QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Blood Pressure Screening Recommendations for Hypertension (HTN)

Screening Criteria and Frequency:

- Yearly for adults 40 years of age or older
- Yearly for adults at risk for hypertension, including those with genetic and physical risk factors such as:

- Elevated blood pressure (BP) between 120/80 mmHg and 129/80 mmHg
- History of cardiovascular disease (heart attack, heart failure, stroke, or transient ischemic attacks)
- Diagnosis of diabetes
- Diagnosis of chronic kidney disease (CKD)
- Diagnosis of sleep apnea
- Overweight or obesity
- Tobacco use
- Overconsumption of alcohol
- Physical inactivity
- Unhealthy diet
- African and/or Asian descent
- History of depression
- Family history of hypertension, premature cardiovascular disease (CVD), familial hypercholesterolemia, diabetes

Screening Procedures:

1. Evaluate BP measurements throughout two or three in-office visits within one- to four-week intervals. Only one in-office visit is necessary for a hypertension diagnosis if blood pressure is ≥180/110 mm Hg and there is evidence of CVD.
2. Confirm hypertension diagnosis with a 24-hour Ambulatory Blood Pressure Monitoring (ABPM) test or patient Self-Measured Blood Pressure (SMBP) monitoring if the patient's BP classifies as high-normal BP or grade 1 hypertension (systolic 130 - 159 mm Hg and/or diastolic 85–99 mm Hg).
3. Complete a physical examination and laboratory analysis to conclude the determination of hypertensive condition including sodium, potassium, serum creatinine, and estimated glomerular filtration rate (eGFR), lipid profile, fasting glucose blood tests, dipstick urine test, and 12-lead electrocardiogram (ECG).

Coding and Billing Codes Related to Hypertension (HTN) Screening Healthcare Procedure Coding System (HCPCS) | Healthcare Effectiveness Data and Information Set (HEDIS) Current Procedural Terminology® (CPT)	
Merit-based Incentive Payment System (MIPS) documentation of blood pressure	**HCPCS:** G8752 or G8753 or **HEDIS CPT/CPT II:** 3074F or 3075F or 3077F **AND HCPCS:** G8754 or G8755 or **HEDIS CPT/CPT II:** 3078F or 3079F or 3080F **OR HCPCS:** G8756
HTN Diagnosis and Adequate Control (140/90 mmHg)	**HCPCS:** G8752 or **HEDIS CPT/CPT II:** 3074F or 3075F **AND HCPCS:** G8754 or **HEDIS CPT/CPT II:** 3078F or 3079F
CPT codes	**Ambulatory blood pressure monitoring:** 93784, 93786, 93788, 93790
	Self–measured blood pressure monitoring: 99473, 99474
2022 MIPS Quality ID #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Measure Description: Percent of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive. **Performance Met:** HCPCS **G8950**	**Patient encounter criteria (CPT or HCPCS) codes:** **Psychiatric diagnostic evaluation services:** 90791, 90792 **General ophthalmological services and procedures:** 92002, 92004, 92012, 92014 **New patient evaluation and management (E/M):** 99202, 99203, 99204,99205 **Established patient office or other outpatient services:** 99212, 99213, 99214, 9921 **Observation or inpatient care services:** 99236 **New or established patient emergency department services:** 99281, 99282, 99283, 99284, 99285 **New or established patient comprehensive nursing facility assessments:** 99304, 99305, 99306 **Subsequent nursing facility care:** 99307, 99308, 99309,99310 **Nursing facility discharge services:** 99315, 99316 **Other nursing facility services:** 99318 **New patient domiciliary, rest home, or custodial care services:** 99324, 99325,99326, 99327,99328,99334, 99335, 99336, 99337, 99339, 99340 **New patient home services:** 99341, 99342, 99343, 99344, 99345 **Established patient home services:** 99347, 99348, 99349, 99350H

