MEDICAL POLICY

Medical Policy Title	**Cardiac Rehabilitation**
Policy Number	**8.01.14**
Current Effective Date	**October 16, 2025**
Next Review Date	**October 2026**

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Monitored Phase I and Phase II cardiac rehabilitation (CR) programs 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. Additional CR services 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. Phase III maintenance programs are considered **not medically necessary**. (Please refer to Policy Guideline IV).

IV. 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.

RELATED POLICIES

Corporate Medical Policy

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. 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

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.

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.

Intensive Cardiac Rehabilitation

According to the Centers for Medicare and Medicaid Services (CMS), 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 (5) 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.

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.

SUPPORTIVE LITERATURE

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.

PROFESSIONAL GUIDELINE(S)

The American College of Cardiology (ACC), American Heart Association (AHA), American College of Emergency Physicians (ACEP), National Association of EMS Physicians (NAEMSP) and Society for Cardiovascular Angiography and Interventions (SCAI) published guideline for the management of patients with acute coronary syndromes (Rao 2025). Their recommendations regarding cardiac rehabilitation state:

- "Patients with ACS should be referred to an outpatient CR program prior to hospital discharge to reduce death, myocardial infarction, hospital readmissions, and improve functional status and quality of life (Class 1; LOE A)."
- "In patients with ACS, a home-based CR program is a reasonable alternative to a center-based CR program to improve functional status and QOL (Class IIa; LOE BR)."

The AHA and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) published a scientific statement addressing the core components of CR and secondary prevention programs (Brown 2024). The core components included patient assessment before beginning the program, nutritional counseling, weight management and body composition, blood pressure management, lipid management, diabetes management, tobacco cessation, psychosocial management, aerobic exercise training, strength training, physical activity counseling, and program quality. Programs that only offered supervised exercise training were not considered cardiac rehabilitation.

The AHA and ACC published a scientific statement regarding the supervised exercise training for chronic heart failure with preserved ejection fraction (Sachdev 2023). Their findings include the following:

- "Current guidelines also include a Class 1 recommendation (Level of Evidence A) for exercise training in patients with HF."
- "To the best of our knowledge, only 4 trials of home-based exercise training for patients with chronic HF have been published. All reported improved exercise capacity and quality-of-life metrics. However, because of the short duration (3–6 months) and small number of exercising subjects (n=67) included, the safety and efficacy of these training regimens remain unproven."

The AHA, ACC, and the Heart Failure Society of America (HFSA) published clinical practice guidelines for the management of heart failure (Heidenreich 2022). They recommend:

- "A cardiac rehabilitation program for patients with HF usually includes a medical evaluation, education regarding the importance of medical adherence, dietary recommendations, psychosocial support, and an exercise training and physical activity counseling program. Patients with HF on optimal [goal directed medical therapy] GDMT, who are in stable medical condition and are able to participate in an exercise program, are candidates for an exercise rehabilitation program."
- "For patients with HF who are able to participate, exercise training (or regular physical activity) is recommended to improve functional status, exercise performance, and QOL."
- "In patients with HF, a cardiac rehabilitation program can be useful to improve functional capacity, exercise tolerance, and health related QOL."

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

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

Code	Description
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; 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
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)

Code	Description
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

REFERENCES

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Ornish D, et al. Can lifestyle changes reverse coronary heart disease? The Lifestyle Heart Trial. Lancet 1990 Jul 21;336(8708):129-33.

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SEARCH TERMS

Cardiac rehabilitation, Cardiac therapy, Heart therapy.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Cardiac Rehabilitation Programs for Chronic Heart Failure (NCD 20.10.1) [accessed 2025 Sep 12]

Intensive Cardiac Rehabilitation (ICR) Programs (NCD 20.31) [accessed 2025 Sep 12]

Benson-Henry Institute Cardiac Wellness Program (NCD 20.31.3) [accessed 2025 Sep 12]

Ornish Program for Reversing Heart Disease (NCD 20.31.2) [accessed 2025 Sep 12]

The Pritikin Program (NCD 20.31.1) [accessed 2025 Sep 12]

Additional information, regarding Cardiac and Intensive Cardiac Rehabilitation Programs, can be found in the Medicare Claims Processing Manual, Section 140. Available from: Medicare Claims Processing Manual [accessed 2025 Sep 12]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, 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 HISTORY/REVISION	
Committee Approval Dates	
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, 06/27/19, 10/24/19, 10/22/20, 10/28/21, 10/20/22, 10/19/23, 10/17/24, 10/16/25	
Date	**Summary of Changes**
10/16/25	• Annual update, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
10/18/01	• Original effective date