

8.03.08 Cardiac Rehabilitation in the Outpatient Setting	
Original Policy Date: September 13, 1989	Effective Date: July 1, 2023
Section: 8.0 Therapy	Page: Page 1 of 27

Policy Statement

- I. Outpatient cardiac rehabilitation programs may be considered **medically necessary** for individuals with a history of the following conditions and procedures:
 - A. Acute myocardial infarction (heart attack) within the preceding 12 months
 - B. Compensated heart failure
 - C. Coronary artery bypass graft surgery
 - D. Current stable angina pectoris
 - E. Heart or heart-lung transplantation
 - F. Heart valve surgery
 - G. Percutaneous transluminal coronary angioplasty or coronary stenting
- II. Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered **investigational**.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

The following components must be included in cardiac rehabilitation programs:

- Provider-prescribed exercise each day cardiac rehabilitation services are provided
- Cardiac risk factor modification
- Psychosocial assessment
- Outcomes assessment
- An 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 before the initiation of cardiac rehabilitation to evaluate the individual 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.

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

- N/A

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 is the leading cause of mortality in the United States, accounting for more than half of all deaths. Coronary artery disease is the most common cause of heart disease. In a 2023 update on heart disease and stroke statistics from the American Heart Association, it was estimated that 720,000 Americans have a new coronary attack (first hospitalized myocardial infarction or coronary heart disease death) and 335,000 have a recurrent attack annually.¹ Both coronary artery disease 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 United States 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.

Cardiac Rehabilitation

In 1995, the U.S. Public Health Service 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.” The U.S. Public Health Service recommended cardiac rehabilitation services for patients with coronary heart disease and 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.”³ Since the 1995 release of the U.S. Public Health Service guidelines, other societies, including in 2005 the American Heart Association⁴ and in 2010 the Heart Failure Society of America⁵ have developed guidelines on the role of cardiac rehabilitation in patient care.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function, including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures

are necessary to ascertain whether a condition improves or worsens and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and the quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Outpatient Cardiac Rehabilitation for Heart Disease

Clinical Context and Therapy Purpose

The purpose of cardiac rehabilitation in patients who have heart disease is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is patients with diagnosed heart disease.

Interventions

The treatment being considered is cardiac rehabilitation. Cardiac rehabilitation includes long-term programs that include medical evaluation, prescribed exercise, modification to reduce cardiac risks, education, and counseling.

Comparators

The comparator of interest is standard management without cardiac rehabilitation. The following practices are currently being used to manage heart disease: medication, surgery, and medical devices.

Outcomes

The general outcomes of interest are overall survival (OS), disease-specific survival, symptoms, and morbid events.

Once diagnosed with heart disease, a patient will require lifelong monitoring by a cardiologist.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.

2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Systematic Reviews

Oldridge (2012) identified 6 independent meta-analyses published since 2000 that reported outcomes from 71 RCTs (N=13,824) following cardiac rehabilitation interventions.⁶ The RCTs included in the meta-analyses enrolled patients with myocardial infarction, coronary heart disease, angina, percutaneous coronary intervention (PCI), and/or coronary artery bypass graft (CABG). The RCTs compared cardiac rehabilitation programs (exercise-only and/or comprehensive rehabilitation) with usual care. Cardiac rehabilitation was associated with a statistically significant ($p<.05$) reduction in all-cause mortality in 4 of the 5 meta-analyses that reported this outcome. In the pooled analysis, cardiac rehabilitation was associated with an 18.5% mean reduction in all-cause mortality. Also, 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 Cochrane reviews. One included patients with coronary heart disease,⁷ 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). Anderson et al (2016) updated a 2011 Cochrane review addressing exercise-based cardiac rehabilitation for individuals with coronary heart disease.^{7,9} Reviewers included RCTs of exercise-based interventions with at least 6 months of follow-up compared with no-exercise controls in patients with myocardial infarction, CABG, or PCI, or with angina pectoris or coronary artery disease. The updated review included 63 RCTs (N=14,486), of which 16 trials had been published 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 the treatment group in any of the studies, but 16 (25%) of 62 studies reported details of blinded assessment of study outcomes. In the 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. 375/3,619 for control subjects; relative risk [RR], 0.74; 95% confidence interval [CI], 0.64 to 0.86). Rates of myocardial infarction, CABG, and PCI were not significantly associated with receiving cardiac rehabilitation.

Long et al (2019) reported a Cochrane Review of studies assessing cardiac rehabilitation in patients with heart failure. A total of 44 RCTs were evaluated, 11 of which were new trials, for the effects of exercise-based cardiac rehabilitation on adults with heart failure (5,783 total participants).¹⁰ A single trial, Exercise Based Cardiac Rehabilitation for Adults With Heart Failure (HF-ACTION), contributed almost half of the patients (with results reported in 18 publications); most other studies were small and single-center. All studies had 6 months or longer follow-up and did not include a formal exercise training intervention as a comparator. The primary outcomes reported were mortality, hospital admission, and health-related quality of life (HRQoL). The overall risk of bias was assessed as being low or unclear, and results were downgraded using the GRADE tool for all outcomes except one. Results showed that cardiac rehabilitation had little effect on all-cause mortality over ≤ 1 year of follow-up (27 trials, 2,596 participants: cardiac rehabilitation 5.1% vs. control 5.8%; low-quality evidence). However, cardiac rehabilitation may make a difference in the long-term (>1 year of follow-up; 6 trials, 2,845 participants: cardiac rehabilitation 17.2% vs. control 19.6%; high-quality evidence). Mortality related to heart failure was not consistently reported in the studies. Chances of avoiding hospital admission for any cause within 12 months of follow-up were better with cardiac rehabilitation (21 trials, 2,182 participants: cardiac rehabilitation 16.5% vs. control 23.7%; moderate-quality evidence). Cardiac rehabilitation may also reduce short-term heart failure-related

hospital admission (14 trials, 1,114 participants: cardiac rehabilitation 7.1% vs. control 11.1%; RR, 0.59, 95% CI, 0.42 to 0.84; $p=.003$), but the evidence was rated low quality. HRQoL was reported by 29 trials, most of which used the Minnesota Living With Heart Failure questionnaire; however, other tools were also used among the 29 trials that reported validated HRQoL measures. For exercise-based cardiac rehabilitation, no trials reported lower HRQoL scores with cardiac rehabilitation than with control, and all but 1 reported on results at ≥ 6 months follow-up. The pooled results from all measures used showed a clinically important improvement (a 5-point difference on the Minnesota Living With Heart Failure) with exercise at up to 12 months follow-up, but the evidence was of very low quality. Compared with the 2014 review, this version included more women, older patients, participants with heart failure with preserved ejection fraction in recent trials, and more trials of cardiac rehabilitation in a home-based setting; this version may be more valid and applicable.

Table 1. Systematic Review Characteristics

Study	Dates	Trials	Participants	N (Range)	Design
Davies et al (2010) ⁸	1995-2008	29	All adults with chronic systolic HF	3,647 (20 to 2,331)	RCT
Oldridge (2012) ⁶	2000-2011	71	Patients with MI, CHD, angina, PCI, and/or CABG	13,824 (6,111 to 10,794)	RCT
Anderson et al (2016) ⁷	1975-2014	63	Patients with MI, angina pectoris, CAD, or who underwent CABG or PCI	14,486 (25 to 3,184)	RCT
Long et al (2019) ¹⁰	1995-2018	44	Patients with HF	5,783 (19 to 2,331)	RCT

CABG: coronary artery bypass graft; CAD: coronary artery disease; CHD: coronary heart disease; HF: heart failure; MI: myocardial infarction; PCI: percutaneous coronary intervention; RCT: randomized controlled trial.

