Policy Statement

Outpatient cardiac rehabilitation programs may be considered medically necessary for patients with a history of any of the following conditions and procedures:

- Acute myocardial infarction (heart attack) within the preceding 12 months
- Compensated heart failure
- Coronary artery bypass graft surgery
- Current stable angina pectoris
- Heart or heart-lung transplantation
- Heart valve surgery
- Percutaneous transluminal coronary angioplasty or coronary stenting

A repeat outpatient cardiac rehabilitation program may be considered medically necessary, based on the above listed criteria, if the patient has another qualifying cardiac event including any of the following:

- Another cardiovascular surgery
- Another coronary vessel intervention procedure (i.e., PTCA or coronary stenting)
- Another documented MI, or extension of initial infarction
- New clinically significant coronary lesions documented by cardiac catheterization
- New evidence of ischemia on an exercise test, including thallium scan

Outpatient cardiac rehabilitation programs are considered not medically necessary for either of the following:

- Phase III cardiac rehabilitation programs, or self-directed, self-controlled/monitored exercise programs (see Policy Guidelines)
- Phase IV cardiac rehabilitation programs or maintenance therapy that may be safely carried out without medical supervision (see Policy Guidelines)

Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational.

Policy Guidelines

The following components must be included in cardiac rehabilitation programs:

- Cardiac risk factor modification
- Individualized treatment plan detailing how each of the above components are utilized
- Outcomes assessment
- Physician-prescribed exercise each day cardiac rehabilitation services are provided
- Psychosocial assessment

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 before initiation of cardiac rehabilitation to evaluate the patient and determine an appropriate exercise program. In addition to a medical examination, an electrocardiogram 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.
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.

Description
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 specified core components to be included in cardiac rehabilitation programs.

Related Policies
- Lifestyle Modification Program for Reversing Heart Disease

Benefit Application
Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status
- N/A

Rationale
**Background**
**Heart Disease**
Heart disease is the leading cause of mortality in the United States, accounting for more than half of all deaths. Coronary artery disease (CAD) is the most common cause of heart disease. In a 2015 update on heart disease and stroke statistics from the American Heart Association, it was estimated that 635,000 Americans have a new coronary attack (first hospitalized myocardial infarction or coronary heart disease death) and 300,000 have a recurrent attack annually.1 Both CAD and various other disorders—structural heart disease and other genetic, metabolic, endocrine, toxic, inflammatory, and infectious causes—can lead to the clinical syndrome of heart failure, of which there are about 650,000 new cases in the U.S. annually.2 Given the 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 from the European Association of Cardiovascular Prevention and Rehabilitation stated: “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.” Since release of the USPHS guideline, other societies, including the American Heart Association (2005) and the Heart Failure Society of America (2010) have developed guidelines on the role of cardiac rehabilitation in patient care.

**Literature Review**

The most recent literature review was performed through May 31, 2017. 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 that include observational studies are also discussed.

**Systematic Reviews**

**Systematic Reviews of Randomized Controlled Trials**

In 2012, Oldridge identified 6 independent meta-analyses published since 2000 that reported outcomes from 71 RCTs (total N=13,824 patients) following cardiac rehabilitation interventions. The RCTs included 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 an 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.

Two of the meta-analyses on cardiac rehabilitation were conducted by Cochrane. One included patients with CHD and the other focused on patients with systolic heart failure. Both addressed exercise-based cardiac rehabilitation programs (exercise alone or as part of a comprehensive program). In 2016, Anderson et al updated a 2011 Cochrane review addressing exercise-based cardiac rehabilitation for individuals with CHD. The updated review included 63 RCTs (total N=14,486 individuals), of which 16 trials were new since the 2011 update. Reviewers 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. Reviewers 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 permit 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 (RR=0.93; 95% 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 the differences in MLWHF scores between exercise and control groups, there was a significant improvement in MLWHF scores with exercise in pooled analysis (mean difference, -5.8; 95% CI, -9.2 to -2.4, p=0.001). Most studies selected for 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. Reviewers did not require that studies only include patients with compensated heart failure.

**Systematic Reviews of Observational Studies**

In 2017, Sumner et al published a systematic review of controlled observational studies evaluating cardiac rehabilitation in patients diagnosed with acute MI. Cardiac rehabilitation interventions consisted of structured multicomponent programs that included exercise in addition to 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 5 studies reporting all-cause mortality (unadjusted outcome), there was a significantly lower risk of death in the group that received cardiac rehabilitation (odds ratio [OR], 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 cardiac rehabilitation (OR=0.47; 95% CI, 0.38 to 0.59). Similarly, a meta-analysis of 3 studies reporting cardiac-related mortality (unadjusted analysis) found a significant benefit from cardiac rehabilitation (OR=0.21; 95% CI, 0.12 to 0.37). Only 1 study reported an adjusted analysis of cardiac-related mortality so data could not be pooled.

**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., which 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 relative risk 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 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.

**Section Summary: Outpatient Cardiac Rehabilitation for Heart Disease**
A number of RCTs, systematic reviews of RCTs, and/or observational studies have evaluated outpatient cardiac rehabilitation in patients with heart disease. An overview of 6 meta-analyses found a statistically significant association between cardiac rehabilitation and all-cause mortality and/or cardiac mortality. The available evidence has limitations, including lack of blinded outcome assessment, but, for the survival-related outcomes of interest, this limitation is less critical.

