physician practice but it is owned by the hospital, on our hospital campus, and the services are billed by the facility. Would you consider this hospital-based?
    **Answer**: During our call, we recommended that you maintain a log, signed by the physician who is supervising services on that day. Upon further review, we believe that the circumstances you describe meet the hospital-based requirements. As we indicate in our web article, direct physician supervision is assumed to be provided when cardiac rehab is provided in a hospital-based setting.

12. **Question:** If a change is needed in the exercise program, does that need to be documented, signed, and dated by the medical director or the ordering physician?

**Answer:** If a significant change to the blueprint signed off on at the beginning of the program or 30-day update is needed, the physician must document, sign, and date the change. It is not acceptable for non-physician staff to make changes to the original order. If the medical director is willing to take responsibility for the change, it is acceptable for the medical director to document the change.

13. **Question:** We received denials for not meeting the direct physician supervision requirement. When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** A redetermination is the first level of appeal and is a separate review from the original medical review decision. Your appeals were most likely denied because the reviewer only had the documentation to support the direct physician supervision requirement and no documentation to support the other coverage requirements for cardiac rehab services. Therefore, the next level of appeal is a reconsideration to the Qualified Independent Contractor (QIC). When you submit a reconsideration request, the QIC will request the documentation you submitted in the original medical review. Since the documentation to support direct physician supervision requirement was not included in the original review, we recommend you submit that with your reconsideration request. In the future, keep in mind that each level of review and/or appeal is a separate review; therefore, all documentation to support the medical necessity of all services on the claim should be submitted.

14. **Question:** Is there a timeframe limitation on any of the covered diagnoses for cardiac rehab services?

**Answer:** If the original order for cardiac rehab is generic, but the specific exercise program is documented in the individualized treatment plan that is signed by the physician every 30 days, is that sufficient, or is it required on the original order?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

15. **Question:** I have a form with a list of the covered diagnoses for cardiac rehab services. If the appropriate diagnosis for the patient is checked and the date of the event indicated, is that sufficient, or do I need to obtain documentation to support that the event occurred?

**Answer:** The medical director and physicians acting as the supervising physician must possess all of the following:

- Expertise in the management of individuals with cardiac pathophysiology
- Cardiopulmonary training in basic life support or advanced cardiac life support

16. **Question:** Some documentation, such as the original order for cardiac rehab is generic, but the specific exercise program is documented in the individualized treatment plan that is signed by the physician every 30 days, is that sufficient, or is it required on the original order?

**Answer:** The limitation of 36 sessions is a frequency limitation and is not dependent upon the patient’s diagnosis. We are instructed to deny claims that exceed 36 sessions when HCPCS modifier KX is not included on the claim line. You do not need to request pre-approval from CGS, but you should ensure your documentation supports the medical necessity of the services beyond 36 sessions and use of HCPCS modifier KX.

**Reference:** CMS Claims Processing Manual (Pub. 100-04), chapter 32, section 140.2.2.4 (http://www.cms.gov/Regulations-and-Guidance/Manuals/Downloads/clm104c32.pdf)

17. **Question:** If a significant change to the blueprint signed off on at the beginning of the program or 30-day update is needed, the physician must document, sign, and date the change. It is not acceptable for non-physician staff to make changes to the original order. If the medical director is willing to take responsibility for the change, it is acceptable for the medical director to document the change.

**Reference:** CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 6, section 20.5.2, the direct physician supervision guidelines for cardiac and pulmonary rehab services are the same. We are in the process of developing an article to address coverage and documentation of pulmonary rehab services and will provide clarification and guidance in that document.

18. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

**Reference:** CMS Claims Processing Manual (Pub. 100-04), chapter 32, section 140.2.2.4 (http://www.cms.gov/Regulations-and-Guidance/Manuals/Downloads/clm104c32.pdf)

19. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

20. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

21. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

22. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

23. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

24. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.

25. **Question:** When we submitted a redetermination request for those denials, we only submitted the physician logs for those services and our appeals were denied. Are we allowed to re-appeal the second denial based on the information given today?

**Answer:** The regulations indicate that an acute myocardial infarction must have occurred within the preceding 12 months of the initiation of cardiac rehab services. Although the other diagnoses do not specify a specific timeframe, we would expect the documentation to support that cardiac rehab services continue to be medically necessary at the time the services are rendered.
for the services being requested, it is important to include that original order. It is not necessary to send the entire medical record every time, but you do want to be sure to include all of the relevant documentation for the appropriate dates of service regardless of its location in the chart.

22. Question: We have received several denials for lack of medical necessity for cardiac patients. We normally send the order that the physician has signed and dated with the diagnosis, the history and physical (H&P), cardiology report, surgery report, and discharge. Are we missing anything?