International Classification of Diseases, Tenth Revision (ICD-10) Coding for Hypertension	
Code and Name	**Description and Code Use**
R03.0: Elevated blood pressure reading	This describes a temporary occurrence of high blood pressure in a patient without a diagnosis of hypertension.
I10: Essential (primary) hypertension (HTN)	The patient meets the criteria for hypertension but does not have comorbid cardiac or renal disease.
I15 Secondary hypertension	**I15.0** Renovascular hypertension **I15.1:** Hypertension secondary to other renal disorders **I15.2:** Hypertension secondary to endocrine disorders **I15.9:** Secondary hypertension, unspecified ***Note**: You must also code the underlying condition.
I11.9: Hypertensive heart disease	**I11.0:** Hypertensive Heart Disease *with* heart failure.
	I11.9: Hypertensive Heart Disease without heart failure
I12: Hypertensive chronic kidney disease (CKD)	**I12.9:** Hypertensive CKD *with* stage 1-4 CKD, *or* unspecified CKD
	I12.0: Hypertensive chronic kidney disease *with* stage 5 CKD or end-stage renal disease (ESRD)
I13: Hypertensive heart and CKD	**I13.0**: Hypertensive heart and CKD with heart failure and stage 1-4 CKD, or unspecified CKD
	I13.1: Hypertensive heart and CKD without heart failure
	I13.10: Hypertensive heart and CKD without heart failure, with stage 1-4 CKD or unspecified CKD
	I13.2: Hypertensive heart and CKD without heart failure, with stage 5 CKD or ESRD

CPT/HCPCS Codes for Cardiovascular Disease-Related Preventative Services	
Cardiovascular disease (CVD) screening	80061, 82465, 83718, 84478
Intensive behavioral therapy (IBT) for cardiovascular disease (CVD)	G0446
Intensive behavioral therapy (IBT) for obesity	G0447
Medical nutrition therapy (MNT) services	97802, 97803, 97804, G0270, G0271
Alcohol misuse screening & counseling	G0442, G0443
Counseling to prevent tobacco use	99406, 99407

References:

1. SMBP CPT® coding: https://www.ama-assn.org/system/files/2020-06/smbp-cpt-coding.pdf
2. Take the Guesswork Out of Hypertension Coding: https://www.aapc.com/blog/52789-take-the-guesswork-out-of-hypertension-coding/
3. 2020 International Society of Hypertension Global Hypertension Practice Guidelines: https://www.ahajournals.org/doi/10.1161/HYPERTENSIONAHA.120.15026#:~:text=Hypertension%20Diagnosis%20%E2%80%93%20Office%20BP%20Measurement&text=Usually%202%E2%80%933%20office%20visits,of%20cardiovascular%20disease%20(CVD).
4. MIPS Quality ID #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2022_Measure_317_MedicarePartBClaims.pdf

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QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Recommendations for Type 2 Diabetes Screening

Screening Is Highly Recommended for the Following Patient Populations:

1. Adults 18-34 years old or older who are overweight or obese (Body Mass Index (BMI) ≥25 kg/m2 or ≥23 kg/m2 in Asian Americans) who have one or more of the following risk factors:
   - First-degree relative with diabetes
   - High-risk ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
   - History of cardiovascular disease
   - Hypertension (≥140/90 mmHg or on therapy for hypertension)
   - High-density lipoprotein cholesterol level <35 mg/dL and/or a triglyceride level >250 mg/dL
   - Women with polycystic ovary syndrome
   - Physical inactivity
   - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
2. Patients with Human Immunodeficiency Virus
3. Adults aged 35 or older

Screening Frequency:

- Annual screening for **all adults** should start at the age of 35.
- Test patients with prediabetes (A1C ≥ 5.7%, impaired glucose tolerance or impaired fasting glucose) yearly.
- Provide lifelong testing at least every three years to women diagnosed with gestational diabetes mellitus.
- Repeat screening test for all patients at least every three years even if initial results were normal. Consider testing more frequently if initial results were concerning and new symptoms or risk factors emerge that indicate a need to screen earlier.

Diabetes Diagnostic Tests

Test	Results Indicating Diabetes Diagnosis
Hemoglobin A1C	≥6.5%
Fasting plasma glucose	≥126 mg/dL
2-hour plasma glucose during 75-g Oral Glucose Tolerance Test	≥200 mg/dL
Random plasma glucose	≥200 mg/dL
Point-Of-Care Testing of Hemoglobin A1C is not recommended for diagnosing diabetes.	

