

Subject: Outpatient Cardiac Rehabilitation
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Description

This document addresses cardiac rehabilitation (CR) services that are provided on an outpatient basis during the immediate post-discharge period and are considered Phase II cardiac rehabilitation programs (see Discussion/General Information section for further information related to the phases of Cardiac Rehabilitation Programs).

Note: For a high-level overview of this document, please see "[Summary for Members and Families](#)" below.

Clinical Indications

Medically Necessary:

Phase II cardiac rehabilitation is considered **medically necessary** when individually prescribed by a physician and the following criteria are met:

- I. Cardiac rehabilitation is initiated within 12 months of ANY of the following:
 - A. Acute myocardial infarction (MI); **or**
 - B. Coronary artery bypass grafting (CABG); **or**
 - C. Heart transplantation; **or**
 - D. Percutaneous coronary intervention (that is, atherectomy, angioplasty, stenting); **or**
 - E. Survivor of sudden cardiac death; **or**
 - F. Survivor of sustained ventricular tachycardia or fibrillation; **or**
 - G. Valve replacement or repair; **or**
 - H. New York Heart Association (NYHA) Class II to IV congestive heart failure (CHF) that is interfering with the ability to perform age-related activities of daily living; **or**
 - I. Coronary artery disease (CAD) with chronic stable angina pectoris that has failed to respond to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living;
and
- II. The individual does not have an absolute contraindication to cardiac rehabilitation (examples include: unstable angina, overt cardiac failure, dangerous arrhythmias, dissecting aneurysm, myocarditis, acute pericarditis, severe obstruction of the left ventricular outflow tract, severe hypertension, exertional hypotension or syncope, uncontrolled diabetes mellitus, severe orthopedic limitations, and recent systemic or pulmonary embolus);
and
- III. A formal exercise stress test has been completed following the qualifying cardiac event and *prior to* initiation of the rehabilitation program or, for individuals at low risk based on current symptoms, clinical features and exercise history, during the first rehabilitation session.

Not Medically Necessary:

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Outpatient Cardiac Rehabilitation

The following are considered **not medically necessary**:

1. When the criteria above are not met;
2. Phase III cardiac rehabilitation programs, or self-directed, self-controlled or monitored exercise programs;
3. Phase IV cardiac rehabilitation programs or maintenance therapy that may be safely carried out without medical supervision;
4. Cardiac rehabilitation when used in a preventive or prophylactic way, such as for angina, hypertension, or diabetes.

Place of Service and Frequency/Duration

Place of Service: Ambulatory, Outpatient Facility

Frequency/Duration:

The frequency and duration of treatment is determined by the following:

- The cardiac risk level; **and**
- The degree of exercise limitation as demonstrated by a treadmill electrocardiogram (ECG) stress test.

High Risk:

Individuals in the *high-risk* category may have ANY of the following:

- Exercise test limited to less than or equal to 5 metabolic equivalents (METs). (MET = a multiple of the resting energy expenditure, and is used as a means of estimating cardiac functional capacity. [1 MET = 3.5ml O₂/kg body wt/min]); **or**
- Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more ST segment depression by ECG; **or**
- Severely depressed left ventricular function (ejection fraction less than 30%); **or**
- Resting complex ventricular arrhythmias; **or**
- Ventricular arrhythmias appearing or increasing with exercise or occurring in the recovery phase of stress testing; **or**
- Decrease in systolic blood pressure of greater than 15 mm Hg with exercise; **or**
- Recent myocardial infarction (less than 6 months) which was complicated by serious ventricular arrhythmias, cardiogenic shock, or congestive heart failure (CHF); **or**
- Survivor of sudden cardiac arrest.

Cardiac rehabilitation programs for *high-risk* individuals may include the following:

- 36 sessions (e.g., 3x/wk x 12 wks) of supervised exercise with continuous telemetry monitoring; **and**
- Educational program for risk factor/stress reduction; **and**
- Creation of an individual outpatient exercise program that can be self-monitored and maintained.

Note: If no clinically significant arrhythmia is documented during the first three weeks of the program, the remaining portion may be completed without telemetry monitoring.