Table 2. Systematic Review Results

Study	All-Cause Mortality	Cardiovascular Mortality
Davies et al (2010) ⁸	13 studies (≤ 12 mo)	NR
Difference in pooled mortality, fixed-effect RR	1.02	NR
95% CI	0.70 to 1.51	NR
p-value	.90	NR
Oldridge (2012) ⁶	6 studies	6 studies
Reduction, mean %	18.50	29.4
p-value	$<.05$	NR
Range, %	NR	20 to 43
Anderson et al (2016) ⁷	47 studies; N=12,455 participants	27 studies; N=7,469 participants
RR	0.96	0.74
95% CI	0.88 to 1.04	0.64 to 0.86
Long et al (2019) ¹⁰	2,845 participants, 6 studies	(studies did not consistently report deaths due to heart failure)
RR	0.88	NR
95% CI	0.75 to 1.02	NR

CI: confidence interval; NR: not reported; RR: relative risk.

Randomized Controlled Trials

Findings of a large, multicenter RCT from the United Kingdom, which evaluated the effectiveness of cardiac rehabilitation in a "real-life" setting, were published by West et al (2012).¹¹ Called the Rehabilitation After Myocardial Infarction Trial (RAMIT), the study included patients from 14 centers with established multifactorial cardiac rehabilitation programs (including exercise, education, and counseling), involved more than 1 discipline, and provided an intervention lasting a minimum of 10

hours. A total of 1,813 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 endpoint including death, nonfatal myocardial infarction, stroke, or revascularization, the RR was 0.96 (95% CI, 0.88 to 1.07). In discussing the study's negative findings, trialists noted that medical management of heart disease had improved over time, and patients in the control group might have had better outcomes than in earlier RCTs on this topic. Moreover, an editorial accompanying the publication of the trial's findings emphasized that RAMIT was not an efficacy trial, but rather, a trial evaluating the effectiveness of actual cardiac rehabilitation programs in the United Kingdom.¹² Finally, these results might in part reflect the degree to which clinically-based cardiac rehabilitation programs in the United Kingdom 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 might 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.

Pandey et al (2017) evaluated endurance exercise training as part of a cardiac rehabilitation program in a population of heart failure patients stratified by ejection fraction.¹³ Participants had heart failure with preserved ejection fraction or reduced ejection fraction, were 65 years of age or older, and had participated in a 16-week exercise program that intensified from 40% to 50% of heart rate reserve in the first 2 weeks to 60% to 70% over the ensuing weeks as part of a previously published RCT.¹⁴ The primary outcome for assessing change in exercise capacity was the percentage change in peak oxygen uptake (mL/kg per minute) from baseline to end of exercise training (16-week follow-up). Data on testing from 48 patients (24 reduced ejection fraction, 24 heart failure with preserved ejection fraction) were assessed. Heart failure with preserved ejection fraction patients experienced greater improvement in exercise training patients (18.7%) than reduced ejection fraction patients (-0.3%; $p < .001$) as measured by peak oxygen uptake. There was no information on subsequent hospitalization rates or clinical outcomes such as heart failure progression or mortality. This secondary analysis was used to assert the appropriateness of cardiac rehabilitation in heart failure with preserved ejection fraction patients.

Opotowsky et al (2018) compared cardiac rehabilitation to the standard of care in 28 subjects (mean age: 41.1 years) with moderate to severe congenital heart disease.¹⁵ Cardiac rehabilitation was associated with a significant increase in peak oxygen consumption with no associated adverse events. There was also a nonsignificant improvement in peak work rate with cardiac rehabilitation as compared to standard of care ($p = .16$) and a significant improvement in self-assessment of overall health ($p < .04$). However, the study was limited by its small sample size and short-term follow-up.

Tables 3 and 4 provide a summary of key RCT characteristics and results.

Table 3. Summary of Key Randomized Controlled Trial Characteristics

Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
West et al (2012); RAMIT ¹¹	United Kingdom	14	1997-2000	Patients diagnosed with acute MI (N=1813)	Cardiac rehabilitation (n=903)	Control (n=910)

Trial	Countries	Sites	Dates	Participants	Interventions
Pandey et al (2017) ¹³	U.S.	1	NR	Patients aged ≥65 years with HFrEF (n=24) or HFpEF (n=24)	16-wk supervised moderate endurance exercise training (n=48) vs. HFpEF (n=24)
Opotowsky et al (2018) ¹⁵	U.S.	1	NR	Patients aged ≥16 years with moderate to severe congenital heart disease (N=28)	12-wk cardiac rehabilitation (n=13) Standard of care (n=15)

HF: heart failure; HFpEF: HF with preserved ejection fraction; HFrEF: HF with reduced ejection fraction; MI: myocardial infarction; NR: not reported; RCT: randomized controlled trial; RAMIT: Rehabilitation After Myocardial Infarction Trial.

Table 4. Summary of Key Randomized Controlled Trial Results

Study	2-yr Mortality	Readmission to Hospital for Any Cardiac Condition at 1 y	Training-Related Improvement in Vo ₂ peak Change
West et al (2012); RAMIT ¹¹	N=1,813 participants	N=1,813 participants	NR
CR	82 patients	222 (25%)	NR
Control	84 patients	239 (26%)	NR
RR	0.98	NR	NR
95% CI	0.74 to 1.30	NR	NR
Pandey et al (2017) ¹³	NR	NR	N=48 participants
HFrEF	NR	NR	18.7+/-17.6
HFpEF	NR	NR	-0.3+/-15.4
p-value	NR	NR	<.001
Opotowsky et al (2018) ¹⁵			N=28 participants
CR	NR	NR	+2.2 mL/kg/min (compared to standard of care)
95% CI; p-value	NR	NR	0.7 to 3.7; p=.002

CI: confidence interval; CR: cardiac rehabilitation; HF: heart failure; HFpEF: HF with preserved ejection fraction; HFrEF: HF with reduced ejection fraction; NR: not reported; RCT: randomized controlled trial; RR: relative risk; Vo₂peak: peak oxygen uptake. RAMIT: Rehabilitation After Myocardial Infarction Trial.

The purpose of the limitations tables (see Tables 5 and 6) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the position statement.

Table 5. Study Relevance Limitations

Study	Population ^a	Intervention ^b	Comparator ^c	Outcomes ^d	Follow-Up ^e
West et al (2012); RAMIT ¹¹	4,5. Descriptions of diversity in study populations were not reported				1,2. Trial was closed prematurely
Pandey et al (2017) ¹³	4. Enrolled populations do not reflect relevant diversity; 81% of participants were White		2. No comparator used		1,2. Only 16 wks follow-up
Opotowsky et al (2018) ¹⁵	4,5. Descriptions of diversity in study populations were not reported			1. Key health outcomes such as mortality or readmission not addressed	1,2. Only 12 wks follow-up

RAMIT: Rehabilitation After Myocardial Infarction Trial.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

^a Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4. Enrolled populations do not reflect relevant diversity; 5. Other.

^b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest. 5: Other.

^c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively. 5: Other.

^d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported. 7. Other.

^e Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms. 3. Other.

