MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	**Cardiac Rehabilitation**
Policy Number	**8.01.14**
Category	**Contract Clarification**
Original Effective Date	**10/18/01**
Committee Approval Date	**10/18/01, 06/20/02, 04/24/03, 03/18/04, 09/01/04, 09/15/05, 12/07/06, 12/13/07, 12/11/08, 12/10/09, 12/09/10, 06/24/11, 06/28/12, 06/27/13, 06/26/14, 06/25/15, 06/22/16, 08/25/17, 06/28/18, 10/22/20, 10/28/21, 10/20/22, 10/19/23, 10/17/24**
Current Effective Date	**10/17/24**
Archived Date	**06/27/19-10/24/19**
Archive Reviewed Date	**10/24/19**
Product Disclaimer	• *Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Based upon our criteria and assessment of the peer-reviewed literature, monitored Phase I and Phase II cardiac rehabilitation (CR) programs have been proven to be medically effective and, therefore, are considered **medically appropriate** for **ANY** of the following indications:
   A. Acute myocardial infarction (MI) within the preceding 12 months;
   B. Percutaneous coronary intervention (i.e., percutaneous transluminal coronary angioplasty (PTCA), atherectomy, stenting) within the preceding 12 months;
   C. Coronary bypass surgery within the preceding 12 months;
   D. Heart transplantation within the preceding 12 months;
   E. Class II or higher congestive heart failure;
   F. Stable angina pectoris;
   G. Valvular disease.

II. Based upon our criteria and assessment of the peer-reviewed literature, additional cardiac CR services have been medically proven to be effective and, therefore, are considered **medically appropriate** if the individual has *another* qualifying cardiac event, including **ANY** of the following:
   A. Another documented MI or extension of initial infarction;
   B. Another cardiovascular surgery or percutaneous intervention;
   C. New, clinically significant coronary lesions documented by cardiac catheterization.

III. Based upon our criteria and assessment of the peer-reviewed literature, Phase III maintenance programs are considered **not medically necessary.** *(Please refer to Policy Guideline IV below).*

IV. Based upon our criteria and assessment of the peer-reviewed literature, intensive cardiac rehabilitation (ICR), is considered **investigational** for all indications, including but not limited to, the following programs:
   A. The Ornish Program for Reversing Heart Disease;

B. The Pritikin Program;
C. The Benson-Henry Institute Cardiac Wellness Program.

Refer to Corporate Medical Policy #11.01.03 Experimental or Investigational Services

POLICY GUIDELINES

I. Due to a strong scientific evidence base for the efficacy of cardiac rehabilitation in adult patients, and the lack of a strong evidence base in pediatric patients, this policy generally applies to adult patients. Cardiac rehabilitation for pediatric patients will be reviewed based on clinical indicators, including, but not limited to the patient's diagnosis (e.g., congenital anomalies, valvular disorders), recent surgical procedures (e.g., cardiac transplant, valvular replacement, or repair), and acceptance into a pediatric cardiac rehabilitation program.

II. Monitored Phase II cardiac rehabilitation programs must be recommended by the patient's cardiologist or primary care physician and rendered by a provider whose cardiac rehabilitation program has been approved by:

A. the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), if the program is rendered at an outpatient free-standing facility or in the practitioner's office; or
B. the AACVPR, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the American Osteopathic Association (AOA), if the program is rendered at a hospital-based facility.

III. Due to the increased risk of experiencing a cardiac event (e.g., ventricular arrhythmia, infarction), Phase II CR programs must include physician supervision and continuous electrocardiographic monitoring during exercise.

IV. Phase III maintenance programs consist of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur.

DESCRIPTION

According to the U.S. Public Health Service, the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), the American College of Cardiology (ACC), and the American Heart Association (AHA), "Cardiac rehabilitation services are comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. These programs are designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or re-infarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients."

A CR program should be initiated as soon as medically indicated following a cardiac event. Examples of cardiac events are acute MI, coronary artery bypass graft, percutaneous transluminal coronary angioplasty (PTCA), heart valve surgery, heart transplantation, stable angina pectoris, or compensated heart failure.

CR consists of three phases, or levels, of service:

I. *Phase I*, or inpatient CR: a program that delivers preventive and rehabilitative services to hospitalized patients following an index cardiovascular disease (CVD) event.
II. *Phase II*, or early outpatient CR: a physician-supervised outpatient program that includes electrocardiographic monitoring during exercise and is intended to improve cardiac function and exercise tolerance. Programs are hospital, physician's office- or clinic-based and must meet federal and state regulatory and licensing requirements; and
III. *Phase III*, or long-term outpatient CR: a supervised or non-supervised maintenance program.