Intermediate Risk:

Individuals in the *intermediate risk* category may have ANY of the following:

- Exercise test limited to 6-9 METs; **or**
- Ischemic ECG response to exercise of less than 2 mm of ST segment depression; **or**

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- Uncomplicated myocardial infarction, coronary artery bypass surgery, or angioplasty and has a post-cardiac event maximal functional capacity of 8 METS or less on ECG exercise test.

Cardiac rehabilitation programs for *intermediate risk* individuals may include the following:

- Provide exercise training for 24 sessions or less of exercise training without continuous ECG monitoring (Note: Some individuals may require less than 3x/wk x 8 wks); **and**
- Be geared towards defining an ongoing exercise program that is self-administered.

Low Risk:

Individuals in the *low risk* category may have ANY of the following:

- Exercise test limited to greater than 9 METS; **or**
- Asymptomatic at rest.

Cardiac rehabilitation programs for *low risk* individuals may include the following:

- 6 one-hour sessions involving risk factor reduction education; **and**
- Supervised exercise to show safety and define a home program (for example 3x/week x 2wks or 2x/week x 3wks).

Additional cardiac rehabilitation services are considered **medically necessary** based on the above listed criteria in the event the individual has ANY of the following:

- Another documented myocardial infarction or extension of initial infarction; **or**
- Another cardiovascular surgery or angioplasty; **or**
- New evidence of ischemia on an exercise test, including thallium scan; **or**
- New clinically significant coronary lesions documented by cardiac catheterization.

Summary for Members and Families

This document describes clinical studies and expert recommendations, and explains whether certain medical services are appropriate. The following summary does not replace the medical necessity criteria or other information in this document. The summary may not contain all of the relevant criteria or information. This summary is not medical advice. Please check with your healthcare provider for any advice about your health.

Key Information

Cardiac rehabilitation (CR) is a type of treatment program that helps people recover and stay healthy after serious heart problems or treatments. It usually starts soon after a person leaves the hospital. The program includes supervised exercise, help with diet and stress, and support for quitting smoking or managing conditions like diabetes. It also teaches people how to safely get active again and avoid future heart issues. There are four stages of CR. The first happens in the hospital right after a heart event. The second stage is outpatient care that lasts up to 12 weeks and includes supervised exercise and education. The third and fourth stages focus on long-term health and are usually done at home or in the community. Exercise training is one of the most important parts of CR. It can help people move better, feel stronger, and improve heart function. The benefits vary depending on the person and how much they stick with the program, but research shows it can help reduce hospital visits and may help people live longer.

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What the Studies Show

Studies show that cardiac CR improves health in several ways. People who take part in CR after heart surgery or heart attacks often have fewer hospital visits and may live longer. For example, one study found that people who joined CR after a heart procedure were 45–47% less likely to die compared to those who didn't. Another study found that people who completed CR had less repeat heart blood vessel blockage than those who did not. Exercise training in these programs improves how much oxygen the body can use, which helps people exercise longer with less strain on the heart.

However, some studies found only small or unclear improvements in survival or hospital visits, especially for people with heart failure or those using heart pumps (called ventricular assist devices). In these cases, CR programs helped with physical fitness but didn't clearly improve quality of life or long-term survival.

Is this clinically appropriate?

This treatment is considered appropriate because many studies show it can improve recovery and lower the chance of future heart problems. It helps people build strength, speeds up return to daily activities, and helps manage heart risks. Some benefits, such as fewer hospital stays and better exercise ability, have been clearly shown in studies. Other possible benefits, like improved survival or quality of life, may depend on the person's health and how closely they follow the program.

[\(Return to Description\)](#)

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. 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.

When services may be Medically Necessary when criteria are met:

CPT

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, non-physician provider, per diem

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ICD-10 Diagnosis

All diagnoses

When services are Not Medically Necessary:

For the procedure codes listed above when criteria are not met, or when the code describes a procedure or situation designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Summary

CR is a comprehensive, multidisciplinary program designed to optimize recovery and long-term health outcomes in individuals with cardiac conditions. The American Heart Association (AHA) and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) describe CR as a coordinated series of interventions that aim to enhance physical, psychological, and social functioning while slowing or reversing atherosclerotic disease progression. These programs typically include baseline assessments, nutritional and psychosocial counseling, risk factor modification (e.g., smoking cessation, weight management, and diabetes control), exercise training, and appropriate pharmacologic therapy. Exercise training is a cornerstone of CR, improving cardiovascular endurance, metabolic efficiency, and muscular strength, typically yielding a 10–50% increase in exercise capacity measured in metabolic equivalents.