Table 6. Study Design and Conduct Limitations

Study	Allocation ^a	Blinding ^b	Selective Reporting ^c	Follow-Up ^d	Power ^e	Statistical ^f
West et al (2012); RAMIT ¹¹	3. Allocation concealment unclear	1,2. Not blinded				
Pandey et al (2017) ¹³	1. Participants not randomly allocated	1,2. Not blinded				
Opotowsky et al (2018) ¹⁵		1,2. Not blinded			1. Power calculations not reported	

RAMIT: Rehabilitation After Myocardial Infarction Trial.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

^a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

^b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

^c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

^d Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

^e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

^f Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

Observational Studies

Sumner et al (2017) published a systematic review of controlled observational studies evaluating cardiac rehabilitation in patients diagnosed with acute myocardial infarction.¹⁶ Cardiac rehabilitation interventions consisted of structured multicomponent programs that included exercise and at least 1 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 (an 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 (an 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.

Nilsson et al (2018) investigated the effect of a 12-week cardiac rehabilitation program with a high-intensity interval exercise component using participant peak oxygen uptake as a measure of improved exercise capacity.¹⁷ Increased exercise capacity has been shown to improve survival among persons with coronary heart disease. The objective of the study was to assess whether this addition to a cardiac rehabilitation program yielded improved long-term results. One hundred thirty-three 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 quality of life questionnaire. Of the 133 patients, 86 patients had complete information for the 15-month follow-up. Mean peak oxygen uptake improved from a baseline of 31.9 mL/kg/min to 35.9 mL/kg/min ($p < .001$) 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 cardiac rehabilitation. The authors concluded that the cardiac rehabilitation program intervention potentially fostered consistent and beneficial exercise habits as demonstrated by improved peak oxygen uptake.

Jafri et al (2021) conducted a retrospective cohort study to evaluate home-based cardiac rehabilitation (HBCR) in patients with established cardiovascular disease.¹⁸ A total of 269 patients at a Veterans Affairs Medical Center were eligible for inclusion (HBCR group, $n=157$; non-HBCR control group, $n=100$); 12 patients were excluded due to having outcomes less than 90 days after enrollment (study follow-up period was between 3 to 12 months). A majority of patients (98%) were male, and the mean age was 72 years. The primary outcome was composite all-cause mortality and hospitalizations and secondary outcomes were all-cause hospitalization, all-cause mortality, and cardiovascular hospitalizations. The primary composite outcome occurred in both the HBCR ($n=30$) and control ($n=30$) (adjusted hazard ratio [HR], 0.56; 95% CI, 0.33 to 0.95; $p=.03$). All-cause mortality occurred in 6.4% of HBCR patients versus 13% of the control group (adjusted HR, 0.43; 95% CI, 0.18 to 1.0; $p=.05$). There was no difference in cardiovascular or all-cause hospitalizations between groups.

Section Summary: Outpatient Cardiac Rehabilitation for Heart Disease

Overall, the evidence from RCTs reviewed in well-structured systematic reviews suggests that cardiac rehabilitation is associated with reduced cardiovascular mortality in patients with coronary heart disease. Additional RCTs, systematic reviews, and observational studies have evaluated outpatient cardiac rehabilitation in patients with heart failure or in the postintervention setting. An overview of 6 meta-analyses found a statistically significant association between cardiac rehabilitation and reduction in 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

Clinical Context and Therapy Purpose

The purpose of repeat cardiac rehabilitation in patients who have heart disease without a second event is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is patients with diagnosed heart disease who have had cardiac rehabilitation before but who have not had a second cardiac event.

Interventions

The treatment being considered is repeat cardiac rehabilitation. Cardiac rehabilitation includes long-term programs that include medical evaluation, prescribed exercise, modification to reduce cardiac risks, education, and counseling.

Comparators

The comparator of interest is standard management with a single course of cardiac rehabilitation. Cardiac rehabilitation includes long-term programs that include medical evaluation, prescribed exercise, modification to reduce cardiac risks, education, and counseling.

Outcomes

The general outcomes of interest are OS, disease-specific survival, symptoms, and morbid events.

Once diagnosed with heart disease, a patient will require lifelong monitoring by a cardiologist.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence

No studies were identified that evaluated the effectiveness of repeat participation in a cardiac rehabilitation program.

Section Summary: Repeat Outpatient Cardiac Rehabilitation

For individuals who have been diagnosed with heart disease without a second event who receive repeat outpatient cardiac rehabilitation, the evidence includes no trials.

Intensive Cardiac Rehabilitation for Heart Disease

There is no standard definition of an intensive cardiac rehabilitation program and, thus, specific programs are reviewed individually. Three programs have been evaluated by the Centers for Medicare & Medicaid Services, and the published evidence supporting these programs is reviewed. The ideal trial design would be an RCT comparing the impact of intensive cardiac rehabilitation with standard cardiac rehabilitation on health outcomes.

Ornish Program for Reversing Heart Disease

Clinical Context and Therapy Purpose

The purpose of the Ornish Program for Reversing Heart Disease in patients who have been diagnosed with heart disease is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is patients with diagnosed heart disease.

Interventions

The treatment being considered is the Ornish Program for Reversing Heart Disease.

The Ornish Program for Reversing Heart Disease is an intensive cardiac rehabilitation program that focuses on exercise, diet, stress management, and support from others.

The multiple 4-hour sessions are administered by an Ornish-certified physician, cardiac therapist, or other certified health care provider.

Comparators

The comparator of interest is standard outpatient cardiac rehabilitation. Cardiac rehabilitation includes long-term programs that include medical evaluation, prescribed exercise, modification to reduce cardiac risks, education, and counseling.

Outcomes

The general outcomes of interest are OS, disease-specific survival, symptoms, and morbid events. Once diagnosed with heart disease, a patient will require lifelong monitoring by a cardiologist.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Randomized Controlled Trials

Ornish et al (1990) conducted an 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 5-year results in 1998.^{19,20} Eligibility for the trial included diagnosed coronary artery disease, left ventricular ejection fraction greater than 25%, no myocardial infarction during the previous 6 weeks, not scheduled for CABG, and not taking lipid-lowering medication. Ninety-four eligible patients were randomized to an intervention group (n=53) or a usual care control group (n=43). Final consenting was done after randomization; 28 (53%) of patients assigned to the intervention group and 20 (43%) assigned to the control group agreed to participate in the trial.

The lifestyle intervention consisted of recommending a low-fat vegetarian diet and an individualized exercise regimen. Also, patients were taught stress management techniques and were taught to practice them at home for at least an hour a day. Also, twice-weekly group discussions were offered to provide social support. It is not clear how long patients attended these group discussions (i.e., the number of weeks or months). As reported by Ornish et al (1990), the mean percentage diameter stenosis decreased from 40% at baseline to 37.8% at 1 year in the intervention group and increased from 42.7% to 46.1% in the control group ($p=.001$). The frequency and duration of chest pain did not differ between groups. However, during chest pain episodes, at 1 year, the intervention group reported mean chest pain severity of 1.7 (on a 7-point scale) whereas the mean score in the control group was 2.5 ($p<.001$).

Twenty (71%) of 28 patients in the intervention group and 15 (75%) of 20 in the control group completed the 5-year follow-up. The intervention and control groups did not differ significantly in the number of myocardial infarction events (2 vs. 4), CABGs (2 vs. 5), or deaths (2 vs. 1). However, compared with the control group, the intervention group had significantly fewer percutaneous transluminal coronary angioplasties (8 vs. 14 ; $p<.050$) and cardiac hospitalizations (23 vs. 44 ; $p<.001$).