Answer: A denial for medical necessity may be for reasons other than lack of a covered diagnosis. Please review the clarifications in our article and ensure all of the coverage requirements are met, clearly documented, and submitted with your responses to Additional Development Requests (ADRs).

23. Question: Do results/outcomes of the assessments/exercise program need to be documented in daily monitoring sheets as well as the treatment plan?

Answer: The purpose of the outcomes assessment requirement is to show that the intervention or services did/did not result in some benefit to the patient. Documentation principles instruct you to document what you’re going to do, document that you did it, and document what happened after you did it. If, for example, a 4-week weight reduction program is indicated in the original treatment plan, you annotate the daily weight of the patient, and the physician signs off on the final weight in the overarching care plan, that is sufficient.

24. Question: When a patient is referred to our facility for cardiac rehab, our exercise physiologist assesses the patient, develops an exercise prescription, and the medical director reviews and signs off on it. If the exercise program cannot be initiated until the physician’s signature is obtained on the exercise prescription, how is the assessment captured?

Answer: Based on your facility’s protocol, the assessment is part of the referral process and is outside of the scope of the cardiac rehab program since cardiac rehab services do not officially start until the physician signs off on all of the required elements addressed in our article.

25. Question: If a psychosocial assessment was completed while the patient was an inpatient and the outcome is documented in the chart, does this meet the psychosocial assessment requirement for the cardiac rehab referral?

Answer: Remember, one of the key components of the psychosocial assessment for cardiac rehab is the application of the results. Therefore, it should be documented that the psychosocial assessment was completed in the hospital with the date and results. Part of the cardiac prescription should also include the plan to monitor the patient and the protocol if the patient later requires further assessment or care.

26. Question: Can you clarify if the physician must review, sign, and date the psychosocial assessment?

Answer: Regardless of the method used to conduct the psychosocial assessment, documentation is expected to include the signature and date of the healthcare professional who conducted the assessment, an interpretation of the results, and the signature and date of the physician who utilized the results to refer the patient to the primary care physician, the cardiac rehab physician must sign and date that he has reviewed the documentation of the assessment, the results, and the plan of care.

27. Question: Is there any flexibility in obtaining the physician’s signature on the individual treatment plan every 30 days (e.g., 30 days falls on a weekend or the patient becomes ill)?

Answer: We would expect the review to occur as close to 30 days as possible, but we would not be so strict to deny services if the 30th day fell on a Sunday and the review and signature didn’t occur until Monday. We would expect what is reasonable based on the patient’s situation.

28. Question: I have a patient that has an LVAD in place and his transplant team requires cardiac rehab prior to receiving a heart transplant, but he doesn’t have any of the covered diagnoses for cardiac rehab. Can you offer any guidance?

Answer: The list of covered diagnoses for cardiac rehab is part of a national policy and we are not able to make coverage determinations for any other diagnoses. This sounds like a requirement specific to the transplant program rather than a Medicare policy; therefore, cardiac rehab services would not be covered by Medicare for this patient. However, if the patient chooses to receive the cardiac rehab services after proper notification and a claim is submitted and subsequently denied, you would have the opportunity to exercise your appeal rights.

29. Question: Based on the 1/18/13 revision date in your posted cardiac rehab article, are the new requirements effective for dates of service starting 1/18/13, or the date of the ADR request? The reason for this question is that, for example, the new physician prescribed exercise requirements as described in the new requirements may be lacking in one of the components (not knowing it was a requirement prior to 1/18/13) that can’t be added retroactively, but can now be included going forward. If these new requirements go into effect for record request date, then facilities will have no way of correcting these retroactively, but can make the needed corrections/additions moving forward. Will there be a “grace period” of sorts for the new clarification of guidelines?

Answer: The requirement to have an exercise prescription has been a requirement from the beginning; however, we understand that the recent clarifications include specific required elements. While there is no “grace period” for the revised language per se, upon request from CGS, we recommend that you submit the prescription as you received it, as well as any subsequent clarification you received from the prescribing physician with regard to the prescription. We review the totality of the medical records you provide and will certainly take other supporting documentation into account.

30. Question: Under the physician prescription of exercise on page 2 of the cardiac rehab article (1/18/13 revision), it speaks to target intensity and gives 2 examples (% of HR and number of METs) of meeting this component. Our facility uses the RPE Range (Rated Perceived Exertion). Would this be considered to meet that requirement?

Answer: Yes, the RPE range is an acceptable indication of target intensity, for purposes of meeting the cardiac rehabilitation documentation and coverage requirements.