Evidence from numerous clinical trials and systematic reviews underscore the benefits of exercise-based CR, although outcomes vary across populations. Studies have shown reductions in mortality and rehospitalization rates among patients participating in CR following cardiac events or interventions such as percutaneous coronary intervention or heart failure management. For example, participation in CR was associated with up to a 47% reduction in mortality post-intervention. However, large randomized controlled trials have shown modest or nonsignificant improvements in some endpoints, emphasizing that while CR offers clear functional and psychosocial benefits, its effects on survival and hospitalization may depend on patient characteristics and adherence. Cochrane reviews support CR's benefits in improving short-term hospital readmission rates and exercise capacity, though evidence quality varies and long-term effects on quality of life and mortality require further research.

CR is typically divided into four progressive phases: inpatient recovery (Phase I), outpatient supervised rehabilitation (Phase II), long-term home or community-based programs (Phase III), and indefinite maintenance (Phase IV). Each phase focuses on gradually restoring functional capacity, promoting safe exercise practices, and reinforcing lifestyle modifications to reduce recurrent cardiac events. Ultimately, CR represents a lifelong commitment to health behavior change, emphasizing continuous risk factor management and physical activity to maintain cardiovascular health and quality of life.

Discussion

Over the past 20 years, risk factor modification programs for individuals with cardiac conditions have evolved into a comprehensive management strategy. The American Heart Association (AHA) and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) define CR programs as, “Coordinated, multifaceted

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interventions designed to optimize a cardiac patient's physical, psychological, and social functioning, in addition to stabilizing, slowing, or even reversing the progression of the underlying atherosclerotic processes, thereby reducing morbidity and mortality" (Leon, 2005). Interventions include, "Baseline patient assessments, nutritional counseling, aggressive risk factor management, (i.e., lipids, hypertension, weight, diabetes, and smoking), psychosocial and vocational counseling, and physical activity counseling and exercise training, in addition to the appropriate use of cardioprotective drugs" (Leon, 2005).

According to a 2007 scientific statement from the AHA and the AACVPR (Balady, 2007), which addresses the core components of CR /secondary prevention programs, the following is noted:

Symptom-limited exercise testing is strongly recommended prior to participation in an exercise-based CR program. The evaluation may be repeated as changes in clinical condition warrant. Test parameters should include assessment of heart rate and rhythm, signs, symptoms, ST-segment changes, hemodynamics, perceived exertion, and exercise capacity. On the basis of patient assessment and the exercise test if performed, it is recommended to risk stratify the patient to determine the level of supervision and monitoring required during exercise training.

A multicenter, randomized controlled trial enrolled 2331 medically stable individuals with heart failure (HF) and reduced ejection fraction who were randomized to receive either usual care plus aerobic exercise training (36 supervised sessions followed by home-based training [traditional CR model]) or usual care alone. The study's primary endpoints included all-cause mortality or hospitalization and prespecified secondary endpoints of all-cause mortality, cardiovascular mortality or hospitalization, and cardiovascular mortality or HF-related hospitalization. In this study sample, 28% of participants were women, and 37% had New York Heart Association (NYHA) class III or IV symptoms. A total of 759 (65%) participants in the exercise-based CR group died or were hospitalized, compared with 796 (68%) in the usual care group (hazard ratio [HR], 0.93; 95% confidence interval [CI], 0.84-1.02; $p=0.13$). There were nonsignificant reductions in the exercise-based CR group for mortality (189 [16%] in the exercise group vs. 198 [17%] in the usual care group; HR, 0.96; 95% CI, 0.79-1.17; $p=0.70$), cardiovascular mortality or cardiovascular hospitalization (632 [55%] in the exercise group vs. 677 [58%] in the usual care group; HR, 0.92; 95% CI, 0.83-1.03; $p=0.14$), and cardiovascular mortality or HF hospitalization (344 [30%] in the exercise group vs. 393 [34%] in the usual care group; HR, 0.87; 95% CI, 0.75-1.00; $p=0.06$). A prespecified supplementary analyses adjusted for highly prognostic baseline characteristics, the resulting HR for all-cause mortality or hospitalization was 0.89 (95% CI, 0.81-0.99; $p=0.03$), for cardiovascular mortality or cardiovascular hospitalization the HR was 0.91 (95% CI, 0.82-1.01; $p=0.09$), and for cardiovascular mortality or HF hospitalization the HR was 0.85 (95% CI, 0.74-0.99; $p=0.03$). Authors concluded that in the protocol-specified primary analysis, exercise-based CR resulted in nonsignificant reductions in the primary endpoint of all-cause mortality or hospitalization and after adjustment for highly prognostic predictors of the primary endpoint, was associated with modest but significant reductions for both all-cause mortality or hospitalization and cardiovascular mortality or HF hospitalization (O'Connor, 2009).