Section Summary: Ornish Program for Reversing Heart Disease

One RCT was identified that evaluated the Ornish Program in patients diagnosed with heart disease and compared it with usual care. This RCT, which included patients with coronary artery disease but no recent cardiac event, had mixed findings at 1 and 5 years. The trial had a small sample size for a cardiac trial (N=48), and only 35 patients were available for the 5-year follow-up. The Ornish Program is considered by the Centers for Medicare & Medicaid Services to be an intensive cardiac rehabilitation program, but the program described in this RCT might meet the criteria for standard cardiac rehabilitation. No studies were identified that compared the Ornish Program with any other cardiac rehabilitation program.

Pritikin Program**Clinical Context and Therapy Purpose**

The purpose of the Pritikin Program in patients who have been diagnosed with heart disease is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is patients with diagnosed heart disease.

Interventions

The treatment being considered is the Pritikin Program.

The Pritikin Program is an intensive cardiac rehabilitation program based on effective exercise, a healthy diet, and a healthy mindset.

Comparators

The comparator of interest is standard outpatient cardiac rehabilitation. Cardiac rehabilitation includes long-term programs that include medical evaluation, prescribed exercise, modification to reduce cardiac risks, education, and counseling.

Outcomes

The general outcomes of interest are OS, disease-specific survival, symptoms, and morbid events. Once diagnosed with heart disease, a patient will require lifelong monitoring by a cardiologist.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence**Nonrandomized Studies**

No RCTs evaluating the Pritikin Program were identified. Lakhani et al (2023) conducted a prospective, nonrandomized study that compared intensive cardiac rehabilitation with the Pritikin Program and traditional outpatient cardiac rehabilitation.²¹ 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 and lack of data for cardiovascular outcomes.

Racette et al (2023) published 7-year outcomes from the first institution to implement the Pritiken Program.²² 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 Pritiken Program. Significant benefit of the Pritiken 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.

Table 7. Summary of Key Nonrandomized Trials

Study	Study Type	Country	Dates	Participants	Intensive cardiac rehabilitation	Traditional cardiac rehabilitation	Follow-Up
Lakhani et al (2023) ²¹ ,	Cohort	U.S.	2017-2021	Referred by a cardiologist for cardiac rehabilitation	n=230	n=62	24 visits
Racette et al (2022) ²² ,	Cohort	U.S.	2013-2019	Enrolled in a cardiac rehabilitation program in the course of usual care	N=1,507	N=456	72 sessions over 18 weeks; 7 year follow-up

Table 8. Summary of Key Nonrandomized Trials

Study	Change in diet quality	Change in QOL	Change in body weight (kg)	Change in BMI (kg/m ²)	Change in 6MWD (m)
Lakhani et al (2023) ²¹ ,	N=292	N=292	NR	NR	NR
Intensive cardiac rehabilitation	<ul style="list-style-type: none"> 90% improved 3% no change 7% worsened 	<ul style="list-style-type: none"> 80% improved 7% no change 13% worsened 	NR	NR	NR
Traditional cardiac rehabilitation	<ul style="list-style-type: none"> 71% improved 5% no change 24% worsened 	<ul style="list-style-type: none"> 71% improved 13% no change 16% worsened 	NR	NR	NR
p-value	.001	NS	NR	NR	NR
Racette et al (2022) ²² ,	NR	NR	N=1,963	N=1,963	N=1,963
Intensive cardiac rehabilitation	NR	NR	-1.4±2.8	-0.5±1.0	46.4±57.8
Traditional cardiac rehabilitation	NR	NR	0.1±3.2	0.1±1.1	44.4±58.9
p-value	NR	NR	<.001	<.001	.106

6MWD: 6-minute walk distance; BMI: body mass index; NR: not reported; NS: not significant; QOL: quality of life.

Section Summary: Pritikin Program

No RCTs have evaluated the Pritikin Program; 2 nonrandomized studies in patients with heart disease were identified. Conclusions cannot be drawn from this limited data on the impact on cardiovascular outcomes of intensive cardiac rehabilitation with the Pritikin Program compared with standard outpatient cardiac rehabilitation.

Benson-Henry Institute Program**Clinical Context and Therapy Purpose**

The purpose of the Benson-Henry Institute Program in patients who have been diagnosed with heart disease is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is patients with diagnosed heart disease.

Interventions

The treatment being considered is the Benson-Henry Institute Program.

The Benson-Henry Institute Program is an intensive cardiac rehabilitation program based on effective exercise, a healthy diet, and a healthy mindset.

Comparators

The comparator of interest is standard outpatient cardiac rehabilitation. Cardiac rehabilitation includes long-term programs that include medical evaluation, prescribed exercise, modification to reduce cardiac risks, education, and counseling.

Outcomes

The general outcomes of interest are OS, disease-specific survival, symptoms, and morbid events. Once diagnosed with heart disease, a patient will require lifelong monitoring by a cardiologist.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence**Case-Control Studies**

Zeng et al (2013) reported outcomes of a Medicare-sponsored demonstration of 2 intensive lifestyle modification programs in patients with symptomatic coronary heart disease: the Cardiac Wellness Program of the Benson-Henry Mind Body Institute and the Dr. Dean Ornish Program for Reversing Heart Disease.²³ This analysis included 461 participants and 1,795 matched controls using Medicare claims data from 1998 to 2008. Four matched controls were sought for each participant from Medicare claims data, 2 of whom had received traditional cardiac rehabilitation within 12 months following their cardiac events (cardiac rehabilitation controls) and 2 of whom had not (non-cardiac rehabilitation controls). Outcomes included mortality rates during the 3 post-enrollment years, total hospitalizations, hospitalizations with a cardiac-related principal discharge diagnosis, and Medicare-paid costs of care. Of the 324 participants in the Benson-Henry Mind Body Medical Institute program

analysis, the authors concluded that during the active intervention and follow-up years, total, cardiac, and non-cardiac hospitalizations were lower in the Benson-Henry program participants than their controls for each comparison ($p < .001$). The investigators further reported that after year 1, the mortality rate was 1.5% in the Benson-Henry program participants compared with 2.5% and 4.2%, respectively, in cardiac rehabilitation and non-cardiac rehabilitation controls. After year 3, comparable figures were 6.2% in Benson-Henry program participants, 10.5% in cardiac rehabilitation controls, and 11.0% in non-cardiac rehabilitation controls. These mortality differences for the Benson-Henry program participants reached borderline significance ($p = .08$).

Case Series

Casey et al (2009) reported the results of a case series that evaluated the effects of an intensive cardiac rehabilitation program, incorporating components of the Benson-Henry Institute Cardiac Wellness Program at a single center.²⁴ From 1997 to 2005, 637 patients with coronary artery disease were enrolled and completed the program, which consisted of 13 weekly 3 hour sessions with supervised exercise, relaxation techniques, stress management, and behavioral interventions. The mean age of participants was 63 years (range, 27 to 92 years); men comprised 72% of the study population. Results revealed significant improvements in clinical (blood pressure, lipids, weight, exercise conditioning, frequency of symptoms of chest pain, and shortness of breath) and psychological outcomes (general severity index, depression, anxiety, and hostility) ($p < .0001$) with the program.

Section Summary: Benson-Henry Institute Program

No RCTs have evaluated the Benson-Henry Institute Program; a case-control study found the program participants to have lower total, cardiac, and non-cardiac hospitalizations during the active intervention and follow-up years compared to controls for each comparison. Additionally, program participants had lower mortality rates compared to controls; however, the mortality differences were borderline significant at year 3. A case series also demonstrated that the implementation of components of the Benson-Henry Institute program resulted in an improvement in clinical and psychological outcomes. Conclusions cannot be drawn from these data on the impact of intensive cardiac rehabilitation with the Benson Henry Institute program compared with standard outpatient cardiac rehabilitation.

