Clinical Policy: Outpatient Cardiac Rehabilitation

Reference Number: CP.MP.176
Date of Last Revision: 02/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The American Heart Association and American Association of Cardiovascular and Pulmonary Rehabilitation define cardiac rehabilitation for coronary heart disease as "coordinated, multifaceted 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."[12] This policy describes the medical necessity guidelines for conventional and intensive outpatient cardiac rehabilitation programs.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that initiation of medically supervised **phase II** outpatient cardiac rehabilitation is **medically necessary** when meeting all the following:

A. Indications, one of the following:
   1. Stable angina pectoris within last 12 months[6];
   2. Percutaneous coronary intervention within last 12 months[6];
   3. Myocardial infarction within last 12 months[6];
   4. Coronary artery bypass graft (CABG) within last 12 months[6];
   5. Coronary artery disease (CAD) within last six months;
   6. New York Heart Association (NYHA), Class II, III, or IV and on a stable medication regimen;[3,6]
   7. Heart or heart-lung transplantation within last six months, or within six months of newly gained ability to participate in rehabilitation regimen[6];
   8. Cardiac valve surgery within last six months[6];
   9. Peripheral artery disease within last 12 months;
   10. History of sustained ventricular tachycardia or fibrillation, or survivors of sudden cardiac death;
   11. Surgical septal myectomy via thoracotomy within last 12 months.

B. Therapy program, all of the following:
   1. Physician-prescribed exercise during each session;
   2. Electrocardiogram monitoring;

C. Request is for ≤ 36 visits over a period of ≤ nine months[16];

D. None of the following contraindications:
   1. Unstable angina;
   2. Orthostatic BP drop of >20 mmHg with symptoms;
   3. Symptomatic severe aortic stenosis (aortic valve area <1.0 cm^2);
   4. Uncontrolled atrial or ventricular arrhythmias with hemodynamic compromise;
   5. Decompensated heart failure;
   6. Active pericarditis or myocarditis;
   7. Active pulmonary embolism, pulmonary infarction or deep vein thrombosis;
   8. Acute thrombophlebitis[41];

9. Acute systemic illness or fever;
10. Unstable or life-threatening noncardiovascular conditions such as active infection, uncontrolled diabetes, end-stage cancer, or unstable psychological issues;
11. Severe orthopedic conditions that would prohibit exercise;
12. Active endocarditis
13. Acute aortic dissection.

II. It is the policy of health plans affiliated with Centene Corporation that continuation of medically supervised **phase II** outpatient cardiac rehabilitation is **medically necessary** when meeting all of the following:

A. Progressive therapy program, all the following:
   1. Physician-prescribed exercise during each session;
   2. Electrocardiogram monitoring;

B. Partial progress made in meeting treatment goals, all of the following:
   1. Reduction in intensity and frequency of symptoms or findings;
   2. Improvement in function and reduction in limitations;
   3. Documented patient adherence to home exercise program;

C. Request is for ≤ 36 visits, including those initially approved. Requests for additional visits will be reviewed by a medical director.

III. It is the policy of health plans affiliated with Centene Corporation that **phase III** or **IV** cardiac rehab programs are **not medically necessary,** as they are primarily educational or training programs.

IV. It is the policy of health plans affiliated with Centene Corporation that there is not sufficient evidence that intensive cardiac rehabilitation programs achieve superior outcomes when compared to conventional cardiac rehabilitation programs.

Background

Cardiac rehabilitation (CR) programs should include comprehensive long-term services involving medical evaluation/baseline patient assessment, exercise training and physical activity counseling, coronary risk factor reduction/secondary prevention, including nutritional counseling and weight management, psychosocial support, and education regarding diet, medications, and exercise tolerance.[3] An updated Cochran systematic review and meta-analyses demonstrate important benefits of cardiac rehabilitation (CR) for coronary heart disease (CHD) and heart failure (HF), such as reduction in mortality, heart attacks and hospital readmissions, as well as improvements in exercise duration and health related quality of life.[2,34] Although the reporting of methods has improved in recent trials, well designed, adequately reported random controlled trials of CR in people with CHD more representative of usual clinical practice are still needed.[2]

Cardiac rehabilitation is recommended for patients with stable New York Heart Association (NYHA) class II to III HF with benefits seen as early as three weeks following training.[25] The Centers for Medicare and Medicaid Services (CMS) further describes stable chronic heart failure as “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 six weeks.

Stable patients are defined as patients who have not had recent (≤ six weeks) or planned (≤ six months) major cardiovascular hospitalizations or procedures".[6]

Phase II outpatient CR programs provide electrocardiogram-monitored, supervised exercise programs tailored to the needs of the patient, usually two to three times weekly for eight to 12 weeks or longer. Goals of CR include reducing coronary risk factors, identifying and managing psychosocial problems that affect patients with cardiac disease, and teaching safe and effective exercise prescribed by a physician or other qualified practitioner.[3]

Intensive cardiac rehabilitation
According to the Centers for Medicare and Medicaid Services, "intensive cardiac rehabilitation (ICR) refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner" than conventional programs. In order to qualify, ICR programs must demonstrate in peer-reviewed literature that they achieved at least one of the following outcomes: (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.[5] Several intensive cardiac rehabilitation programs have been established including, but not limited to The Pritikin Program, the Ornish Program for Reversing Heart Disease, and the Benson-Henry Institute Cardiac Wellness Program. The Pritikin, Ornish, and Benson-Henry Institute programs are licensed, commercial products with varying program components, which include exercise, nutrition counseling, stress management and small group support that often includes one to two-year follow up.[5,11,35,36,37]

A small randomized controlled trial of 93 patients with coronary artery disease compared patients assigned to ICR (the Ornish program) with those assigned to conventional CR. The report demonstrated significant improvements in dietary habits, weight and body mass index (BMI) as compared with the conventional group. However, there was no significant reduction in the carotid intima-media thickness of the carotid artery in the Ornish group or the conventional CR group.[1]

An additional study of 314 patients with high-risk cardiovascular disease (CVD) were assessed to evaluate ICR and standard CR programs with 101 patients enrolled in the ICR program and 213 patients enrolled in the standard CR program. Findings demonstrated significant improvements in cardiometabolic outcomes for those in the ICR program and improvement in dietary habits, psychosocial well-being, and reduced incidence of long-term major adverse cardiac events. Despite encouraging results, further research is needed to evaluate various components associated with ICR safety, effectiveness, feasibility and long-term benefits in CVD patients. The authors caution that further generalizations based on their findings "requires caution associated with sample size, one year period of follow-up, and lack of no control group, which may be considered as a limitation".[35]

In a study conducted by Medicare from 2000 to 2008 examining outcomes of 580 patients enrolled in two intense lifestyle modification programs (The Dr. Dean Ornish Program for Reversing Heart Disease [Ornish] and the Cardiac Wellness Program of the Benson-Henry Mind/Body Medical Institute [MBMI]), findings demonstrated statistically significant reductions

in both programs in body weight, systolic and diastolic blood pressure, and LDL cholesterol. The changes were sustained in participants who remained in each program for two years. Expressed limitations of the study include the observational pre-post design and the absence of a control group. Additionally, the authors note that additional research is needed to determine the relative effectiveness and cost-effectiveness of traditional cardiac rehabilitation versus no cardiac rehabilitation relative to patient outcomes.[37]

A retrospective analysis was conducted to determine the benefits of the first Pritikin outpatient ICR program. The retrospective analysis followed patients referred to ICR or conventional cardiac rehabilitation between 2013 through 2019. The ICR program consisted of education sessions in addition to monitored exercise sessions that comprise the conventional CR. A total of 1,963 patients enrolled in the program with 1,141 patients completing the program. The Pritikin outpatient ICR program demonstrated improvements in several cardiovascular health indices. The authors note that critical next steps are to assess long-term health outcomes following ICR, including cardiac events and mortality.[11]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Codes that support coverage criteria

CPT® Codes	Description
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Codes that do not support coverage criteria

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

Codes that do not support coverage criteria

HCPCS Codes	Description
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

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed. Reviewed by interventional cardiologist.	05/19	05/19
References reviewed and updated. Removed uncontrolled diabetes from the list of contraindications and added I.D., "If diabetic, documentation supports that it is adequately controlled."	04/20	05/20
Removed the word "investigational" from the policy statement in IV regarding intensive cardiac rehab programs, and reordered the sentence. Codes and references reviewed and updated. Replaced all instances of "member" with "member/enrollee."	04/21	05/21
Annual review completed. Added "Surgical septal myectomy via thoracotomy within last 12 months" to I.A. Minor rewording with no clinical significance. Background updated with no impact to criteria. References reviewed and updated. Changed "Review Date" in the header to "Date of Last Revision" and "Date" in the revision log header to "Revision Date". Specialist reviewed.	05/22	05/22
Annual review completed. Minor rewording with no clinical significance. Background updated with no impact to clinical criteria. ICD-10 diagnosis code table removed. References reviewed and updated.	05/23	05/23
Annual review. Edited I.A.7. to indicate Classes as NYHA, changed I.E.7. from uncompensated to decompensated, added I.E.13 "Unstable or life-threatening...psychological issues". References reviewed and updated. Reviewed by external specialist.	04/24	04/24
Annual review. Removed I.A.2. History of unstable angina pectoria within last 12 months. Removed I.D. If diabetic, documentation supports that it is adequately controlled. Removed I.E.2. Uncontrolled hypertension- resting systolic blood pressure (SBP) >180 mmHg and/or resting diastolic (DBP) >110 mmHg. Under I.D.3. replaced "Significant" with "Symptomatic severe". Added "with hemodynamic compromise" to I.D.4. Removed previous I.E.6. and I.E.8. Under new I.E.8. replaced "Recent" with "Active pulmonary" and added "pulmonary infarction or deep vein thrombosis. Removed I.E.13. Other metabolic conditions, such as acute thyroiditis, hypokalemia, hyperkalemia, or hypovolemia (until adequately treated). Added I.E.13. Active endocarditis and I.E.14. Acute aortic dissection. Under II.C. removed "a total of". Minor rewording in background with no clinical significance. References reviewed and updated.	02/25	02/25

References

1. Aldana SG, Greenlaw R, Salberg A, Merrill RM, Hager R, Jorgensen RB. The effects of an intensive lifestyle modification program on carotid artery intima-media thickness: a randomized trial. *Am J Health Promot*. 2007;21(6):510 to 516. doi:10.4278/0890-1171-21.6.510.

2. Dibben G, Faulkner J, Oldridge N, et al. Exercise-based cardiac rehabilitation for coronary heart disease. *Cochrane Database Syst Rev*. 2021;11(11):CD001800. Published 2021 Nov 6. doi:10.1002/14651858.CD001800.pub4
3. Braun LT, Wenger NK, Rosenson RS. Cardiac rehabilitation programs. UpToDate. www.uptodate.com. Updated May 15, 2024 Accessed January 21, 2025.
4. Centers for Medicare and Medicaid Services. CMS Manual System: Pub 100-04 Medicare Claims Processing Transmittal 3848. https://www.cms.gov/files/document/r11179otn.pdf. Published January 12, 2022. Accessed January 21, 2025.
5. National coverage determination: intensive cardiac rehabilitation (ICR) programs (20.31). Centers for Medicare and Medicaid Services Web site. www.cms.hhs.gov/mcd/search.asp. Published August 12, 2010. Accessed January 21, 2025.
6. National coverage determination (NCD) for Cardiac Rehabilitation Programs for Chronic Heart Failure (20.10.1). Centers for Medicare and Medicaid Services Web site www.cms.hhs.gov/mcd/search.asp. Published August 18, 2014. Accessed January 21, 2025.
7. Coven, DL. Acute Coronary Syndrome. Medscape. https://emedicine.medscape.com/article/1910735-overview. Updated September 30, 2020. Accessed January 21, 2025.
8. Downing J, Balady GJ. The role of exercise training in heart failure. *J Am Coll Cardiol*. 2011;58(6):561 to 569. doi:10.1016/j.jacc.2011.04.020
9. Hansen D, Abreu A, Ambrosetti M, et al. Exercise intensity assessment and prescription in cardiovascular rehabilitation and beyond: why and how: a position statement from the Secondary Prevention and Rehabilitation Section of the European Association of Preventive Cardiology [published correction appears in *Eur J Prev Cardiol*. 2023 Dec 22;] *Eur J Prev Cardio.* 2022;29(1):230 to 245. doi:10.1093/eurjpc/zwab007
10. Hillis LD, Smith PK, Anderson JL, et al. 2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery. A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Developed in collaboration with the American Association for Thoracic Surgery, Society of Cardiovascular Anesthesiologists, and Society of Thoracic Surgeons. *J Am Coll Cardiol*. 2011;58(24):e123 to e210. doi:10.1016/j.jacc.2011.08.009
11. Racette SB, Park LK, Rashdi ST, et al. Benefits of the first pritikin outpatient intensive cardiac rehabilitation program. *J Cardiopulm Rehabil Prev*. 2022;42(6):449 to 455. doi:10.1097/HCR.0000000000000700
12. Jessup M, Abraham WT, Casey DE, et al. 2009 focused update: ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines: developed in collaboration with the International Society for Heart and Lung Transplantation. *Circulation*. 2009;119(14):1977 to 2016. doi:10.1161/CIRCULATIONAHA.109.192064
13. Karapolat H, Engin C, Eroglu M, et al. Efficacy of the cardiac rehabilitation program in patients with end-stage heart failure, heart transplant patients, and left ventricular assist device recipients. *Transplant Proc*. 2013;45(9):3381 to 3385. doi:10.1016/j.transproceed.2013.06.009
14. Kwan G, Balady GJ. Cardiac rehabilitation 2012: advancing the field through emerging science. *Circulation*. 2012;125(7):e369 to e373. doi:10.1161/CIRCULATIONAHA.112.093310

15. 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 [published correction appears in Circulation. 2005 Apr 5;111(13):1717]. *Circulation*. 2005;111(3):369 to 376. doi:10.1161/01.CIR.0000151788.08740.5C
16. Local Coverage Article. Billing and Coding: Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation (A53775). Centers for Medicare and Medicaid Services Web site: https://www.cms.gov/medicare-coverage-database/search.aspx Published October 1, 2015 (revised January 1, 2025). Accessed January 21, 2025.
17. Long L, Mordi IR, Bridges C, et al. Exercise-based cardiac rehabilitation for adults with heart failure. *Cochrane Database Syst Rev*. 2019;1(1):CD003331. Published 2019 Jan 29. doi:10.1002/14651858.CD003331.pub5
18. Levine GN, Bates ER, Bittl JA, et al. 2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines: An Update of the 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention, 2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery, 2012 ACC/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease, 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction, 2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes, and 2014 ACC/AHA Guideline on Perioperative Cardiovascular Evaluation and Management of Patients Undergoing Noncardiac Surgery [published correction appears in Circulation. 2016 Sep 6;134(10):e192-4]. *Circulation*. 2016;134(10):e123 to e155. doi:10.1161/CIR.0000000000000404
19. Mezzani A, Hamm LF, Jones AM, et al. Aerobic exercise intensity assessment and prescription in cardiac rehabilitation: a joint position statement of the European Association for Cardiovascular Prevention and Rehabilitation, the American Association of Cardiovascular and Pulmonary Rehabilitation and the Canadian Association of Cardiac Rehabilitation. *Eur J Prev Cardiol*. 2013;20(3):442 to 467. doi:10.1177/2047487312460484
20. Morgan JP. Clinical manifestations, diagnosis, and management of the cardiovascular complications of cocaine abuse. UpToDate. www.uptodate.com. Updated October 2, 2024. Accessed January 21, 2025.
21. Nielsen KM, Zwisler AD, Taylor RS, et al. Exercise-based cardiac rehabilitation for adult patients with an implantable cardioverter defibrillator. *Cochrane Database Syst Rev*. 2019;2(2):CD011828. Published 2019 Feb 12. doi:10.1002/14651858.CD011828.pub2
22. O'Gara PT, Kushner FG, Ascheim DD, et al. 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: executive summary: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines: developed in collaboration with the American College of Emergency Physicians and Society for Cardiovascular Angiography and Interventions. *Catheter Cardiovasc Interv*. 2013;82(1):E1 to E27. doi:10.1002/ccd.24776

23. Paulus M. Methamphetamine use disorder: Epidemiology, clinical manifestations, course, assessment, and diagnosis. UpToDate. www.uptodate.com. Updated August 23, 2024. Accessed January 21, 2025.
24. Palermo P, Corrà U. Exercise prescriptions for training and rehabilitation in patients with heart and lung disease. *Ann Am Thorac Soc*. 2017;14(Supplement_1):S59 to S66. doi:10.1513/AnnalsATS.201702-160FR
25. Piña Il. Cardiac rehabilitation in patients with heart failure. UpToDate. www.uptodate.com. Updated July 16, 2024. Accessed January 21, 2025.
26. Risom SS, Zwisler AD, Johansen PP, et al. Exercise-based cardiac rehabilitation for adults with atrial fibrillation. *Cochrane Database Syst Rev*. 2017;2(2):CD011197. Published 2017 Feb 9. doi:10.1002/14651858.CD011197.pub2
27. Squires RW, Kaminsky LA, Porcari JP, Ruff JE, Savage PD, Williams MA. Progression of exercise training in early outpatient cardiac rehabilitation: An official statement from the American Association of Cardiovascular and Pulmonary rehabilitation. *J Cardiopulm Rehabil Prev*. 2018;38(3):139 to 146. doi:10.1097/HCR.0000000000000337
28. Smith SC Jr, Benjamin EJ, Bonow RO, et al. AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and other Atherosclerotic Vascular Disease: 2011 update: a guideline from the American Heart Association and American College of Cardiology Foundation [published correction appears in Circulation. 2015 Apr 14;131(15):e408]. *Circulation*. 2011;124(22):2458 to 2473. doi:10.1161/CIR.0b013e318235eb4d
29. Task Force Members, Montalescot G, Sechtem U, et al. 2013 ESC guidelines on the management of stable coronary artery disease: the Task Force on the management of stable coronary artery disease of the European Society of Cardiology [published correction appears in Eur Heart J. 2014 Sep 1;35(33):2260-1]. *Eur Heart J*. 2013;34(38):2949 to 3003. doi:10.1093/eurheartj/eht296
30. Wenger NK, Rosenson RS, Braun LT. Cardiac rehabilitation: Indications, efficacy, and safety in patients with coronary heart disease. UpToDate. www.uptodate.com. Updated December 5, 2023. Accessed January 21, 2025.
31. Yamamoto S, Hotta K, Ota E, Matsunaga A, Mori R. Exercise-based cardiac rehabilitation for people with implantable ventricular assist devices. *Cochrane Database Syst Rev*. 2018;9(9):CD012222. Published 2018 Sep 30. doi:10.1002/14651858.CD012222.pub2
32. Smith JR, Layrisse V, Medina-Inojosa JR, Berg JD, Ommen SR, Olson TP. Predictors of exercise capacity following septal myectomy in patients with hypertrophic cardiomyopathy. *European Journal of Preventive Cardiology*. 2020 Jul 1;27(10):1066 to 73
33. Abraham LN, Sibilitz KL, Berg SK, et al. Exercise-based cardiac rehabilitation for adults after heart valve surgery. *Cochrane Database Syst Rev*. 2021;5(5):CD010876. Published 2021 May 7. doi:10.1002/14651858.CD010876.pub3
34. American College of Cardiology (ACC). 2022 AHA/ACC/HFSA guideline for the management of heart failure. www.acc.org. Published May 3, 2022. Accessed January 21, 2025.
35. Świątkiewicz I, Di Somma S, De Fazio L, Mazzilli V, Taub PR. Effectiveness of Intensive Cardiac Rehabilitation in High-Risk Patients with Cardiovascular Disease in Real-World Practice. *Nutrients*. 2021;13(11):3883. Published 2021 Oct 29. doi:10.3390/nu13113883
36. Centers for Medicare and Medicaid Services. CMS Manual System: Pub 100-03 Medicare National Coverage Determinations Transmittal 175. https://www.cms.gov/Regulations-and-

Guidance/Guidance/Transmittals/Downloads/R175NCD.pdf Published October 3, 2014. Accessed January 21, 2025.
37. Razavi M, Fournier S, Shepard DS, Ritter G, Strickler GK, Stason WB. Effects of lifestyle modification programs on cardiac risk factors. *PLoS One*. 2014;9(12):e114772. Published 2014 Dec 9. doi:10.1371/journal.pone.0114772
38. Molloy CD, Long L, Mordi IR, et al. Exercise-based cardiac rehabilitation for adults with heart failure - 2023 Cochrane systematic review and meta-analysis. *Eur J Heart Fail*. 2023;25(12):2263-2273. doi:10.1002/ejhf.3046
39. Virani SS, Newby LK, Arnold SV, et al. 2023 AHA/ACC/ACCP/ASPC/NLA/PCNA Guideline for the Management of Patients with Chronic Coronary Disease: A Report of the American Heart Association/American College of Cardiology Joint Committee on Clinical Practice Guidelines [published correction appears in Circulation. 2023 Sep 26;148(13):e148] [published correction appears in Circulation. 2023 Dec 5;148(23):e186]. Circulation. 2023;148(9):e9-e119. doi:10.1161/CIR.0000000000001168
40. Fletcher GF, Ades PA, Kligfield P, et al. Exercise Standards for Testing and Training. *Circulation*. 2013;128(8):873-934. doi:https://doi.org/10.1161/cir.0b013e31829b5b44
41. Tessler J, Bordoni B. Cardiac Rehabilitation. In: *StatPearls*. Treasure Island (FL): StatPearls Publishing; June 4, 2023.
42. Tribouilloy C, Rusinaru D, Bohbot Y, Maréchaux S, Vanoverschelde J, Enriquez-Sarano M. How Should Very Severe Aortic Stenosis Be Defined in Asymptomatic Individuals? *Journal of the American Heart Association*. 2019;8(3). doi:https://doi.org/10.1161/jaha.118.011724

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.