Goel and colleagues (2011) conducted a retrospective review which looked at 2395 individuals over a 14 year period that underwent percutaneous coronary intervention. Of the 2395 individuals who underwent percutaneous coronary intervention, 964 of them enrolled in CR following the intervention. Mean follow-up was 6.3 years. During that time, there were 503 deaths, of which 199 were due to cardiovascular disease. Revascularization was required in 755 individuals and 394 individuals had subsequent myocardial infarction. The authors reported a 45%

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to 47% decrease in mortality of those individuals who participated in CR after percutaneous intervention compared with those individuals who did not participate in CR.

A study by Lee and colleagues (2014) reported on 576 individuals who were post drug-eluting stent implantation for coronary artery disease who were then referred for CR. A total of 288 participants successfully completed the CR program. The primary endpoint was in-stent luminal loss at a 9-month angiographic follow-up. Those who completed the CR program had a 35% less in-stent luminal loss when compared to those who didn't complete the CR. Those in the CR group also showed an improvement in overall risk factors including current smoking, biochemical profiles, depression, obesity and exercise capacity.

A Cochrane review investigating the effect of exercise-based CR on individuals with HF included 44 studies which were comprised of 5783 participants (Long, 2024). All studies included a 'no formal exercise' training intervention comparator, although a wide range of comparators were seen across studies (such as, education, psychological intervention or usual medical care alone). The review concluded that there were probable benefits of exercise-based CR, including a reduction in the risk of overall hospital admissions in the short term, as well as a potential reduction in HF-related admissions. The effect of exercise-based rehabilitation on health-related quality of life (QoL) for individuals with HF remains uncertain due to 'very low-quality evidence' as rated by the GRADE method. Authors conclude that exercise-based rehabilitation may make little or no difference in all-cause mortality in the short-term (less than 12 months; risk ratio [RR], 0.89, 95% CI, 0.66-1.2) but may impact all-cause mortality in the longer-term (RR, 0.88, 95% CI, 0.75 to 1.02; high-quality evidence) and that further evidence is needed to better elucidate the effects of exercise-based CR on individuals with HF in both the long and short-term.

Another Cochrane review investigating the effect of exercise-based CR on individuals with implantable ventricular assist devices (VADs) included two studies which combined were comprised of just 40 participants (Yamamoto, 2018). In the studies, exercise-based CR consisted of aerobic training, resistance training, or both three times per week for 6 to 8 weeks. Exercise intensity was measured as 50% of oxygen consumption (VO₂) reserve, or 60% to 80% of heart rate reserve. A large difference in quality of life was observed between groups at the end of follow-up (standardized mean difference 0.88, 95% CI, 0.12-1.88). The effectiveness of exercise-based CR was not realized due to the age of participants (relatively young), high risk of performance bias and small sample size, which resulted in very low-quality evidence (using GRADE method). Ideally, well-designed clinical trials would also measure the effect of exercise-based CR on mortality, rehospitalization or heart transplantation, but these outcomes were not reported in either study. Cochrane authors concluded that, "evidence is currently inadequate to assess the safety and efficacy of exercise-based CR for people with implantable VADs compared with usual care".