Virtual Cardiac Rehabilitation

Clinical Context and Therapy Purpose

The purpose of virtual cardiac rehabilitation in patients who have been diagnosed with heart disease is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with diagnosed heart disease.

Interventions

The treatment being considered is virtual cardiac rehabilitation.

Virtual cardiac rehabilitation is HBCR delivered by virtual or remote interactions between patients and providers, including video conferencing, phone, email, text, smartphone applications, or wearable devices.

Comparators

The comparator of interest is standard outpatient cardiac rehabilitation. Cardiac rehabilitation includes long-term programs that include medical evaluation, prescribed exercise, modification to reduce cardiac risks, education, and counseling.

Outcomes

The general outcomes of interest are OS, disease-specific survival, symptoms, and morbid events. Once diagnosed with heart disease, a patient will require lifelong monitoring.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Systematic Reviews

Several meta-analyses/systematic reviews are available for virtual cardiac rehabilitation.²⁵⁻³⁰ In general, these reviews have found significant effects on physical activity, cardiovascular risk factors, and quality of life, but evidence for cardiovascular outcomes is limited.

The analysis by Cruz-Cobo et al (2022) included 20 randomized studies (N=4,535) of mobile health interventions in patients who had experienced a coronary event.²⁸ Beneficial effects of mobile health interventions were found for exercise capacity, physical activity, adherence to treatment, and quality of life. All-cause hospital readmission ($p=.04$) and hospital readmission for cardiovascular causes ($p=.05$) were statistically lower in the mobile health intervention group compared to the control group, but these may not be clinically relevant differences (point estimates for actual risk differences were -0.03 and -0.04 , respectively). There was no difference between groups in mortality. A major limitation of this study is lack of clarity of how many individuals received mobile health interventions for the purpose of cardiac rehabilitation.

Randomized Controlled Trials

Numerous RCTs with virtual cardiac rehabilitation have been published.³¹⁻⁴¹ Of these, only 2 have reported results for cardiovascular outcomes of interest. Indraratna et al (2022) found that unplanned hospital readmissions and cardiac readmissions were significantly lower with a smartphone-based intervention to facilitate the transition to outpatient cardiac care (including rehabilitation) compared to usual care among 164 patients being discharged after hospitalization for acute coronary syndrome or heart failure.³⁴ However, only 100 patients in the study received cardiac rehabilitation after discharge and rehospitalization rates were not provided for this cohort alone. Other limitations of this study include short duration of follow-up (6 months) and that enrollment was terminated in March 2020 so the study may not reflect how usual care is delivered in the post-COVID-19 pandemic era. Piotrowicz et al (2020) conducted a 9-week RCT of telerehabilitation compared to usual care in 850 patients with heart failure.³⁶ Both groups had a median follow-up of 793 days. The primary outcome (days alive and out of the hospital through end of follow-up) was similar between groups (median, 775 days [telerehabilitation] vs. 776 days [usual care]). There was also no difference between telerehabilitation and usual care in all-cause hospitalization (HR, 0.913; 95% CI, 0.762 to 1.093), cardiovascular hospitalization (HR, 0.837; 95% CI, 0.667 to 1.050), all-cause mortality (HR, 1.035; 95% CI, 0.706 to 1.517), or cardiovascular mortality (HR, 0.985; 95% CI, 0.619 to 1.569). Since the study only included patients with heart failure, the results may not be applicable to patients with other forms of heart disease. Other limitations include a lack of power for hospitalization and mortality outcomes, and that the cardiac monitoring device used in the study may not reflect the effect of video- or smartphone-based virtual rehabilitation methods used in current practice.

Retrospective Studies

Nkonde-Price et al (2022) conducted a retrospective study of virtual cardiac rehabilitation compared to traditional cardiac rehabilitation in a cohort of 2,556 patients with cardiovascular disease.⁴² Virtual cardiac rehabilitation consisted of home-based cardiac rehabilitation using a mobile phone application linked to a wearable smartwatch, self-directed exercise sessions, weekly nurse phone calls, and health education for 8 weeks. The primary outcome, all-cause hospitalization during 12 months of follow-up, was lower in patients who experienced the virtual cardiac rehabilitation program compared to traditional outpatient cardiac rehabilitation (14.8% vs. 18.1%; OR, 0.79; 95% CI, 0.64 to 0.97; $p=.03$). There was no difference between groups in 30-day or 90-day all-cause or cardiovascular hospitalization. Mortality was not addressed.

Section Summary: Virtual Cardiac Rehabilitation

Systematic reviews and RCTs suggest that virtual cardiac rehabilitation may have similar effects on cardiovascular outcomes compared to standard outpatient cardiac rehabilitation, but evidence about the effect on hospital readmission is inconsistent. One RCT in patients with heart failure found no difference between virtual cardiac rehabilitation and standard outpatient cardiac rehabilitation on the primary outcome of days alive and out of the hospital. No RCTs have been adequately powered to detect or reported a difference in all-cause mortality or cardiovascular mortality.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Cardiology Foundation

In 2013, the American College of Cardiology Foundation and the American Heart Association updated their joint guidelines on the management of heart failure.⁴³ These guidelines included the following class IIA recommendation on cardiac rehabilitation (level of evidence: B): "Cardiac rehabilitation can be useful in clinically stable patients with heart failure to improve functional capacity, exercise duration, health-related quality of life, and mortality." The 2022 guideline from the same organizations did not include additional information on cardiac rehabilitation.⁴⁴

American College of Physicians

In 2012, the American College of Physicians and 6 other cardiology associations published joint guidelines on the management of stable ischemic heart disease.⁴⁵ 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." The 2014 update to the guideline did not include additional information on cardiac rehabilitation.⁴⁶

American Heart Association

In 2007, the American Heart Association and the American Association of Cardiovascular and Pulmonary Rehabilitation issued a consensus statement on the core components of cardiac rehabilitation programs.² 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 offered supervised exercise training were 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 guidelines did not specify the optimal overall length of programs or the number or duration of sessions.

In 2019, the American Heart Association, with the American Association of Cardiovascular and Pulmonary Rehabilitation and the American College of Cardiology, released a scientific statement on home-based cardiac rehabilitation (HBCR).⁴⁷ They make the following suggestions for healthcare providers:

- Recommend center-based cardiac rehabilitation (CBCR) to all eligible patients.
- As an alternative, recommend HBCR to clinically stable low- and moderate-risk patients who cannot attend CBCR.
- Design and test HBCR "using effective processes of care for CVD [cardiovascular disease] secondary prevention."
- For healthcare organizations, develop and support the following:
 - Maximization of cardiac rehabilitation (CR) referrals
 - High-quality CBCR and HBCR programs "using evidence-based standards and guidelines, strategies to maximize patient adherence both in the shorter and longer-term, and outcome tracking methods to help promote continuous quality improvement."
 - "Testing and implementation of an evidence-based hybrid approach to CR" that are optimized for each patient and that "promote long-term adherence and favorable behavior change."
- For CR professionals, "work with other healthcare professionals and policymakers to implement additional research and...expand the evidence base for HBCR."

