Cardiac Rehabilitation in the Outpatient Setting

Policy Number: 8.03.08
Origination: 12/1990
Last Review: 9/2016
Next Review: 9/2017

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for cardiac rehabilitation when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered
Outpatient Cardiac rehabilitation programs are considered medically necessary for patients with a history of the following conditions and procedures:
- acute myocardial infarction (MI, “heart attack”) within the preceding 12 months;
- coronary artery bypass graft (CABG) surgery;
- percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
- heart valve surgery;
- heart or heart-lung transplantation;
- current stable angina pectoris;
- compensated heart failure.

When Policy Topic is not covered
Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational.

Considerations
The following components must be included in cardiac rehabilitation programs:
- Physician-prescribed exercise each day cardiac rehabilitation services are provided;
- Cardiac risk factor modification;
- Psychosocial assessment;
- Outcomes assessment; and
- Individualized treatment plan detailing how each of the above components are utilized.
A cardiac rehabilitation exercise program is eligible for coverage for 3 sessions per week up to a 12-week period (36 sessions). Programs should start within 90 days of the cardiac event and be completed within 6 months of the cardiac event.

A comprehensive evaluation may be performed prior to initiation of cardiac rehabilitation to evaluate the patient and determine an appropriate exercise program. In addition to a medical examination, an EKG stress test may be performed. An additional stress test may be performed at the completion of the program.

Physical and/or occupational therapy are not medically necessary in conjunction with cardiac rehabilitation unless performed for an unrelated diagnosis.

Services that are educational in nature, e.g., lectures or counseling, which are performed as part of the cardiac rehabilitation program, are not eligible for coverage, even when occurring on a different date of service, unless specifically specified in the contract or certificate of coverage. Psychological testing and psychotherapy are not a usual component of cardiac rehabilitation. Such services for patients who have a psychiatric diagnosis must be considered under the Mental Health benefits of the contract.

The ongoing maintenance program that follows the 12-week rehabilitation program is not eligible for coverage.

Some contracts have an exclusion for cardiac rehabilitation, as this is considered “self-care” or “self-help” training. In these cases, any related diagnostic testing must also be excluded.

**Description of Procedure or Service**

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: • With diagnosed heart disease</td>
<td>Interventions of interest are: • Outpatient cardiac rehabilitation</td>
<td>Comparators of interest are: • Standard management without cardiac rehabilitation</td>
<td>Relevant outcomes include: • Overall survival • Disease-specific survival • Symptoms • Morbid events</td>
</tr>
<tr>
<td>Individuals: • With diagnosed heart disease without a second event</td>
<td>Interventions of interest are: • Repeat outpatient cardiac rehabilitation</td>
<td>Comparators of interest are: • Single course of outpatient cardiac rehabilitation</td>
<td>Relevant outcomes include: • Overall survival • Disease-specific survival • Symptoms • Morbid events</td>
</tr>
</tbody>
</table>

Cardiac rehabilitation refers to comprehensive medically supervised programs in the outpatient setting that aim to improve the function of patients with heart disease and prevent future cardiac events. National organizations have recently specified core components to be included in cardiac rehabilitation programs.
The evidence for outpatient cardiac rehabilitation in individuals who have diagnosed heart disease includes multiple randomized controlled trials and systematic reviews of these trials. Relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. Meta-analyses of the available trials have found that cardiac rehabilitation improves health outcomes for selected patients, particularly those with coronary heart disease. The available evidence has limitations, including lack of blinded outcome assessment, but, for the survival-related outcomes of interest, this limitation is less critical. The evidence is sufficient to determine qualitatively that the technology results in meaningful improvements in the net health outcome.

The evidence for repeat outpatient cardiac rehabilitation in individuals who have diagnosed heart disease without a second event includes limited research. Relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. No studies were identified that evaluated the effectiveness of repeat participation in a cardiac rehabilitation program. The evidence is insufficient to determine the effects of the technology on health outcomes.