A systematic review was conducted to summarize and characterize the current state of evidence related to the effects of exercise-based CR on the health-status of individuals diagnosed with stable angina (Long, 2019a). A total of 7 studies, which included 581 study participants in total met the criteria for analysis. The effect of exercise-based CR on all-cause mortality (RR, 1.01, 95% CI, 0.18-5.67), acute myocardial infarction (RR, 0.33, 95% CI, 0.07-1.63) and cardiovascular-related hospital admissions (RR, 0.14, 95% CI, 0.02 to 1.1) relative to control were not determined to be statistically significant. Exercise-based CR was determined to have a moderately positive impact on exercise capacity (standard mean difference 0.45, 95% CI, 0.20 to 0.70), though this was based on low-quality evidence (GRADE method). There was limited and very low-quality evidence on the effect of exercise-based CR on health related QoL measures. Authors concluded that exercise-based CR may improve short-term exercise

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capacity in individuals with stable angina but well-designed, randomized controlled clinical trials are needed to definitely determine the impact on outcomes including mortality, morbidity and QoL.

Exercise training is the principal component of CR, since it results in increased peak exercise capacity, which is usually expressed in METs (metabolic equivalents). This is the total oxygen requirement of the body, with 1 MET equal to 3.5 mL of oxygen consumed per kilogram of body weight per minute. Exercise training improves MET capacity by 10% to 50%, resulting in improved oxygen delivery and extraction by exercising skeletal muscles, thereby decreasing the cardiovascular requirements of exercise and increasing the amount of work that can be done before ischemia occurs. Although dynamic aerobic exercise is necessary to improve cardiovascular endurance, resistance exercise is becoming a useful adjunctive component of the exercise regimen as well. Resistance training should be included in the exercise program to minimize loss of muscle mass.

CR programs are generally divided into four phases: phase I, inpatient or recovery phase; phase II, outpatient or intermediate phase; phase III, community-based or home long-term phase; phase IV, maintenance (Thompson, 2007).

Phases of Cardiac Rehabilitation

Phase	Type of Program	Duration	Description
I	Inpatient	Days	• Inpatient or recovery phase. • Begins as soon as the individual is medically stable following a cardiac event (e.g., myocardial infarction, bypass surgery) and continues while the individual remains in the hospital. • Consists of 1) early assumption of upright posture; 2) progressive exercise and self-care based on individual tolerance; 3) education; and 4) risk factor identification and initial attempts at modification.
II	Outpatient, immediately after hospitalization	2 – 12 weeks	• Outpatient or intermediate phase. • Initiated within a few weeks after hospital discharge. • Consists of 1) supervised exercise training to maximize functional capacity, teach safe exercise practices, and identify individuals at risk for complications; 2) risk factor modification; and 3) education about medications, signs and symptoms of heart disease and its progression, dietary modifications and activity guidelines.
III	Late recovery period	Minimum of 6 months beyond phase II	• Community-based or home long-term phase. • Consists of a lifelong program committed to encourage exercise and a healthful lifestyle to minimize recurrence of cardiac problems. • Such programs are usually undertaken at home or in a fitness center.

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IV	Maintenance	Indefinite	- Consists of efforts to modify risk factors and a routine program of physical activity that individuals should continue indefinitely. - For some programs, phase IV rehabilitation is combined with phase III. All cardiac rehabilitation programs, however, recommend some form of indefinite maintenance for their participants.
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Definitions

Duke Treadmill Score (DTS): A quantitative means of expressing cardiac risk derived entirely from the exercise ECG. It incorporates ST segment deviation (depression or elevation), treadmill time (METS) and exercise-induced angina. The angina index has a value of 0 if there is no angina during exercise, 1 if the individual had non-limiting angina and 2 if angina was the reason the individual stopped exercising. The typical observed range for the DTS is highest risk of -25 to lowest risk of +15.

New York Heart Association (NYHA) Classes of Heart Failure:

Class Patient Symptoms

I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

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Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Medical Policy take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically. Clinical UM guidelines are used when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether or not to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the back of the member's card.