The guideline does not use the terminology "virtual" cardiac rehabilitation, but it states that electronic tools such as text messaging, smartphone applications, and wearable sensors may allow patients to follow personalized recommendations for exercise, dietary, and behavioral interventions, and thus expand the number of patients who can participate in cardiac rehabilitation. Other benefits of technology-assisted HBCR include greater patient engagement and patient-provider communication. The panel stated that studies were needed regarding the effect of technology-assisted HBCR on outcomes.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage Cardiac Rehabilitation

Since 1989, Medicare has had a national coverage determination for cardiac rehabilitation. In 2010, there was a change in Medicare coverage for cardiac rehabilitation.⁴⁸ Indications for coverage remained the same; namely, patients who have experienced at least 1 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 or coronary stenting
- Heart or heart-lung transplant

As of February 2014, patient eligibility criteria were expanded for cardiac rehabilitation to include 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."⁴⁹

The 2010 criteria specify the required components of cardiac rehabilitation programs. Programs must include all of the following⁴⁸:

- “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 January 2010, the criteria on the frequency and duration of cardiac rehabilitation services were updated⁴⁸:

“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.”

In October 2020, virtual cardiac rehabilitation and intensive cardiac rehabilitation were added to the list of telehealth services that Medicare would cover during the COVID-19 public health emergency.⁵⁰ Virtual cardiac rehabilitation will continue to be covered through the end of 2023.^{51,52}

Intensive Cardiac Rehabilitation

In January 2010, Medicare added intensive cardiac rehabilitation as a benefit. Intensive cardiac rehabilitation programs must be approved by Medicare on an individual basis.⁴⁹

The national coverage determination 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 1 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 5 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.”

In 2010, the Centers for Medicare & Medicaid Services also issued 2 decision memos on specific programs. One stated that the Ornish Program for Reversing Heart Disease met the intensive cardiac rehabilitation program requirements and was included on the list of approved intensive cardiac rehabilitation programs.⁵³ It provided the following description of the Ornish Program: “The Ornish Program for Reversing Heart Disease (also known as the Multisite Cardiac Lifestyle Intervention Program, Multicenter Cardiac Lifestyle Intervention Program and the Lifestyle Heart Trial program) ... incorporates comprehensive lifestyle modifications including exercise, a low-fat diet,

smoking cessation, stress management training, and group support sessions. Over the years, the Ornish program has been refined but continues to focus on these specific risk factors."

The other stated that the Pritikin Program met program requirements and was included on the list of approved intensive cardiac rehabilitation programs.⁵⁴ As described in the decision memo: "The Pritikin program (also known as the Pritikin Longevity Program) evolved into a comprehensive program that is provided in a physician's office and incorporates a specific diet (10% to 15% of calories from fat, 15% to 20% from protein, 65% to 75% from complex carbohydrates), exercise and counseling lasting 21 to 26 days. An optional residential component is also available for participants."

In 2014, Centers of Medicare & Medicaid Services issued another decision memo on the Benson-Henry Institute Cardiac Wellness Program.⁵⁵ The memo stated that "the evidence is sufficient to expand the intensive care rehabilitation benefit to include the Benson-Henry Institute Cardiac Wellness Program. The Cardiac Wellness Program is a multicomponent intervention program that includes supervised exercise, behavioral interventions, and counseling, and is designed to reduce cardiovascular risk and improve health outcomes."

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 9.

Table 9. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT04245813	Effectiveness of a Cardiac Rehabilitation Program in Patients With Heart Failure	144	May 2023
NCT02984449	Preventive Heart Rehabilitation in Patients Undergoing Elective Open Heart Surgery to Prevent Complications and to Improve Quality of Life (Heart-ROCC) - A Prospective Randomized Open Controlled Trial, Blinded End-point (PROBE)	350	Aug 2025
NCT05270993	An Integrative Cardiac Rehabilitation Employing Smartphone Technology (iCREST) for Patients With Post-myocardial Infarction: A Randomized Controlled Trial	124	Dec 2023
NCT05689385	The Effectiveness of eHealth-based Cardiac Rehabilitation in Post-myocardial Infarction Patients: a Randomized Controlled Trial	150	Dec 2024
NCT05610358	Efficacy of Smartphone Application Based Rehabilitations in Patients With Chronic Respiratory or Cardiovascular Disease	162	Dec 2024
NCT02791685	Smartphone Delivered In-home Cardiopulmonary Rehabilitation	300	Dec 2026
<i>Unpublished</i>			
NCT03218891	Cardiac Rehabilitation in Patients With Refractory Angina	72	Feb 2022
NCT05489913	The Effect of Web Based Cardiac Rehabilitation Support on the Healthy Lifestyle Behaviors, Medication Adherence and Quality of Life in Coronary Artery Patients	70	Jun 2021

NCT: national clinical trial.

References

1. Tsao CW, Aday AW, Almarzooq ZI, et al. Heart Disease and Stroke Statistics-2023 Update: A Report From the American Heart Association. *Circulation*. Feb 21 2023; 147(8): e93-e621. PMID 36695182
2. Balady GJ, Williams MA, Ades PA, et al. Core components of cardiac rehabilitation/secondary prevention programs: 2007 update: a scientific statement from the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of

Cardiovascular and Pulmonary Rehabilitation. *Circulation*. May 22 2007; 115(20): 2675-82. PMID 17513578

3. Corrà U, Piepoli MF, Carré F, et al. Secondary prevention through cardiac rehabilitation: physical activity counselling and exercise training: key components of the position paper from the Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation. *Eur Heart J*. Aug 2010; 31(16): 1967-74. PMID 20643803
4. Leon AS, Franklin BA, Costa F, et al. Cardiac rehabilitation and secondary prevention of coronary heart disease: an American Heart Association scientific statement from the Council on Clinical Cardiology (Subcommittee on Exercise, Cardiac Rehabilitation, and Prevention) and the Council on Nutrition, Physical Activity, and Metabolism (Subcommittee on Physical Activity), in collaboration with the American association of Cardiovascular and Pulmonary Rehabilitation. *Circulation*. Jan 25 2005; 111(3): 369-76. PMID 15668354
5. Lindenfeld J, Albert NM, Boehmer JP, et al. HFSA 2010 Comprehensive Heart Failure Practice Guideline. *J Card Fail*. Jun 2010; 16(6): e1-194. PMID 20610207
6. Oldridge N. Exercise-based cardiac rehabilitation in patients with coronary heart disease: meta-analysis outcomes revisited. *Future Cardiol*. Sep 2012; 8(5): 729-51. PMID 23013125
7. Anderson L, Thompson DR, Oldridge N, et al. Exercise-based cardiac rehabilitation for coronary heart disease. *Cochrane Database Syst Rev*. Jan 05 2016; 2016(1): CD001800. PMID 26730878
8. Davies EJ, Moxham T, Rees K, et al. Exercise based rehabilitation for heart failure. *Cochrane Database Syst Rev*. Apr 14 2010; (4): CD003331. PMID 20393935
9. Heran BS, Chen JM, Ebrahim S, et al. Exercise-based cardiac rehabilitation for coronary heart disease. *Cochrane Database Syst Rev*. Jul 06 2011; (7): CD001800. PMID 21735386
10. Long L, Mordi IR, Bridges C, et al. Exercise-based cardiac rehabilitation for adults with heart failure. *Cochrane Database Syst Rev*. Jan 29 2019; 1(1): CD003331. PMID 30695817
11. West RR, Jones DA, Henderson AH. Rehabilitation after myocardial infarction trial (RAMIT): multi-centre randomised controlled trial of comprehensive cardiac rehabilitation in patients following acute myocardial infarction. *Heart*. Apr 2012; 98(8): 637-44. PMID 22194152
12. Doherty P, Lewin R. The RAMIT trial, a pragmatic RCT of cardiac rehabilitation versus usual care: what does it tell us?. *Heart*. Apr 2012; 98(8): 605-6. PMID 22505460
13. Pandey A, Kitzman DW, Brubaker P, et al. Response to Endurance Exercise Training in Older Adults with Heart Failure with Preserved or Reduced Ejection Fraction. *J Am Geriatr Soc*. Aug 2017; 65(8): 1698-1704. PMID 28338229
14. Kitzman DW, Brubaker PH, Morgan TM, et al. Exercise training in older patients with heart failure and preserved ejection fraction: a randomized, controlled, single-blind trial. *Circ Heart Fail*. Nov 2010; 3(6): 659-67. PMID 20852060
15. Opotowsky AR, Rhodes J, Landzberg MJ, et al. A Randomized Trial Comparing Cardiac Rehabilitation to Standard of Care for Adults With Congenital Heart Disease. *World J Pediatr Congenit Heart Surg*. Mar 2018; 9(2): 185-193. PMID 29544423
16. Sumner J, Harrison A, Doherty P. The effectiveness of modern cardiac rehabilitation: A systematic review of recent observational studies in non-attenders versus attenders. *PLoS One*. 2017; 12(5): e0177658. PMID 28498869
17. Nilsson BB, Lunde P, Grøgaard HK, et al. Long-Term Results of High-Intensity Exercise-Based Cardiac Rehabilitation in Revascularized Patients for Symptomatic Coronary Artery Disease. *Am J Cardiol*. Jan 01 2018; 121(1): 21-26. PMID 29096886
18. Jafri SH, Imran TF, Medbury E, et al. Cardiovascular Outcomes of Patients Referred to Home Based Cardiac Rehabilitation. *Heart Lung*. 2022; 52: 1-7. PMID 34801771
19. Ornish D, Brown SE, Scherwitz LW, et al. Can lifestyle changes reverse coronary heart disease? The Lifestyle Heart Trial. *Lancet*. Jul 21 1990; 336(8708): 129-33. PMID 1973470
20. Ornish D, Scherwitz LW, Billings JH, et al. Intensive lifestyle changes for reversal of coronary heart disease. *JAMA*. Dec 16 1998; 280(23): 2001-7. PMID 9863851
21. Lakhani F, Racette SB, Park LK, et al. Prospective Study of the Impact of Outpatient Intensive Cardiac Rehabilitation on Diet Quality, Health-related Quality of Life, and Cardiovascular Health Indices. *Am J Cardiol*. Feb 01 2023; 192: 60-66. PMID 36736014