Multiple national organizations have guidelines addressing use of outpatient cardiac rehabilitation for heart failure and coronary heart disease, and components of cardiac rehabilitation programs. The medically necessary policy statements and criteria for outpatient cardiac rehabilitation programs derive from these guidelines.

**Background**

Heart disease is the leading cause of mortality in the U.S., causing more than half of all deaths. Coronary artery disease (CAD) is the most common cause of heart disease. Annually, it is estimated that 785,000 Americans suffer a new myocardial infarction (MI), and 470,000 have a recurrent MI. In addition, CAD can lead to the clinical syndrome of heart failure, which occurs in about 650,000 new cases in the U.S. annually. Heart failure may be secondary to or coexist with to CAD, but can also be related to structural heart disease and other genetic, metabolic, endocrine, toxic, inflammatory, and infectious causes. Given the disease burden of heart disease, preventing secondary cardiac events and treating the symptoms of heart disease and heart failure have received much attention from national organizations.

In 1995, the U.S. Public Health Service (USPHS) defined cardiac rehabilitation services as, in part, “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 reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients.” This USPHS guideline recommended cardiac rehabilitation services for patients with coronary heart disease and with heart failure, including those awaiting or following cardiac transplantation. A 2010 definition of cardiac rehabilitation by the Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation is as follows: “Cardiac rehabilitation can be viewed as the
clinical application of preventive care by means of a professional multi-disciplinary integrated approach for comprehensive risk reduction and global long-term care of cardiac patients.”(4) Since the release of the USPHS guideline, other societies, including the American Heart Association(5) and the Heart Failure Society of America(6) have developed guidelines about the role of cardiac rehabilitation in patient care.

Note: This policy does not address programs considered to be “Intensive Cardiac Rehabilitation Programs,” such as the Dean Ornish Program for Reversing Heart Disease and the Pritikin Program.

Rationale
This evidence review was created in May 1997. It was archived from 2003 to 2010, after which time it returned to active review and was updated periodically with literature reviews, most recently through January 29, 2016. The following is a description of the key literature to date.

Outpatient Cardiac Rehabilitation for Heart Disease
Many randomized controlled trials (RCTs) have been published comparing cardiac rehabilitation with usual care for patients with established heart disease, and a number of meta-analyses of RCTs have been performed, which are the focus of this review.

Systematic Reviews and Meta-Analyses
In 2012, Oldridge identified 6 independent meta-analyses published since 2000 that reported outcomes from 71 RCTs (N=13,824 patients) following cardiac rehabilitation interventions.6 The RCTs included in the meta-analyses enrolled patients with myocardial infarction (MI), coronary heart disease (CHD), angina, percutaneous coronary intervention (PCI), and/or coronary artery bypass graft (CABG). RCTs compared cardiac rehabilitation programs (exercise only and/or comprehensive rehabilitation) with usual care. Cardiac rehabilitation was associated with a statistically significant (p<0.05) reduction in all-cause mortality in 4 of the 5 meta-analyses that reported this outcome. In pooled analysis, cardiac rehabilitation was associated with a 18.5% mean reduction in all-cause mortality. In addition, cardiac rehabilitation was associated with a statistically significant reduction in cardiac mortality in 3 of the 4 meta-analyses that reported disease-specific mortality as an outcome.

Cochrane Reviews
Two of the meta-analyses on cardiac rehabilitation were conducted by Cochrane. One included patients with CHD7 and the other focused on patients with systolic heart failure.8 Both addressed exercise-based cardiac rehabilitation programs (exercise alone or as part of a comprehensive program).