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Outpatient Cardiac Rehabilitation

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Websites for Additional Information

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Cardiac Rehabilitation
Phase II Cardiac Rehabilitation

History

Status	Date	Action
Reviewed	11/06/2025	Medical Policy & Technology Assessment Committee (MPTAC) review. Revised Description, Discussion, References, and Websites sections. Added new 'Members and Families' section.
Reviewed	11/14/2024	MPTAC review. Updated References and Websites section.
Revised	11/09/2023	MPTAC review. Added "When the criteria above are not met" to Not Medically Necessary statement. Updated References and Websites section. Corrected date error in History section.
Reviewed	11/10/2022	MPTAC review. Updated References and Websites section.
Reviewed	11/11/2021	MPTAC review. Updated Discussion/General Information, References, and Websites sections.
Reviewed	11/05/2020	MPTAC review. Updated References and Websites sections. Reformatted Coding section.
Revised	11/07/2019	MPTAC review. Clarified Clinical Indications section. Updated Description, Place of Service and Frequency/Duration, Discussion/General Information, Definitions, References and Websites sections.
Revised	01/24/2019	MPTAC review. Revised Medically Necessary criteria to include Class II CHF individuals and remove need to have failed pharmacotherapy. Updated Websites for Additional Information section.
Reviewed	09/13/2018	MPTAC review. Updated References and Websites for Additional Information sections.
Reviewed	11/02/2017	MPTAC review. The document header wording updated from "Current Effective Date" to "Publish Date." Updated References section.
Reviewed	11/03/2016	MPTAC review. Updated formatting in Clinical Indications section. Updated Discussion/General Information and Reference sections.
Revised	11/05/2015	MPTAC review. Title changed to Outpatient Cardiac Rehabilitation. Clarification to Clinical Indications. Updated References. Removed ICD-9 codes from Coding section.
Reviewed	11/13/2014	MPTAC review. Updated Discussion/General Information and References.
Revised	11/14/2013	MPTAC review. Clarification to the Medically Necessary statement. Updated References.
Reviewed	11/08/2012	MPTAC review. Updated Discussion/General Information and References. Updated Coding section with 01/01/2013 CPT descriptor changes; removed revenue code 0943.
Reviewed	11/17/2011	MPTAC review. Updated Coding, Description, Discussion/General Information, References and Web Sites for Additional Information.
Reviewed	11/18/2010	MPTAC review. Updated Discussion/General Information and References.
Reviewed	11/19/2009	MPTAC review. No change to criteria. References were updated. Updated Coding section with 01/01/2010 HCPCS changes.

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Outpatient Cardiac Rehabilitation

Revised	11/20/2008	MPTAC review. A criterion was revised to clarify the timing and need for pre-rehab program stress testing or for testing during the first CR session for low risk patients. The requirement under 'Frequency/Duration' of services for pre-rehab testing within three weeks of initiating the CR Program was removed. Also, the time for initiation of a Cardiac Rehab Program following the qualifying cardiac event was changed from six months to within twelve months. Annual review was also performed. Discussion section and References were also updated.
Reviewed	05/15/2008	MPTAC review. No change to criteria. References were updated.
Reviewed	05/17/2007	MPTAC review. No change to guideline criteria. References were updated.
Reviewed	06/08/2006	MPTAC review. No change to guideline criteria. The Discussion section and References updated to include the 2005 AHA/AACVPR guideline and the 2005 AHRQ Technology Assessment.
	11/17/2005	Added reference for Centers for Medicare and Medicaid Services (CMS) – National Coverage Determination (NCD).
Revised	09/22/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem Midwest	04/08/2005	RA-011	Cardiac Rehabilitation (Midwest Medical Review & Utilization Management Criteria)
Anthem West Region	10/01/2004	UMR.001	Cardiac Rehabilitation, Outpatient
Anthem Southeast	N/A	Memo 1111	Cardiac Rehabilitation
Anthem CT			Cardiac Rehabilitation Benefit Detail
Anthem ME			Cardiac Rehabilitation Benefit Detail
WellPoint Health Networks, Inc.	12/02/2004	2.04.01	Cardiac Rehabilitation
	12/02/2004	Clinical Guideline	Cardiac Rehabilitation

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