22. Racette SB, Park LK, Rashdi ST, et al. Benefits of the First Pritikin Outpatient Intensive Cardiac Rehabilitation Program. *J Cardiopulm Rehabil Prev*. Nov 01 2022; 42(6): 449-455. PMID 35861951
23. Zeng W, Stason WB, Fournier S, et al. Benefits and costs of intensive lifestyle modification programs for symptomatic coronary disease in Medicare beneficiaries. *Am Heart J*. May 2013; 165(5): 785-92. PMID 23622916
24. Casey A, Chang BH, Huddleston J, et al. A model for integrating a mind/body approach to cardiac rehabilitation: outcomes and correlators. *J Cardiopulm Rehabil Prev*. 2009; 29(4): 230-8; quiz 239-40. PMID 19451830
25. Jin Choo Y, Chang MC. Effects of telecardiac rehabilitation on coronary heart disease: A PRISMA-compliant systematic review and meta-analysis. *Medicine (Baltimore)*. Jul 15 2022; 101(28): e29459. PMID 35839029
26. Nacarato D, Sardeli AV, Mariano LO, et al. Cardiovascular telerehabilitation improves functional capacity, cardiorespiratory fitness and quality of life in older adults: A systematic review and meta-analysis. *J Telemed Telecare*. Dec 05 2022: 1357633X221137626. PMID 36469017
27. Cavalheiro AH, Silva Cardoso J, Rocha A, et al. Effectiveness of Tele-rehabilitation Programs in Heart Failure: A Systematic Review and Meta-analysis. *Health Serv Insights*. 2021; 14: 11786329211021668. PMID 34188484
28. Cruz-Cobo C, Bernal-Jiménez M^Á, Vázquez-García R, et al. Effectiveness of mHealth Interventions in the Control of Lifestyle and Cardiovascular Risk Factors in Patients After a Coronary Event: Systematic Review and Meta-analysis. *JMIR Mhealth Uhealth*. Dec 02 2022; 10(12): e39593. PMID 36459396
29. Maulana S, Trisyani Y, Mirwanti R, et al. The Potential of Cardiac Telerehabilitation as Delivery Rehabilitation Care Model in Heart Failure during COVID-19 and Transmissible Disease Outbreak: A Systematic Scoping Review of the Latest RCTs. *Medicina (Kaunas)*. Sep 21 2022; 58(10). PMID 36295482
30. Ramachandran HJ, Jiang Y, Tam WWS, et al. Effectiveness of home-based cardiac telerehabilitation as an alternative to Phase 2 cardiac rehabilitation of coronary heart disease: a systematic review and meta-analysis. *Eur J Prev Cardiol*. May 25 2022; 29(7): 1017-1043. PMID 34254118
31. Nagatomi Y, Ide T, Higuchi T, et al. Home-based cardiac rehabilitation using information and communication technology for heart failure patients with frailty. *ESC Heart Fail*. Aug 2022; 9(4): 2407-2418. PMID 35534907
32. Brouwers RWM, Kemps HMC, Herkert C, et al. A 12-week cardiac telerehabilitation programme does not prevent relapse of physical activity levels: long-term results of the FIT@Home trial. *Eur J Prev Cardiol*. May 25 2022; 29(7): e255-e257. PMID 35040993
33. Brouwers RWM, Kraal JJ, Regis M, et al. Effectiveness of Cardiac Telerehabilitation With Relapse Prevention: SmartCare-CAD Randomized Controlled Trial. *J Am Coll Cardiol*. Jun 01 2021; 77(21): 2754-2756. PMID 34045031
34. Indraratna P, Biswas U, McVeigh J, et al. A Smartphone-Based Model of Care to Support Patients With Cardiac Disease Transitioning From Hospital to the Community (TeleClinical Care): Pilot Randomized Controlled Trial. *JMIR Mhealth Uhealth*. Feb 28 2022; 10(2): e32554. PMID 35225819
35. Snoek JA, Prescott EI, van der Velde AE, et al. Effectiveness of Home-Based Mobile Guided Cardiac Rehabilitation as Alternative Strategy for Nonparticipation in Clinic-Based Cardiac Rehabilitation Among Elderly Patients in Europe: A Randomized Clinical Trial. *JAMA Cardiol*. Apr 01 2021; 6(4): 463-468. PMID 33112363
36. Piotrowicz E, Pencina MJ, Opolski G, et al. Effects of a 9-Week Hybrid Comprehensive Telerehabilitation Program on Long-term Outcomes in Patients With Heart Failure: The Telerehabilitation in Heart Failure Patients (TELEREH-HF) Randomized Clinical Trial. *JAMA Cardiol*. Mar 01 2020; 5(3): 300-308. PMID 31734701