In 2016, Anderson et al updated the earlier Cochrane review (published in 2011), which addressed exercise-based cardiac rehabilitation for individuals with CHD.2.2 The review included RCTs of exercise-based interventions with at least 6 months of
follow-up compared with no-exercise controls in patients with MI, CABG, or PCI, or with angina pectoris or coronary artery disease. The updated review included 63 RCTs with a total of 14,486 individuals, of which 16 trials were new since the last update. The authors reported that the overall risk of bias was unclear, although the quality of reporting improved with more recent trials. Due to the nature of the intervention, patients were not blinded to treatment group in any of the studies, but 16 (25%) of 62 studies reported details of blinded assessment of study outcomes. In pooled analysis, cardiac rehabilitation was not significantly associated with overall mortality. However, among 27 studies, cardiac rehabilitation was significantly associated with reduced cardiovascular mortality (292/3850 for cardiac rehabilitation subjects vs 375/3619 for control subjects; relative risk [RR], 0.74; 95% confidence interval [CI], 0.64 to 0.86). Rates of MI, CABG, and PCI were not significantly associated with receiving cardiac rehabilitation.

A 2014 Cochrane review by Taylor et al reported on studies assessing cardiac rehabilitation in patients with heart failure, updating a 2010 Cochrane review by Davies et al. The 2014 review included 33 trials (total N=4740 individuals), with 14 studies added with the latest update. One large trial (HF-ACTION) contributed 50% of patients; most other studies were small and single center. The population was predominantly patients with heart failure with reduced ejection fraction and New York Heart Association class II and III heart failure. The trials had a moderate risk of bias; many earlier studies (particularly pre-2000) had insufficient detail to allow assessment of risk of bias. In the 25 studies that reported all-cause mortality up to 12-month follow-up, there was no difference in pooled mortality between groups (risk ratio, 0.93; 95% confidence interval [CI], 0.69 to 1.27; p=0.59). For health-related quality of life (QOL), most studies reported disease-specific QOL with the Minnesota Living With Heart Failure (MLWHF) questionnaire. Although there was statistical heterogeneity in differences in MLWHF scores between exercise and control groups, there was a significant improvement in MLWHF score with exercise in pooled analysis (mean difference, -5.8; 95% CI, -9.2 to -2.4, p=0.001). Most of the studies included in the Cochrane review, including the HF-ACTION trial, were exercise-only interventions; thus, conclusions cannot be drawn from this review about the impact of comprehensive cardiac rehabilitation programs on mortality or hospital admissions in patients with heart failure. The Cochrane review did not require that studies only include patients with compensated heart failure.

**Additional Meta-Analyses**

A 2011 meta-analysis by Lawler et al addressed exercise-based cardiac rehabilitation programs for patients who had a recent MI. To be included in the review, trials needed to include a minimum intervention duration of 2 weeks and a minimum of 12 weeks of follow-up. Interventions could involve any form of exercise program, with or without other interventions. A total of 34 RCTs with 6111 patients met the review’s inclusion criteria. In a pooled analysis of data from 18 trials, patients randomized to cardiac rehabilitation had a significantly lower risk of reinfarction than patients randomized to a control condition (odds ratio [OR], 0.53; 95% CI, 0.38 to 0.76). There was also a significantly lower risk of all-
cause mortality (OR=0.74; 95% CI, 0.58 to 0.95) and cardiovascular mortality (OR=0.60; 95% CI, 0.40 to 0.76) in the group randomized to cardiac rehabilitation compared with a control intervention.

**Randomized Controlled Trials**
Overall, the evidence from well-conducted systematic reviews suggests that cardiac rehabilitation is associated with reduced cardiovascular mortality in patients with CHD.