Healthcare Effectiveness Data and Information Set Measure Codes	
Hemoglobin A1C control for patients with diabetes (HBD)	Hemoglobin A1C test: 83037, 83036
	HbA1C Level < 7.0%: 3044F
	HbA1C Level ≥ 7.0% and <8.0%: 3051F
	HbA1C Level ≥ 8.0% and ≤ 9.0%:3052F

Current Procedural Terminology®/Health Care Procedure Coding System (HCPCS) Codes for Diabetes-Related Preventative Services	
Diabetes screening	82947, 82950, 82951
Depression screening	G0444
Glaucoma screening	G0117, G0118
Cardiovascular disease screening	80061, 82465, 83718, 84478
Intensive behavioral therapy (IBT) for cardiovascular disease (CVD)	G0446
Intensive behavioral therapy (IBT) for obesity	G0447
Medical nutrition therapy (MNT) services	97802, 97803, 97804, G0270, G0271
Alcohol misuse screening & counseling	G0442, G0443
Counseling to prevent tobacco use	99406, 99407
Hepatitis B vaccine	90740, 90743, 90744, 90746, 90747, G0010

References:

1. 2022 Diabetes Standards of Care: https://diabetesjournals.org/clinical/article/40/1/10/139035/Standards-of-Medical-Care-in-Diabetes-2022
2. Treatment of Diabetes in Older Adults: An Endocrine Society Clinical Practice Guideline: https://pubmed.ncbi.nlm.nih.gov/30903688/

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QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Recommendations for Chronic Kidney Disease (CKD) Screening

Patient Risk Factors	Screening Test	Clinical Indicators of CKD
○ Diabetes ○ Hypertension ○ Age 60 years or older ○ Family history of CKD, diabetes, or hypertension ○ History of acute kidney injury ○ *U.S. ethnic minority status	Single Void Specimen for albumin-to-creatinine ratio (ACR) to detect albuminuria Serum creatinine to estimate glomerular filtration rate (GFR)	**Present for three months or more:** ○ ACR >30 mg/g ○ GFR <60 mL/min/1.73 m2 ○ Abnormalities of kidney structure or function

*Black/African American, Hispanic/Latino, Asian American, Pacific Islander, American Indian, Alaska Native, Native Hawaiian, or Other Pacific Islander

Annually assess urinary albumin levels using single void specimen for albumin-to-creatinine ratio (UACR) and evaluate the estimated glomerular filtration rate (eGFR) of:

- All patients with Type 2 diabetes annually, regardless of treatment.
- Patients with Type 1 diabetes with a disease duration of ≥5 years.

Bi-annual monitoring of UACR and eGFR is recommended to guide treatment for patients with diabetes and urinary albumin ≥300 mg/g creatinine and/or an eGFR 30–60 mL/min/1.73 m2.

Current Procedural Terminology/Health Care Procedure Coding System Codes for Chronic Kidney Disease-Related Preventative Services	
Diabetes screening	82947, 82950, 82951
Cardiovascular disease screening	80061, 82465, 83718, 84478
Intensive behavioral therapy (IBT) for cardiovascular disease (CVD)	G0446
Intensive behavioral therapy (IBT) for obesity	G0447
Medical nutrition therapy (MNT) services	97802, 97803, 97804, G0270, G0271
Alcohol misuse screening & counseling	G0442, G0443
Counseling to prevent tobacco use	99406, 99407

References:

1. National Kidney Foundation (NKF) CKD Reference Card: https://www.kidney.org/sites/default/files/NKF-CKD-Card.pdf

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QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Considerations for Referrals to Clinical Specialty Services

Initiate timely referrals to nephrologists and registered dietitian nutritionists (RDN) to slow the development and progression of chronic kidney disease (CKD) and end-stage renal disease.