ICR refers to a physician-supervised program that furnishes CR services more frequently, and often in a more rigorous manner. As required by §1861(eee)(4)(A) of the U.S. Social Security Act (the "Act"), an ICR program must demonstrate, through peer-reviewed, published research, that it accomplished one or more of the following for its patients:

I. Positively affected the progression of coronary heart disease (CHD);
II. Reduced the need for coronary bypass surgery; or
III. Reduced the need for percutaneous coronary interventions.

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

I. Low-density lipoprotein;
II. Triglycerides;
III. Body mass index;
IV. Systolic blood pressure;
V. Diastolic blood pressure; and
VI. the need for cholesterol, blood pressure, and diabetes medications.

According to CMS, ICR program sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks. There is no standard definition of an ICR program and, thus, specific programs are reviewed individually.

RATIONALE

CR program providers are subject to state and federal licensing requirements. Due to the advances in the diagnosis and treatment of cardiac disease, there is a shift of CVD from an acutely fatal event to a chronic disease. There is a growing need for medical services to aid patients in improving their quality of life, lessen symptoms, increase functional capacity, and decrease disability. Formal CR programs meet this need for select cardiac patients and improve their net health outcomes by decreasing the incidence of cardiac death.

Sumner et al. (2017) published a systematic review of controlled observational studies evaluating CR in patients diagnosed with acute MI. CR interventions consisted of structured, multi-component programs that included exercise and at least one of the following: education, information, health behavior change, and psychological or social support. Usual care interventions, generally supervised medical interventions, were the control conditions. Ten studies met reviewers' eligibility criteria. In a meta-analysis of five studies reporting all-cause mortality (an unadjusted outcome), there was a significantly lower risk of death in the group that received CR (odds ratio, 0.25; 95% CI, 0.16 to 0.40). Three studies that reported an adjusted analysis of all-cause mortality also found a significant benefit from CR (odds ratio, 0.47; 95% CI, 0.38 to 0.59). Similarly, a meta-analysis of three studies reporting cardiac-related mortality (an unadjusted analysis) found a significant benefit from CR (odds ratio, 0.21; 95% CI, 0.12 to 0.37). Only one study reported an adjusted analysis of cardiac-related mortality, so data could not be pooled.

Nilsson et al. (2018) investigated the effect of a 12-week CR program with a high-intensity interval exercise component using participant VO2peak as a measure of improved exercise capacity. Increased exercise capacity has been shown to improve survival among persons with CHD. The objective of the study was to assess whether this addition to a CR program yielded improved long-term results. A total of 133 coronary patients participated in this prospective cohort study and were evaluated at baseline, at the end of the 12-week program, and again at a 15-month follow-up. Additional test measurements included a cardiopulmonary exercise test, body mass index, blood pressure tests, and a quality of life questionnaire. Of the 133 patients, 86 patients had complete information for the 15-month follow-up. Mean VO2peak improved from a baseline of 31.9 mL/kg/min to 35.9 mL/kg/min ($p<0.001$) at the end of the 12-week program, and to 36.8 mL/kg/min (CI not reported) at 15-month follow-up. Most of the 86 patients reported maintaining an exercise routine. Study limitations included the small sample size, a relatively low-risk male population at baseline, and lack of information on the qualifying event for CR. The authors concluded that the CR program intervention potentially fostered consistent and beneficial exercise habits, as demonstrated by improved VO2peak.

The benefits of formal CR programs outweigh those of informal exercise programs or the lack of a rehabilitative program. Through clinical trials, supervised/formal CR programs have been proven to improve the health outcomes of select cardiac patients.

Intensive Cardiac Rehabilitation

Ornish et al. (1990) conducted a randomized, controlled trial (RCT), called the Lifestyle Heart Trial, comparing a version of the Ornish Program for Reversing Heart Disease with usual care. Initial results were reported in 1990, and five-year results in 1998. Twenty (71%) of 28 patients in the intervention group and 15 (75%) of 20 in the control group completed the five-year follow-up. The intervention and control groups did not differ significantly in the number of MI events (2

versus 4), CABGs (2 versus 5), or deaths (2 versus 1). However, compared with the control group, the intervention group had significantly fewer percutaneous transluminal coronary angioplasties (8 versus 14, p<0.050) and cardiac hospitalizations (23 versus 44, p<0.001). The trial had a small sample size for a cardiac trial (N=48), and only 35 patients were available for the five-year follow-up.

Lakhani et al. (2023) conducted a prospective, nonrandomized study that compared intensive cardiac rehabilitation with the Pritikin Program and traditional outpatient cardiac rehabilitation. The primary outcomes of interest were change in diet quality and quality of life from baseline to visit 24. There was a significant improvement in diet quality but not in quality of life between the Pritikin Program and traditional cardiac rehabilitation groups. Body mass index was also improved in patients who received intensive rehabilitation. Limitations of the study include a short follow-up, lack of data for cardiovascular outcomes, and nonrandomization.

Racette et al. (2022) published seven-year outcomes from the first institution to implement the Pritikin Program. Retrospective data for 1,507 patients who received the intensive cardiac rehabilitation program and 456 patients who received traditional cardiac rehabilitation were compared. Outcomes of interest (e.g., anthropometric measures, dietary patterns, 6-minute walk distance [6MWD], grip strength, and HRQoL) all improved with the Pritikin Program. Significant benefit of the Pritikin Program compared to traditional cardiac rehabilitation were noted for change in body weight (p<.0001), body mass index (p<.0001), waist circumference (p<.0001), and diet quality as measured by the Rate Your Plate score (p<.0001). There was no difference in 6MWD or grip strength between groups. Cardiovascular outcomes, including rehospitalization or mortality, were not assessed and there was no follow up on the patients who did not complete the program.

No RCTs have evaluated the Pritikin Program or the Benson-Henry Institute Cardiac Wellness Program, in comparison to usual care or to standard CR; therefore, conclusions cannot be drawn for these programs regarding their impact on health outcomes.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	with continuous ECG monitoring (per session)

HCPCS Codes

Code	Description
G0422 **(E/I)**	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
G0423 **(E/I)**	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session
S9472	Cardiac rehabilitation program, non-physician provider, per diem

ICD10 Codes

Code	Description
A52.03	Syphilitic endocarditis

Code	Description
I01.1	Acute rheumatic endocarditis
I02.0	Rheumatic chorea with heart involvement
I05.0-I09.9	Chronic rheumatic heart diseases (code range)
I20.1	Angina pectoris with documented spasm
I20.8-I20.9	Other or unspecified forms of angina pectoris (code range)
I21.01-I21.3	ST elevation (STEMI) myocardial infarction (code range)
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I21.9	Acute myocardial infarction, unspecified
I21.A1-I21.A9	Other type of myocardial infarction (code range)
I22.0-I22.9	Subsequent ST (STEMI) or non-ST (NSTEMI) elevation myocardial infarction (code range)
I25.10-I25.9	Chronic ischemic heart disease (code range)
I34.0-I34.9	Nonrheumatic mitral valve disorders (code range)
I35.0-I35.9	Nonrheumatic aortic valve disorders (code range)
I36.0-I36.9	Nonrheumatic tricuspid valve disorders (code range)
I37.0-I37.9	Nonrheumatic pulmonary valve disorders (code range)
I50.1-I50.9	Heart failure (code range)
Q23.2	Congenital mitral stenosis
Z94.1	Heart transplant status
Z94.3	Heart and lungs transplant status
Z95.1	Presence of aortocoronary bypass graft
Z95.2	Presence of prosthetic heart valve
Z95.5	Presence of coronary angioplasty implant and graft
Z95.812	Presence of fully implantable artificial heart
Z98.61	Coronary angioplasty status

Revenue Codes

Code	Description
943	Cardiac rehabilitation

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*Key Article

KEY WORDS

Cardiac rehabilitation, Cardiac therapy, Heart therapy.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for Cardiac Rehabilitation Programs for Chronic Heart Failure (20.10.1). Please refer to the following website for Medicare Members:

[http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=359&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=cardiac+rehab&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAABAAAAAAAAA%3d%3d&] accessed 09/17/24.

There is currently a National Coverage Determination (NCD) for Intensive Cardiac Rehabilitation (ICR) Programs (20.31). Please refer to the following NCD website for Medicare Members:

[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=339&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=cardiac+rehabilitation&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAACAAAAAA&] accessed 09/17/24.

There is currently a National Coverage Determination (NCD) for Benson-Henry Institute Cardiac Wellness Program (20.31.3). Please refer to the following NCD website for Medicare Members:

[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=362&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=cardiac+rehabilitation&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAACAAAAAA&] accessed 09/17/24.

There is currently a National Coverage Determination (NCD) for Ornish Program for Reversing Heart Disease (20.31.2). Please refer to the following NCD website for Medicare Members:

[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=341&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=cardiac+rehabilitation&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAACAAAAAA&] accessed 09/17/24.

There is currently a National Coverage Determination (NCD) for The Pritikin Program (20.31.1). Please refer to the following NCD website for Medicare Members:

[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=340&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=cardiac+rehabilitation&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAACAAAAAA&] accessed 09/17/24.

Additional information, regarding Cardiac and Intensive Cardiac Rehabilitation Programs, can be found in the Medicare Claims Processing Manual, Section 140, and can be accessed at: [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf] accessed 09/17/24.