Findings of a large, multicenter RCT from the U.K. that evaluated the effectiveness of cardiac rehabilitation in a “real-life” setting were published by West et al in 2012. Called the Rehabilitation After Myocardial Infarction Trial (RAMIT), the study included patients from 14 centers with established cardiac rehabilitation programs that were multifactorial (including exercise, education, and counseling), involved more than 1 discipline, and provided an intervention lasting a minimum of 10 hours. A total of 1813 patients were randomized: 903 to cardiac rehabilitation and 910 to a control condition. Vital status was obtained at 2 years for 99.9% (all but 1 patient) and at 7 to 9 years for 99.4% of patients. By 2 years, 166 patients had died, 82 in the cardiac rehabilitation group and 84 in the control group. The between-group difference in mortality at 2 years (the primary study outcome) was not statistically significant (RR=0.98; 95% CI, 0.74 to 1.30). After 7 to 9 years, 488 patients had died, 245 in the cardiac rehabilitation group and 243 in the control group (RR=0.99; 95% CI, 0.85 to 1.15). In addition, at 1 year, cardiovascular morbidity did not differ significantly between groups. For a combined end point including death, nonfatal MI, stroke or revascularization, the RR was 0.96 (95% CI, 0.88 to 1.07). In discussing the study’s negative findings, the trial authors noted that medical management of heart disease has improved over time, and patients in the control group may have had better outcomes than in earlier RCTs on this topic. Moreover, an editorial accompanying the publication of the study’s findings emphasized that RAMIT was not an efficacy trial, but rather, a trial evaluating the effectiveness of actual cardiac rehabilitation programs in the U.K. Finally, these results may in part reflect the degree to which clinically based cardiac rehabilitation programs in the U.K. differ from the treatment protocols used in RCTs that are based in research settings.

A concern raised by the negative findings in the RAMIT trial is that most of the RCTs evaluating cardiac rehabilitation were conducted in an earlier era of heart disease management and may not be relevant to current care. However, RAMIT’s results, along with 15 additional RCTs reported since a 2011 Cochrane review, were included in the updated 2016 Cochrane review, which found improvements in cardiovascular mortality associated with exercise-based cardiac rehabilitation.

**Repeat Outpatient Cardiac Rehabilitation**
No studies were identified that evaluated the effectiveness of repeat participation in a cardiac rehabilitation program.
Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tr>
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<td></td>
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<tr>
<td>NCT01732419</td>
<td>Effects of Homebased Training With Telemonitoring Guidance in Low to Moderate Risk Patients Entering Cardiac Rehabilitation</td>
<td>90</td>
<td>Oct 2015 (ongoing)</td>
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<tr>
<td>NCT01822769</td>
<td>Cardiopulmonary Rehabilitation for Adolescents and Adults With Congenital Heart Disease</td>
<td>60</td>
<td>Dec 2015 (ongoing)</td>
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<tr>
<td>NCT00981253</td>
<td>Enhancing Standard Cardiac Rehabilitation With Stress Management Training in Patients With Heart Disease</td>
<td>150</td>
<td>Feb 2006</td>
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<tr>
<td>NCT01395095</td>
<td>OPTimal Cardiac REhabilitation (OPTICARE)Following Acute Coronary Syndromes: A Randomized, Controlled Trial to Investigate the Benefits of an Expanded Educational and Behavioural Intervention Program</td>
<td>1200</td>
<td>Mar 2016</td>
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<td>NCT01914315</td>
<td>Multi-Disciplinary Rehabilitation Program in Recently Hospitalized Patients With Preserved Ejection Fraction Heart Failure</td>
<td>1100</td>
<td>Jun 2016</td>
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<tr>
<td><strong>Unpublished</strong></td>
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<td></td>
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</tr>
<tr>
<td>NCT02204449</td>
<td>Mentorship to Promote Cardiac Rehabilitation Enrollment: A Randomized Controlled Trial</td>
<td>94</td>
<td>Jan 2015 (completed)</td>
</tr>
<tr>
<td>NCT01617850</td>
<td>Efficacy of Physical Exercise in Cardiac Rehabilitation</td>
<td>70</td>
<td>Jun 2014</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

Summary of Evidence
The evidence for outpatient cardiac rehabilitation in individuals who have diagnosed heart disease includes multiple randomized controlled trials and systematic reviews of these trials. Relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. Meta-analyses of the available trials have found that cardiac rehabilitation improves health outcomes for selected patients, particularly those with coronary heart disease. The available evidence has limitations, including lack of blinded outcome assessment, but, for the survival-related outcomes of interest, this limitation is less critical. The evidence is sufficient to determine qualitatively that the technology results in meaningful improvements in the net health outcome.

The evidence for repeat outpatient cardiac rehabilitation in individuals who have diagnosed heart disease without a second event includes limited research. Relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. No studies were identified that evaluated the effectiveness of repeat participation in a cardiac rehabilitation program. The evidence is insufficient to determine the effects of the technology on health outcomes.
Supplemental Information

Practice Guidelines and Position Statements

**American College of Cardiology Foundation and the American Heart Association**

In 2013, the American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) published updated guidelines on the management of heart failure. These guidelines include the following class IIA recommendation related to cardiac rehabilitation (level of evidence: B): “Cardiac rehabilitation can be useful in clinically stable patients with HF [heart failure] to improve functional capacity, exercise duration, health-related quality of life, and mortality.”

**American College of Physicians et al**

In 2012, the American College of Physicians, ACCF, AHA, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, and Society of Thoracic Surgeons published a joint guideline on management of stable ischemic heart disease. The guideline included the following statement on cardiac rehabilitation: “Medically supervised exercise programs (cardiac rehabilitation) and physician-directed, home-based programs are recommended for at-risk patients at first diagnosis.”

**AHA and American Association of Cardiovascular and Pulmonary Rehabilitation**

In 2007, AHA and the American Association of Cardiovascular and Pulmonary Rehabilitation issued an updated consensus statement on the core components of cardiac rehabilitation programs. These core components include patient assessment before beginning the program, nutritional counseling, weight management, blood pressure management, lipid management, diabetes management, tobacco cessation, psychosocial management, physical activity counseling, and exercise training. Programs that only offer supervised exercise training are not considered to be cardiac rehabilitation. The updated guidelines specify the assessment, interventions, and expected outcomes for each of the core components. For example, symptom-limited exercise testing before exercise training is strongly recommended. The national guideline does not specify the optimal overall length of programs or number or duration of sessions.

**European Association of Cardiovascular Prevention and Rehabilitation**

In 2010, Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation published a position paper on cardiac rehabilitation. Recommendations were based on a review of national guidelines from the United States and Europe. These recommendations state that components of a multidisciplinary cardiac rehabilitation program are “…patient assessment, physical activity counselling, exercise training, diet/nutritional counselling, weight control management, lipid management, blood pressure monitoring, smoking cessation, and psychosocial management.”
The recommended criteria for adequate exercise training are:

- **Mode:** “Continuous endurance: walking, jogging, cycling, swimming, rowing, stair climbing, elliptical trainers, and aerobic dancing.”
- **Duration:** “At least 20-30 min [minutes] (preferably 45-60 min [minutes]).”
- **Frequency:** “Most days (at least 3 days/week and preferably 6-7 days/week).”
- **Intensity:** “50–80% of peak oxygen consumption (close to anaerobic threshold) or of peak heart rate or 40–60% of heart rate reserve; 10/20–14/20 of the Borg Rating of Perceived Exertion.”

The position paper did not address repeat participation in cardiac rehabilitation programs.

**U.S. Preventive Services Task Force Recommendations**

Not applicable.

**Medicare National Coverage**

Medicare has had a National Coverage Determination for cardiac rehabilitation since 1989. There was a change in Medicare coverage for cardiac rehabilitation as of January 1, 2010. Indications for coverage remain the same; namely, patients who have experienced at least one of the following:

- Acute myocardial infarction within the preceding 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- Heart or heart-lung transplant

As of February 18, 2014, a change was made to the patient criteria to expand eligibility for cardiac rehabilitation to patients with the following: “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. Stable patients are defined as patients who have not had recent (≤ 6 weeks) or planned (≤ 6 months) major cardiovascular hospitalizations or procedures.”

