CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12497	**Date: February 8, 2024**
	Change Request 13513

SUBJECT: Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation (PR/CR/ICR) Expansion of Supervising Practitioners

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make contractors aware of policy updates for the Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation (PR/CR/ICR) Expansion of Supervising Practitioners resulting from changes specified in the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) Final Rule (88 FR 78818), published in the Federal Register on November 16, 2023.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 12, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/140/Cardiac Rehabilitation (CR) Programs, Intensive Cardiac Rehabilitation ((ICR) Programs, and Pulmonary Rehabilitation (PR) Programs On or After January 1, 2024
R	32/140/140.1.1/Coding Requirements for Cardiac Rehabilitation Services Furnished On or Before Dec. 31, 2009
R	32/140/140.2/Cardiac Rehabilitation Program Services Effective for Dates of Service On or After January 1, 2024
R	32/140/140.2.1/Coding Requirements for CR Services Furnished On or After January 1, 2010
R	32/140/140.3/ICR Program Services Effective for Dates of Service On or After January 1, 2024
R	32/140/140.4/PR Program Services Effective for Dates of Service On or After January 1, 2024
R	32/140/140.4.2.5/Edits for PR Services Exceeding 72 Sessions
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III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12497	Date: February 8, 2024	Change Request: 13513

SUBJECT: Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation (PR/CR/ICR) Expansion of Supervising Practitioners

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 12, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to make Medicare contractors aware of the conditions of coverage for Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) resulting from changes specified in the calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) final rule (FR) published on November 16, 2023.

B. Policy: Updates to PR, CR, and ICR Conditions of Coverage:

In the CY 2024 MPFS DR issued November 16, 2023, CMS finalized additions and revisions to the PR and CR/ICR regulations to codify the statutory changes made in section 51008 of the 2018 Bipartisan Budget Act to expand the types of practitioners that may supervise PR, CR, and ICR. These additions and revisions include changes to the regulatory language in the definitions, settings, and supervising practitioner standards under §§ 410.47 and 410.49 and are effective January 1, 2024.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13513 - 04.1	Effective for claims with dates of service on and after January 1, 2024, contractors shall be aware of the changes in coverage for PR, CR, and ICR. See Pub 100-04, Claims Processing Manual (CPM), chapter 32, section 140.	X	X							
13513 - 04.2	Contractors shall not search their files, but contractors shall adjust claims brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			DME MAC	CEDI	
		A	B	HHH			
13513 - 04.3	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

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140 - Cardiac Rehabilitation (CR) Programs, Intensive Cardiac Rehabilitation (ICR) Programs, and Pulmonary Rehabilitation (PR) Programs *On or After January 1, 2024*

(Rev.12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

Cardiac rehabilitation (CR) means a physician *or nonphysician practitioner* supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Intensive cardiac rehabilitation (ICR) program means a physician *or nonphysician practitioner* supervised program that furnishes CR and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements described in 42 CFR 410.49(c). *Nonphysician practitioner means a physician assistant, nurse practitioner, or clinical nurse specialist as those terms are defined in section 1861(aa)(5)(A) of the Social Security Act (the Act).*

Effective *January 1, 2024*, Medicare Part B pays for CR/ICR if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which it is administered, and the physician administering the program.

Pulmonary rehabilitation (PR) means a physician *or nonphysician practitioner* supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. *Nonphysician practitioner means a physician assistant, nurse practitioner, or clinical nurse specialist as those terms are defined in section 1861(aa)(5)(A) of the Act.*

Effective *January 1, 2024*, Medicare Part B pays for PR if specific criteria are met by the Medicare beneficiary, the PR program itself, the setting in which it is administered, and the physician administering the program, as outlined below.

140.1.1 - Coding Requirements for Cardiac Rehabilitation Services Furnished On or Before Dec. 31, 2009

(Rev.12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

The following are the applicable Healthcare Common Procedure Coding System (HCPCS) codes:

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

93798 - Physician *or other qualified health care professional* services for outpatient cardiac rehabilitation; with continuous ECG
monitoring (per session).
Note: The above HCPCS descriptors are effective January 1, 2013.

Effective for dates of service on or after January 1, 2008, and before January 1, 2010, providers and practitioners may report more than one unit of CPT code 93797 or 97398 for a date of service if more than one CR session lasting at least 1 hour each is provided on the same day. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the CR provided on a given day total 1 hour and 50 minutes, then only one session should be billed to report the CR provided on that day.

140.2 – Cardiac Rehabilitation Program Services *Effective for Dates of Service On or After January 1, 2024*

(Rev.12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

As specified at 42 CFR 410.49, Medicare Part B covers CR for beneficiaries who have experienced one or more of the following:

• An acute MI within the preceding 12 months;
• A coronary artery bypass surgery;
• Current stable angina pectoris;
• Heart valve repair or replacement;
• PTCA or coronary stenting;
• A heart or heart-lung transplant;
• Stable, chronic heart failure defined as patients with left ventricular ejection fraction
of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, on or after February 18, 2014; or,
• Other cardiac conditions as specified through a national coverage determination (NCD).

CR must include all of the following components:

• Physician prescribed exercise each day CR items and
services are furnished.
• Cardiac risk factor modification, including education, counseling, and behavioral
intervention, tailored to the individual's needs.
• Psychosocial assessment.
• Outcomes assessment.
• An individualized treatment plan detailing how components are utilized for each
patient. The individualized treatment plan must be established, reviewed, and signed
by a physician every 30 days.

Medicare Part B pays for CR in a physician's office or a hospital outpatient setting. All settings must have a physician *or nonphysician practitioner* immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician *or nonphysician practitioner* meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27.
Note: Nonphysician practitioners are eligible to supervise CR effective January 1, 2024.