<table>
<tr><th colspan="7">Considerations for Referring Patients to Nephrology Specialty Services</th></tr>
<tr><td colspan="2">CKD Stage 1</td><td>CKD Stage 2</td><td colspan="2">CKD Stage 3</td><td>CKD Stage 4</td><td>CKD Stage 5</td></tr>
<tr><td colspan="2">Kidney damage and GFR > 90</td><td>Kidney damage and GFR 60-89</td><td>3A
GFR 45-59</td><td>3B
GFR 30-44</td><td>GFR 15-29</td><td>GFR <15 (no dialysis)</td></tr>
<tr><td colspan="3">ACR > 30 mg/g</td><td>ACR: 30-300 mg/g</td><td colspan="2">ACR: > 300 mg/g</td></tr>
<tr><td colspan="3">Refer patients for nephrology consultation if the trend of their eGFR values indicates a decline by > 4mL/min/yr. If GFR is low, evaluate for proteinuria.</td><td colspan="2">Consider referring patients for a nephrology consult and nutritional assessment by an RDN to help patients strengthen self-management skills that slow disease progression.</td><td>Patients should be referred to a nephrologist and RDN for nutritional assessment and discussion about treatment options, including eligibility and preparation for organ transplant or dialysis.

Patients should be provided with kidney disease patient education (KDE) services.</td><td>Patients require management by a nephrology specialty team (nephrologist, renal dietitian, nephrology nurse, nurse practitioner or physician assistant).</td></tr>
<tr><td colspan="7">Consider consulting with a nephrologist at any point in a patient's CKD disease process, especially if they experience a steady reduction in their GFR of more than 25-30%.</td></tr>
<tr><td colspan="7">*Assessment of estimated glomerular filtration rate (eGFR) and presence or severity of proteinuria is more precise than only using serum creatinine (SCr) concentrations to recognize advanced CKD, particularly in elderly and frail patients.</td></tr>
<tr><td>ICD-10-CM</td><td>N18.1</td><td>N18.2</td><td colspan="2">N18.3</td><td>N18.4</td><td>N18.5</td></tr>
</table>

Medicare Billing Codes for KDE Services for Patients with Stage 4 CKD:

- **Use diagnosis code 585.4** (chronic kidney disease, stage IV (severe) to code for KDE services.
- **G0420:** Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour
- **G0421:** Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour

References:

1. Chronic Kidney Disease (CKD) Provider's Guide to Coding and Documenting Diagnosis Cigna-HealthSpring: https://www.cigna.com/static/docs/medicare-2018/hcp-icd-ckd.pdf
2. Medicare Claims Processing: Coverage of Kidney Disease Patient Education Services https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1876CP.pdf

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QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Initiate Timely Referrals to Registered Dietitian Nutritionists (RDNs) To Slow the Progression of Chronic Kidney Disease (CKD) and Diabetes

Considerations for Referring Patients to RDN for Medical Nutrition Therapy (MNT) Services for Diabetes and CKD Care

- Upon initial diagnosis
- When the hemoglobin A1c trend is worsening
- Upon changes in treatment and medication regimen
  (Example: conversion from oral to non-insulin injectable or insulin and changes in insulin regimen)
- If there is a development or progression of hypertension
- For management of congestive heart failure and dyslipidemia
- With the presence of an eating disorder
- Upon the new onset of chronic disease complications and signs/symptoms of disease progression

Medicare Coverage and When to Refer to MNT Services

- **Medicare Advantage plans** must cover MNT services for diabetes and renal disease because MNT is a Part B benefit.
- Basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes is three hours. MNT services in subsequent years for renal disease or diabetes include two (2) hours.
- Patients can be referred to individual or group MNT sessions (groups must include 2 or more people).
- Provide a second referral to MNT in the same year for change in diagnosis, medical condition or treatment regimen, including additional hours needed for renal disease.
- Patients can be referred for additional MNT services beyond the three hours in the initial calendar year and two follow-up hours in subsequent years that are typically covered by Medicare when a physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary and provides a new MNT referral.

Payable MNT

- **97802** – Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each is 15 minutes. This code is used only once for the initial assessment of a new patient.
- **97803** - Reassessment and intervention, individual, face-to-face with the patient, each is 15 minutes. This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient.
- **97804** – Group MNT counseling (two or more individuals), each is 30 minutes. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient, and the patient is attending in a group.

Payable Codes for MNT when there is a Change in a Beneficiaries' Condition

- **G0270** - Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral
  in the same year for change in diagnosis, medical condition, or treatment regimen (including additional hours
  needed for renal disease), individual, face-to-face with the patient, each is 15 minutes.
- **G0271** - Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral
  in the same year for change in diagnosis, medical condition or treatment regimen (including additional hours
  needed for renal disease) group (2 or more individuals), each is 30 minutes.

Telehealth Options for Registered Dietitian Nutritionist (RDN) Services

The Academy of Nutrition and Dietetics confirms that registered dietitian nutritionists and nutrition professionals are approved to offer the following Medicare Part B services via telehealth:

- Medical nutrition therapy, individual and group (CPT: 97802,97803, 97804)
- Diabetes self-management training, individual and group (G0108, G0109)
- Intensive behavioral therapy for cardiovascular disease (G0446: must be billed by the primary care provider)
- Behavioral counseling for obesity, individual (G0447: must be billed by the primary care provider)
- Annual wellness visit (G0438, G0439 must be billed by the primary care provider)

RDN Medicare providers may use the following G codes with their Medicare Part B beneficiaries after an initial MNT encounter:

- **G2061**: Qualified nonphysician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes
- **G2062**: Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the days; 11-20 minutes)
- **G2063**: Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

Additional information about coverage for telehealth, medical nutrition therapy, and other Medicare Part B services provided by RDNs here: **https://www.eatrightpro.org/practice/practice-resources/telehealth/medicare-telehealth-services-and-registered-dietitians**

Find a RDN near you: https://www.eatright.org/find-a-nutrition-expert

References:

1. Medical Nutrition Therapy Benefit for Diabetes & ESRD: https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=53
2. Tip Sheet: Medical Nutrition Therapy (MNT): https://www.ncoa.org/article/medical-nutrition-therapy-mnt-tip-sheet

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QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Diabetes Self-Management Training (DSMT) Provided by Diabetes Care and Education Specialist (CDCES)

Refer patients with diabetes to a diabetes care and education specialist (CDCES) for diabetes self-management training (DSMT) at these critical points in their disease process:

- At diagnosis
- During an annual assessment
- When a person with diabetes has new complicating factors that affect their self–management abilities
- Upon transitions in care

In patients aged 65 years and older with diabetes, an endocrinologist or diabetes care specialist should be primarily responsible for diabetes care if the patient has type 1 diabetes, requires complex hyperglycemia treatment to achieve treatment goals, or has recurrent severe hypoglycemia, or has multiple diabetes complications.

Medicare Current Procedural Technology (CPT) codes for DSMT services:

- **G0108** – DSMT, individual, per 30 minutes
- **G0109** – DSMT, group (2 or more), per 30 minutes

Medicare covers 10 initial hours of DSMT within 12 consecutive months upon initiation of the services and then two hours of follow-up DSMT each following calendar year with a new referral.

Medicare will cover both DSMT and medical nutrition therapy (MNT) in the initial and subsequent years. A beneficiary can receive the full 10 hours of initial DSMT and the full three hours of MNT if providers do not bill for both DSMT and MNT on the same date of service for the same beneficiary.

- **CPT 95249, 95250 -** Ambulatory Continuous Glucose Monitoring (CGM) of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours. A CDCES may also perform elements in these codes if "incident to guidelines" are met, meaning they are providing the services directed by a physician or other qualified healthcare provider.

References:

1. CDC DSMT Referral Process: https://www.cdc.gov/diabetes/dsmes-toolkit/referrals-participation/referral-process.html
2. CDC Medicare Reimbursement Guidelines for DSMT: https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medicare.html
3. Treatment of Diabetes in Older Adults: An Endocrine Society Clinical Practice Guideline: https://pubmed.ncbi.nlm.nih.gov/30903688/

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QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Connect Patients Eligible for Cardiac Rehabilitation or Intensive Cardiac Rehab (ICR) to Life-Saving Services

Alliant Health Solutions has compiled this two page resource with eligibility, key components, benefits and procedure codes for Cardiac Rehabilitation (Cardiac Rehab) and Intensive Cardiac Rehabilitation (ICR) services.

Cardiac Rehab Referral Eligibility	
Cardiac-related conditions or events	**Cardiac procedures**
• Heart attack in the past 12 months • Stable chronic heart failure • Current stable angina	• Coronary angioplasty or stent • Bypass surgery • Heart valve replacement or repair • Heart or heart-lung transplant

The Importance of Cardiac Rehab From the Agency for Healthcare Research and Quality (AHRQ) TakeHeart® Initiative		
Core Cardiac Rehab Components	**Patient Benefits**	**Cardiac Rehab Hospital Benefits**
✓ Supervised exercise training ✓ Education and skills development ✓ Psychosocial counseling	✓ Reduced risk of death ✓ Fewer symptoms, such as angina and fatigue ✓ Decreased heart attack recurrence ✓ Better medication adherence ✓ Improved exercise performance ✓ Increased quality of life and ability to perform daily living activities ✓ Better patient understanding of heart disease and its management ✓ Improved patient mood	✓ Improved quality of care and outcomes ✓ Reduced readmissions ✓ Improved quality metrics ✓ Increased readiness for value-based payment initiatives

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

- **93797** (Physician or other qualified health care professional services for outpatient cardiac rehabilitation without continuous electrocardiogram (ECG) monitoring (per session))
- **93798** (Physician or other qualified care health professional services for outpatient cardiac rehabilitation with continuous ECG monitoring (per session))

The following are the applicable Health Care Procedure Coding System (HCPCS) codes for ICR:

- **G0422** (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session)
- **G0423** (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session)

see page 2 for additional information on ICR eligibility and assessment

QUICK GUIDE TO STANDARDS OF CARE FOR CHRONIC DISEASE SCREENING

Know When To Refer Patients to an Advanced Heart Failure Center for Intensive Cardiac Rehabilitation

Intensive Cardiac Rehabilitation Referral Eligibility	
• If patient's left ventricular ejection fraction is less than 35% • Patient shows signs of American Heart Association Class III-IV functional status; see breakdown below • Patient had two or more hospital admissions in the last year or readmission within six months • There is an increased left ventricular end-diastolic dimension (6.5 cm or greater) • Patient experienced reduced end-organ perfusion in renal or hepatic function	• Patient has reduced tolerance or there is a medical inability to up titrate Angiotensin Converting Enzyme (ACE) inhibitors and beta blockers for them • Patient's blood pressure is consistently low with systolic pressure of less than 100 mm Hg • There is a need for intravenous inotropic medication support • There is an increased need for diuretics or patient presents with persistent edema

New York Heart Association Functional Classification (Adapted from the American Heart Association Classes of Heart Failure)

Class	Patient Symptoms	Class	Objective Assessment
I	No limitation on physical activity. Ordinary physical activity does not cause undue fatigue, palpitation or dyspnea (shortness of breath).	A	No objective evidence of cardiovascular disease. No symptoms and no limitations in ordinary physical activity.
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation or dyspnea (shortness of breath).	B	Objective evidence of minimal cardiovascular disease. Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation or dyspnea (shortness of breath).	C	Objective evidence of moderately severe cardiovascular disease. Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.	D	Objective evidence of severe cardiovascular disease. Severe limitations. Experiences symptoms even while at rest.

References:

1. AHRQ Take Heart Cardiac Rehab Benefits Page: https://takeheart.ahrq.gov/case-cardiac-rehabilitation/benefits#eligible
2. Guidance for Timely and Appropriate Referral of Patients With Advanced Heart Failure: A Scientific Statement From the American Heart Association | Circulation (ahajournals.org): https://www.ahajournals.org/doi/10.1161/CIR.0000000000001016
3. Medicare Claims Processing: https://www.cms.gov/files/document/r11426cp.pdf
4. American Heart Association Classes of Heart Failure: https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure

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