The 2010 criteria specify the required components of cardiac rehabilitation programs. Programs must include all of the following:

- “Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished;
- Cardiac risk factor modification, including education, counseling and behavioral intervention at least once during the program, tailored to patients’ individual needs;
- Psychosocial assessment;
- Outcomes assessment; and
- An individualized treatment plan detailing how components are utilized for each patient.”
In addition, criteria on the frequency and duration of cardiac rehabilitation services were updated. On or before December 31, 2009, Medicare covered 18 weeks of cardiac rehabilitation services, with contractor discretion to cover services beyond 18 weeks. Coverage could not exceed a total of 72 sessions for 36 weeks.

Beginning January 1, 2010, the criteria are:

“Cardiac rehabilitation items and services must be furnished in a physician’s office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time items and services are being furnished under the program....

...[C]ardiac rehabilitation program 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 of an additional 36 sessions over an extended period of time if approved by the Medicare contractor.”

Also, beginning on January 1, 2010, Medicare added intensive cardiac rehabilitation as a benefit. Intensive cardiac rehabilitation programs must be approved by Medicare on an individual basis.18

References

**Billing Coding/Physician Documentation Information**

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<thead>
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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S9472</td>
<td>Cardiac rehabilitation program, non-physician provider, per diem</td>
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<tr>
<td>93015</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report</td>
</tr>
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<td>93016</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report</td>
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<td>93797</td>
<td>Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)</td>
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<tr>
<td>93798</td>
<td>Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)</td>
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</table>

**ICD-10 Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I20.8-</td>
<td>Angina pectoris, other/unspecified code range</td>
</tr>
<tr>
<td>I20.9</td>
<td></td>
</tr>
<tr>
<td>I21.01-</td>
<td>ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction code range</td>
</tr>
<tr>
<td>I21.4</td>
<td></td>
</tr>
<tr>
<td>I50.1-</td>
<td>Heart failure code range</td>
</tr>
</tbody>
</table>
I50.9
Z94.1  Heart transplant status
Z94.3  Heart and lungs transplant status
Z95.1  Presence of aortocoronary bypass graft
Z95.2- Presence of heart valve code range
Z95.4
Z95.5  Presence of coronary angioplasty implant and graft
Z98.61 Coronary angioplasty status

Additional Policy Key Words
N/A

Policy Implementation/Update Information
12/1/90 New policy.
6/1/00 No policy statement changes.
6/1/01 Policy statement revised to include:
chronic stable angina as medically necessary with criteria; and
cardiac rehab for CHF requires medical director approval; and
Phase III rehab is not eligible for coverage.
Prior authorization requirement added.
6/1/02 No policy statement changes.
1/1/03 No policy statement changes. Prior authorization requirement is removed.
6/1/03 No policy statement changes.
6/1/04 Policy statement revised to require the program to begin within 90 days
of the event and be completed within 6 months of the cardiac event
(previously, the cardiac event was required within 6 months).
6/1/05 Policy statement revised to remove medical director approval
requirement for CHF.
6/1/06 No policy statement changes.
6/1/07 No policy statement changes.
6/1/08 No policy statement changes.
6/1/09 No policy statement changes.
6/1/10 No policy statement changes.
10/1/10 Changes to existing medically necessary policy statement included the
addition of the indications heart-lung transplantation and coronary
stenting, and specification of components in cardiac rehabilitation
programs; second policy statement that repeat programs are
investigational added. “In the outpatient setting” added to policy title.
6/1/11 No policy statement changes.
6/1/12 No policy statement changes.
6/1/13 No policy statement changes.
9/1/13 No policy statement changes.
9/1/14 No policy statement changes.
9/1/15 Removed not medically necessary statement: Physical and/or
occupational therapy are not medically necessary in conjunction with
cardiac rehabilitation unless performed for an unrelated diagnosis.
No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.