As specified at 42 CFR 410.49(f)(1), the number of CR sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the
Medicare Administrative Contractor (MAC).

140.2.1 – Coding Requirements for CR Services Furnished On or After January 1, 2010

(Rev.12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

The following are the applicable Current Procedural Technology (CPT) codes for CR services:

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

93798 Physician or other qualified care health professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (Per Session)
Note: The above HCPCS descriptors are effective January 1, 2013.

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 2 1-hour sessions per day. In order to report one session of CR in a day, the duration of treatment must be at least 31 minutes. Two sessions of CR may only be reported in the same day if the duration of treatment is at least 91 minutes. In other words, the first session would account for 60 minutes and the second session would account for at least 31 minutes if two sessions are reported. If several shorter periods of CR are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.

Example: If the patient receives 20 minutes of CR in the day, no CR session may be reported because less than 31 minutes of services were
furnished.

Example: If a patient receives 20 minutes of CR in the morning and 35 minutes of CR in the afternoon of a single day, the hospital or practitioner would report 1 session of CR under 1 unit of the appropriate CPT code for the total duration of 55 minutes of CR on that day.

Example: If the patient receives 70 minutes of CR in the morning and 25 minutes of CR in the afternoon of a single day, the hospital or practitioner would report two sessions of CR under the appropriate CPT code(s) because the total duration of CR on that day of 95 minutes exceeds 90 minutes.

Example: If the patient receives 70 minutes of CR in the morning and 85 minutes of CR in the afternoon of a single day, the hospital or practitioner would report two sessions of CR under the appropriate CPT code(s) for the total duration of CR of 155 minutes. A maximum of two sessions per day may be reported, regardless of the total duration of CR.

sessions after 36 (to include completed ICR sessions prior to switch). In these cases, and consistent with the information above, the -KX modifier must be included on the claim should the beneficiary participate in more than 36 CR sessions following the switch.

See Pub. 100-06, Medicare Financial Management Manual, chapter 6, section 420, and Pub.
100-02, Medicare Benefit Policy Manual, chapter 15, section 232, and Pub. 100-08, Medicare

Program Integrity Manual, chapter 10, section 10.2.2.5 for detailed information regarding CR and ICR policy and claims processing.

140.3 – ICR Program Services *Effective for Dates of Service On or After January 1, 2024*

(Rev.12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

As specified at 42 CFR 410.49, Medicare Part B covers ICR for beneficiaries who have experienced one or more of the following:

• An acute MI within the preceding 12 months;
• A coronary artery bypass surgery;
• Current stable angina pectoris;
• Heart valve repair or replacement;
• PTCA or coronary stenting;
• A heart or heart-lung transplant;
• Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and NYHA class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, on or after February 9, 2018; or,
• Other cardiac conditions as specified through an NCD. The NCD process may also be used to specify non-coverage of a cardiac condition for ICR if coverage is not supported by clinical evidence.

ICR must include all of the following components:

• Physician prescribed exercise each day CR items and services are furnished.
• Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the individual's needs.
• Psychosocial assessment.
• Outcomes assessment.
• An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

A list of approved ICR programs, identified through the NCD process, will be listed in the Federal Register and is available on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/ICR. In order to be approved, a program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following for its patients:

• Positively affected the progression of coronary heart disease.
• Reduced the need for coronary bypass surgery.
• Reduced the need for percutaneous coronary interventions.

An ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before CR services to after CR services:

• Low density lipoprotein.
• Triglycerides.
• Body mass index.
• Systolic blood pressure.
• Diastolic blood pressure.
• The need for cholesterol, blood pressure, and diabetes medications.

Medicare Part B pays for ICR in a physician's office or a hospital outpatient setting. All settings must have a physician *or nonphysician practitioner* immediately available and accessible for medical consultations and

emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician *or nonphysician practitioner* meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27.
Note: Nonphysician practitioners are eligible to supervise ICR effective January 1, 2024.

As specified at 42 CFR 410.49(f)(2), ICR sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

140.4 – PR Program Services *Effective for Dates of Service On or After January 1, 2024*

(Rev.12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

As specified in 42 CFR 410.47, Medicare Part B covers PR for beneficiaries:

- With moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease;
- Who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks (effective January 1, 2022);
- Additional medical indications for coverage for PR may be established through an NCD.

PR must include all of the following components:

• Physician prescribed exercise during each pulmonary rehabilitation session.
• Education or training that is closely and clearly related to the individual's care and treatment which is tailored to the individual's needs and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life. Education must include information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
• Psychosocial assessment.
• Outcomes assessment.
• An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

Medicare Part B pays for PR in a physician's office or a hospital outpatient setting. All settings must have the following: (i) A physician *or nonphysician practitioner* immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician *or nonphysician practitioner* meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27, and, (ii) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.
Note: Nonphysician practitioners are eligible to supervise PR effective January 1, 2024.

As specified at 42 CFR 410.47(e), the number of PR sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the MACs.

140.4.2.5 – Edits for PR Services Exceeding 72 Sessions

(Rev.12497; Issued: 02-08-24; Effective: 01-01-24; Implementation: 03-12-24)

Effective for claims with dates of service on and after January 1, 2010, through December 31, 2021, CWF shall reject PR claims that exceed 72 sessions. Medicare contractors shall deny PR claims that exceed 72 sessions regardless of whether the -KX modifier is submitted on the claim line.

The following messages shall be used when Medicare contractors deny PR claims that exceed 72 sessions:

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N362: "The number of days or units of service exceeds our acceptable maximum."

MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."

Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Effective for claims with dates of service on and after January 1, 2022, Medicare Contractors shall deny PR claims that exceed 72 sessions only when the -KX modifier is not submitted on the claim line.