**Repeat Outpatient Cardiac Rehabilitation**
No studies were identified that evaluated the effectiveness of repeat participation in a cardiac rehabilitation program.

**Summary of Evidence**
For individuals who have diagnosed heart disease who receive outpatient cardiac rehabilitation, the evidence includes multiple randomized controlled trials (RCTs) 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 select 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 that the technology results in a meaningful improvement in the net health outcome.

For individuals who have diagnosed heart disease without a second event who receive repeat outpatient cardiac rehabilitation, the evidence includes no trials. Relevant outcomes are overall survival, disease-specific survival, symptoms, and morbid events. No studies were identified evaluating 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 et al**
In 2013, the American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) updated their joint guidelines on the management of heart failure. These guidelines included 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 joint guidelines on management of stable ischemic heart disease. The guidelines 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.”
American Heart Association et al
In 2007, AHA and the American Association of Cardiovascular and Pulmonary Rehabilitation issued a consensus statement on the core components of cardiac rehabilitation programs. The core components included 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 cardiac rehabilitation. The guidelines specified the assessment, interventions, and expected outcomes for each of the core components. For example, symptom-limited exercise testing before exercise training was strongly recommended. The national guidelines did not specify the optimal overall length of programs or number or duration of sessions.

European Association of Cardiovascular Prevention and Rehabilitation
In 2010, 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 stated 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 were:
- **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
Cardiac Rehabilitation
Medicare has had a national coverage determination (NCD) for cardiac rehabilitation since 1989. There was a change in Medicare coverage for cardiac rehabilitation in January 2010. Indications for coverage remained 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 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
- 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 in January 2010, the criteria were updated:

“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.”

**Intensive Cardiac Rehabilitation**

Beginning in January 2010, Medicare added intensive cardiac rehabilitation as a benefit. Intensive cardiac rehabilitation programs must be approved by Medicare on an individual basis.

The NCD described intensive cardiac rehabilitation in the following manner:

“Intensive cardiac rehabilitation (ICR) refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner. As required by §1861(eee)(4)(A) of the Social Security Act (the Act), an ICR program must show, in peer-reviewed published research, that it accomplished one or more of the following for its patients: (1) positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; and, (3) 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 measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services: (1) low density lipoprotein; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and, (6) the need for cholesterol, blood pressure, and diabetes medications. Individual ICR programs must be approved through the national coverage determination process to ensure that they demonstrate these accomplishments.”

**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>
<td>NC01822769</td>
<td>Cardiopulmonary Rehabilitation for Adolescents and Adults With Congenital Heart Disease</td>
<td>60</td>
<td>Dec 2017</td>
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<tr>
<td>NC02619422</td>
<td>More Intensive Cardiac Rehabilitation Programs in Less Time (másPORmenos)</td>
<td>509</td>
<td>Mar 2018</td>
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8.03.08  Cardiac Rehabilitation in the Outpatient Setting

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<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
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<tr>
<td>NCT02984449</td>
<td>Preventive Heart Rehabilitation to Prevent Complications in Patients Undergoing Elective Open Heart Surgery (HeartROCQ)</td>
<td>350</td>
<td>Aug 2025</td>
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</tbody>
</table>

NCT: national clinical trial.

References


**Documentation for Clinical Review**

Please provide the following documentation (if/when requested):

- History and physical and/or cardiac consultation notes including:
  - Current disease condition(s) and comorbidity status
  - Current functional, mobility, and psychosocial status
  - Documentation of cardiac event(s) including dates of occurrence
  - Individualized treatment plan (description of the diagnosis, type/amount/frequency and duration of the cardiac rehabilitation services)
  - Surgical procedure(s) and procedure date(s) pertaining to request
  - Type of cardiac rehabilitation program and components requested

**Post Service**

- Daily cardiac rehabilitation treatment records
- Physician measured outcomes assessment (e.g., from the commencement and conclusion of cardiac rehabilitation services)

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

**MN/IE**

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.
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<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<tr>
<td>CPT®</td>
<td>93015</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report</td>
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<td></td>
<td>93016</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report</td>
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<td></td>
<td>93797</td>
<td>Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)</td>
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<tr>
<td></td>
<td>93798</td>
<td>Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)</td>
</tr>
<tr>
<td></td>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
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<td>Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session</td>
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<td>G0423</td>
<td>Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session</td>
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**ICD-10 Procedure**

None

**ICD-10 Diagnosis**

All Diagnoses

**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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<th>Effective Date</th>
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<tr>
<td>09/13/1989</td>
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<td>Administrative Review</td>
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<td>Policy Review and update. Added content from the Lifestyle Treatment for Coronary Heart Disease Medical Policy to Cardiac Rehabilitation Services.</td>
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<td>Policy revision with position change. Policy placed on No Further Routine Literature Review and Update Status.</td>
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<td>Description</td>
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<td>08/01/2017</td>
<td>Policy revision without position change</td>
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**Definitions of Decision Determinations**

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.