37. Yudi MB, Clark DJ, Tsang D, et al. SMARTphone-based, early cardiac REHAbilitation in patients with acute coronary syndromes: a randomized controlled trial. *Coron Artery Dis.* Aug 01 2021; 32(5): 432-440. PMID 32868661
38. Hakala S, Kivistö H, Paajanen T, et al. Effectiveness of Distance Technology in Promoting Physical Activity in Cardiovascular Disease Rehabilitation: Cluster Randomized Controlled Trial, A Pilot Study. *JMIR Rehabil Assist Technol.* Jun 18 2021; 8(2): e20299. PMID 34142970
39. Dalli Peydró E, Sanz Sevilla N, Tuzón Segarra MT, et al. A randomized controlled clinical trial of cardiac telerehabilitation with a prolonged mobile care monitoring strategy after an acute coronary syndrome. *Clin Cardiol.* Jan 2022; 45(1): 31-41. PMID 34952989
40. Maddison R, Rawstorn JC, Stewart RAH, et al. Effects and costs of real-time cardiac telerehabilitation: randomised controlled non-inferiority trial. *Heart.* Jan 2019; 105(2): 122-129. PMID 30150328
41. Lear SA, Singer J, Banner-Lukaris D, et al. Randomized trial of a virtual cardiac rehabilitation program delivered at a distance via the Internet. *Circ Cardiovasc Qual Outcomes.* Nov 2014; 7(6): 952-9. PMID 25271050
42. Nkonde-Price C, Reynolds K, Najem M, et al. Comparison of Home-Based vs Center-Based Cardiac Rehabilitation in Hospitalization, Medication Adherence, and Risk Factor Control Among Patients With Cardiovascular Disease. *JAMA Netw Open.* Aug 01 2022; 5(8): e2228720. PMID 36006642
43. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure: executive summary: a report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines. *Circulation.* Oct 15 2013; 128(16): 1810-52. PMID 23741057
44. Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol.* May 03 2022; 79(17): e263-e421. PMID 35379503
45. Qaseem A, Fihn SD, Dallas P, et al. Management of stable ischemic heart disease: summary of a clinical practice guideline from the American College of Physicians/American College of Cardiology Foundation/American Heart Association/American Association for Thoracic Surgery/Preventive Cardiovascular Nurses Association/Society of Thoracic Surgeons. *Ann Intern Med.* Nov 20 2012; 157(10): 735-43. PMID 23165665
46. Lanza GA, Grea F. Stable Ischemic Heart Disease: The Update to the 2012 Guideline. <https://www.acc.org/latest-in-cardiology/articles/2015/01/30/12/26/stable-ischemic-heart-disease-the-update-to-the-2012-guideline>. Accessed February 7, 2023.
47. Thomas RJ, Beatty AL, Beckie TM, et al. Home-Based Cardiac Rehabilitation: A Scientific Statement From the American Association of Cardiovascular and Pulmonary Rehabilitation, the American Heart Association, and the American College of Cardiology. *J Am Coll Cardiol.* Jul 09 2019; 74(1): 133-153. PMID 31097258
48. Centers for Medicare % Medicaid Services (CMS). National Coverage Determination (NCD) for Intensive Cardiac Rehabilitation Programs (20.31). 2010; <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=339&ncdver=1&CoverageSelection=National&Keyword=intensive+cardiac&KeywordLookUp=Title&KeywordSearchType=And&clickon=search&bc=gAAAABAAAA&>. Accessed February 7, 2023.
49. Centers for Medicare & Medicaid Services (CMS). CMS Manual System: Pub 100-03 Medicare National Coverage Determinations. Cardiac Rehabilitation Programs for Chronic Heart Failure. 2014; <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r171ncd.pdf>. Accessed February 6, 2023.
50. Centers for Medicare and Medicaid Services. Trump Administration Drives Telehealth Services in Medicaid and Medicare. October 14, 2020. <https://www.cms.gov/newsroom/press-releases/trump-administration-drives-telehealth-services-medicare-and-medicare>. Accessed February 17, 2023.

51. Centers for Medicare and Medicaid Services. List of Telehealth Services. Updated February 13, 2023. <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>. Accessed February 16, 2023.
52. Centers for Medicare and Medicaid Services. Billing and Coding: Outpatient Cardiac Rehabilitation. Revision effective date October 1, 2022. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=54070>. Accessed February 15, 2023.
53. Centers for Medicare & Medicaid Services (CMS). Decision Memo for Intensive Cardiac Rehabilitation (ICR) Program - Dr. Ornish's Program for Reversing Heart Disease (CAG-00419N). 2010; <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/R125NCD.pdf>. Accessed February 7, 2023.
54. Centers for Medicare & Medicaid Services (CMS). Decision Memo for Intensive Cardiac Rehabilitation (ICR) Program - Pritikin Program (CAG-00418N). 2010; <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=239&NCDId=339&ncdver=1&CoverageSelection=National&Keyword=intensive+cardiac&KeywordLookUp=Title&KeywordSearchType=And&clickon=search&IsPopup=y&bc=AAAAAAACAAAAA%3d%3d&>. Accessed February 5, 2023.
55. Centers for Medicare and Medicaid Services. Decision memo for intensive cardiac rehabilitation (ICR) program - Benson-Henry Institute Cardiac Wellness Program (CAG-00434N). May 6, 2014. <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/R175NCD.pdf>. Accessed February 3, 2023.

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
- Provider 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 product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report
	93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report
	93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report
	93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only
	93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
	93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
HCPCS	G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
	G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session
	S9472	Cardiac rehabilitation program, nonphysician provider, per diem

Policy History

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

Effective Date	Action
09/13/1989	New Policy Adoption
10/09/2003	Administrative Review
06/26/2009	Policy Review and update. Added content from the Lifestyle Treatment for Coronary Heart Disease Medical Policy to Cardiac Rehabilitation Services.
01/15/2010	Coding Update
06/09/2010	Administrative Review
09/13/2010	Coding Update
09/27/2013	Policy revision with position change. Policy placed on No Further Routine Literature Review and Update Status.
12/15/2014	Policy title change from Cardiac Rehabilitation Services Policy revision with position change effective 2/15/2015
02/15/2015	Policy revision with position change
06/01/2016	Policy revision without position change
08/01/2017	Policy revision without position change
06/01/2018	Policy revision without position change
05/01/2019	Policy revision without position change
06/01/2023	Policy reactivated. Previously archived from 05/01/2020 to 05/31/2023.
07/01/2023	Administrative update.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

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 and Feedback (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 at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

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.

Appendix A

POLICY STATEMENT	
BEFORE <i>Red font: Verbiage to be removed</i>	AFTER
<p>Cardiac Rehabilitation in the Outpatient Setting 8.03.08</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Outpatient cardiac rehabilitation programs may be considered medically necessary for individuals with a history of the following conditions and procedures: <ul style="list-style-type: none"> A. Acute myocardial infarction (heart attack) within the preceding 12 months B. Compensated heart failure C. Coronary artery bypass graft surgery D. Current stable angina pectoris E. Heart or heart-lung transplantation F. Heart valve surgery G. Percutaneous transluminal coronary angioplasty or coronary stenting II. Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational. <i>III. Intensive cardiac rehabilitation with the Ornish Program for Reversing Heart Disease, Pritikin Program, or Benson-Henry Institute Program is considered investigational.</i> <i>IV. Virtual cardiac rehabilitation is considered investigational.</i> 	<p>Cardiac Rehabilitation in the Outpatient Setting 8.03.08</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Outpatient cardiac rehabilitation programs may be considered medically necessary for individuals with a history of the following conditions and procedures: <ul style="list-style-type: none"> A. Acute myocardial infarction (heart attack) within the preceding 12 months B. Compensated heart failure C. Coronary artery bypass graft surgery D. Current stable angina pectoris E. Heart or heart-lung transplantation F. Heart valve surgery G. Percutaneous transluminal coronary angioplasty or coronary stenting II. Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational.