

Medical Coverage Policy



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Cardiac Rehabilitation (Phase II Outpatient)

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Related Coverage Resources

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses cardiac rehabilitation (Phase II) services that are provided on an outpatient basis post facility discharge.

Coverage Policy

Coverage for cardiac rehabilitation (CR) varies across plans. Refer to the customer's benefit plan document for coverage details.

If benefit coverage is available for cardiac rehabilitation, then the following conditions apply.

A medically supervised outpatient Phase II Cardiac Rehabilitation program is considered medically necessary within six months of ANY of the following events:

- acute myocardial infarction (MI)
- coronary artery bypass grafting (CABG)
- percutaneous coronary vessel remodeling
- valve replacement or repair

- heart or heart-lung transplant
- coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities
- heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities
- following surgical septal myectomy via thoracotomy
- heart transplantation or heart-lung transplantation
- major pulmonary surgery, great vessel surgery, or MAZE arrhythmia surgery
- placement of a ventricular assist device
- sustained ventricular tachycardia or fibrillation, or survivors of sudden cardiac arrest

When medical necessity for outpatient Phase II Cardiac Rehabilitation has been established, the program must meet ALL of the following requirements:

- direct supervision by a physician or nurse practitioner/physician assistant
- physician prescribed exercise each session
- cardiac risk factor modification
- psychosocial assessment
- individualized treatment plan
- outcome assessment
- provides a maximum of two one-hour sessions per day for up to thirty six sessions (most commonly two to three sessions per week for twelve to eighteen weeks)

Additional cardiac rehabilitation services are considered medically necessary, based on the above listed criteria, when the individual has ANY of the following conditions:

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

Phase III or IV cardiac rehabilitation programs, Outpatient Intensive Cardiac Rehabilitation programs including, but not limited to, the Pritikin Program, the Ornish Program for Reversing Heart Disease and the Benson-Henry Institute Cardiac Wellness Program are educational and training in nature and considered not medically necessary.

General Background

The 2005 American Heart Association/American Association of Cardiovascular and Pulmonary Rehabilitation (AHA/AACVPR) scientific statement defines cardiac rehabilitation (CR) 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 (Leon, et al., 2005).

The candidates for CR/secondary prevention programs are patients who recently have had a myocardial infarction (MI); have undergone coronary artery bypass graft surgery (CABG) or percutaneous coronary interventions; heart transplant candidates or recipients; or patients with stable chronic heart failure, peripheral arterial disease with claudication, or other forms of cardiovascular disease or cardiac surgical procedures such as valvular heart disease (Leon, et al., 2005).

CR/secondary prevention programs currently 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. Additionally, CR programs include

the appropriate use of cardioprotective drugs that have evidence-based efficacy for secondary prevention (Leon, et al., 2005).

The early CR programs initiated mobilization after a myocardial infarction and were referred to as Phase I or inpatient CR. The goal was to condition the patient to safely carry out activities of daily living following discharge. Such programs entailed prescribing activity in rigid steps with successively higher metabolic equivalents (METs). Comprehensive CR programs eventually grew to include four phases (Thompson, 2019; Goroll and Mulley, 2009):

- **Phase I (Inpatient):** Inpatient rehabilitation, usually lasting for the duration of hospitalization for an acute coronary event or surgery. It emphasizes a gradual, progressive approach to exercise and an education program that helps the patient understand the disease process, the rehabilitation process, and initial preventive efforts to slow the progression of disease. Submaximal exercise testing before hospital discharge is done to provide important prognostic information and help restore patient confidence. These programs are uncommon due to the brevity of most hospital stays.
- **Phase II (Outpatient Electrocardiographically-Monitored):** Multifaceted outpatient rehabilitation, lasting from hospital discharge to 2–12 weeks later. Phase II CR emphasizes safe physical activity to improve conditioning with continued behavior modification aimed at smoking cessation, weight loss, healthy eating, and other factors to reduce disease risk (see below).
- **Phase III (Supervised):** Supervised rehabilitation, lasting 6–12 months. Establishes a prescription for safe exercise that can be performed at home or in a community service facility, such as a senior center, and continues to emphasize risk-factor reduction.
- **Phase IV (Maintenance/Follow-Up):** This is usually an indefinite program. The goal is to encourage lifelong adherence to the healthy habits established during Phase III. Follow-up visits can occur at 6–12 month intervals. Blood pressure and pulse measurement, serum lipid levels, and even repeat maximal exercise tolerance tests can provide useful feedback to the patient and indicate areas that may require lifestyle changes to minimize coronary.

Phase II (Outpatient) Cardiac Rehabilitation (CR)

Phase II CR is described by the U.S. Public Health Service as consisting of “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 of sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients.” CR programs aim to reduce subsequent cardiovascular related morbidity and mortality. Phase II CR refers to outpatient, medically supervised programs that provide both electrocardiogram (ECG) monitored and non-electrocardiogram (ECG) monitored sessions. The programs are typically initiated within one to three weeks after hospital discharge and generally administered within the six months following discharge from the hospital (Wenger, et al., 1995).

It is recommended that patients referred to CR undergo a symptom-limited exercise tolerance/stress test before entering the CR program. The exercise test is to exclude important symptoms, ischemia, or arrhythmias that might require other interventions before exercise training. The exercise test also serves to establish baseline exercise capacity and to determine maximum heart rate for use in preparing an exercise prescription. These tests are generally done with the patient on their usual medications to mimic the heart rate response likely to occur during exercise training. Maximal heart rate is usually determined by an exercise stress test using the form of exercise anticipated (e.g., treadmill testing for a walking/jogging program or bicycle ergometer testing for a cycling program). Bicycle ergometry should be considered for individuals with balance deficits, mild neurologic impairment, or orthopedic limitations (Thompson, 2019; Goroll and Mulley, 2009; Davis, 2008; Ades and Hambrecht, 2007).

Exercise intensity is regulated by monitoring peak heart rate. The exercise training modalities used during Phase II, as in Phase I, usually consist of walking and stationary bicycling. The patient and family are educated about coronary risk (Goroll and Mulley, 2009).

Most Phase II exercise programs consist of three sessions per week for 12 weeks. However, the frequency and duration may be impacted by the level of cardiac risk stratification. Risk stratification is used to identify patients at risk for death or reinfarction and to provide guidelines for the rehabilitative process.

The exercise program design is supervised by a physician, monitored by electrocardiographic equipment to ensure patient safety and conducted by professionals trained in emergency treatment, in facilities with emergency equipment available. Patients are evaluated to determine eligibility, risk category and exercise program. Exercise prescriptions are based on risk factors, and exercise capacity measured by heart rate and oxygen consumption. Each cardiac rehabilitation session is individualized to meet patient needs. Exercise training is the principal component of the program, as it results in increased peak exercise capacity, usually expressed in METS. The MET is the total oxygen requirement of the body, with one MET equal to 3.5 milliliters of oxygen consumed per kilogram of body weight per minute. Exercise training is aimed to improve MET capacity, resulting in improved oxygen delivery and extraction, by exercising skeletal muscles, decreasing the cardiovascular requirements of exercise and increasing the amount of work that can be done before ischemia (i.e., blood deficiency) occurs.

CR programs differ in how they deliver the education and counseling. Many programs educate individuals when they are on the exercise apparatus. Some programs make printed material available to the participants. Other programs use television monitors and either locally prepare or commercially available video programs to deliver the counseling and risk reduction education (Thompson, et al., 2019).

Prior to initiating CR, it is recommended there be documentation that the patient underwent a form of exercise stress testing and did not experience **ANY** of the following:

- severe dyspnea at low exercise workload (< 5 METS)
- angina at low exercise workload (< 5 METS)
- heart rate > 120 beats per minute
- malignant ventricular arrhythmias
- ST segmental changes at low exercise workload (< 5 METS)
- significant ischemia at low work rates (< 5 METS)
- decreased systolic blood pressure during exercise

Contraindications to CR include the following (Ades and Hambrecht, 2007):

- marked progressive worsening of exercise tolerance suggesting an acute pathologic process
- worsening of dyspnea during exercise over the previous three to five days
- uncontrolled diabetes
- acute systemic illness or fever
- recent embolism
- acute pericarditis
- moderate to severe aortic stenosis
- MI within three weeks
- new onset of atrial fibrillation
- ventricular dysfunction, with a history of previous heart illness prior to a recent cardiac event
- acute thrombophlebitis
- unstable ischemia
- uncontrolled arrhythmias
- decompensated congestive heart failure (CHF)

Cardiac Risk Classification

The medically necessary frequency and duration of CR is individualized by assessing the patient's history and current need of cardiac risk factor modification.

Centers for Medicare and Medicaid Services (CMS)

CMS currently covers CR for the following indications (CMS, 2010):

- a documented acute myocardial infarction (AMI) within the preceding 12 months
- CABG surgery
- stable angina pectoris
- heart valve replacement/repair
- percutaneous transluminal coronary angioplasty (PTCA) or coronary artery stenting
- heart or heart/lung transplant.

CMS lists the following cardiac rehabilitation program requirements:

- 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 individual needs.
- Psychosocial assessment; outcomes assessment; and an individualized treatment plan detailing how components are utilized for each individual.

In 2010, CMS updated criteria on the frequency and duration of cardiac rehabilitation services stating that 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. Cardiac rehabilitation program sessions are limited to a maximum of two 1-hour sessions per day for up to 36 sessions over up to 36 weeks, with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor.

Literature Review

Clark et al. (2005), from the University of Alberta Evidence-based Practice Center for the AHRQ Technology Assessment Program, conducted a meta-analysis of coronary heart disease management programs. The purpose of the study was to determine the effectiveness of secondary cardiac prevention programs with and without exercise components. The interventions tested in the trials, and frequency and duration of the interventions, varied substantially among the studies. The studies enrolled highly selected patient populations. After reviewing 46 randomized controlled trials in 188,821 patients with coronary artery disease, the authors concluded that secondary prevention programs for patients already diagnosed with cardiac disease improved processes of care, enhanced quality of life/function status, reduced recurrent myocardial infarctions, reduced hospitalizations, and reduced long-term mortality in patients with established CAD.

Professional Societies/Organizations

The American College of Cardiology (ACC) guideline recommendations are classified as Class I, Class IIa, Class IIb, and Class III. The classification system is described as follows:

- Class I: Benefit >>>Risk; Procedure/Treatment should be performed/administered
- Class IIa: Benefit >> Risk; Additional studies with focused objectives needed. It is reasonable to perform procedure/administer treatment
- Class IIb: Benefit ≥ Risk; Additional studies with broad objectives needed; additional registry data would be helpful. Procedure/treatment may be considered.
- Class III: Risk ≥ Benefit; Procedure/treatment should not be performed/administered, since it is not helpful and may be harmful.

The weight of evidence supporting each recommendation is classified as follows:

- Level A: Multiple populations evaluated. Data derived from multiple randomized clinical trials or meta-analyses.
- Level B: Limited populations evaluated. Data derived from a single randomized trial or nonrandomized studies.
- Level C: Very limited populations evaluated. Only consensus opinion of experts, case studies, or standard of care.

The 2013 update of the 2004 American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) practice guideline for the management of patients with ST-elevation MI (STEMI) recommends under post hospitalization plan of care that exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI. Class I recommendation with Level of Evidence: A (O’Gara, et al., 2013). There has been no update to this guideline since 2013.

The 2013 ACC/AHA guideline for the management of heart failure recommends that exercise training (or regular physical activity) is safe and effective for patients with heart failure who are able to participate to improve functional status. Class I recommendation with Level of Evidence: A. 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. Class IIa recommendation with Level of Evidence: B (Yancy, et al., 2013). The 2017 focused update to the guideline does not mention cardiac rehabilitation (Yancy, et al., 2017).

The 2012 focused update to the 2007 ACC/AHA guideline for the management of patients with unstable angina/non-ST-elevation MI recommends CR/secondary prevention programs, when available, for patients with unstable angina/non ST-elevation MI, particularly those with multiple modifiable risk factors and those with moderate- to high-risk patients in whom supervised or monitored exercise training is warranted. Class I recommendation with Level of Evidence: B. The patient’s risk after unstable angina/non-ST-elevation MI should be assessed on the basis of an in-hospital determination of risk. A physical activity history or an exercise test to guide initial prescription is beneficial. Class I recommendation with Level of Evidence: B (Anderson, et al., 2013; 2007).

The 2011 updated ACC/AHA practice guideline for coronary artery bypass graft (CABG) recommends that CR should be offered to all eligible patients after CABG Class I recommendation with Level of Evidence: A (Hillis et al., 2011).

The 2011 ACC/AHA/Society for Cardiovascular Angiography and Interventions (SCAI) update to the 2005 practice guideline for percutaneous coronary intervention recommends for patients entering a formal cardiac rehabilitation program after percutaneous intervention (PCI), treadmill exercise testing is reasonable. Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for moderate to high-risk patients for whom supervised exercise training is warranted. Class I recommendation with Level of Evidence: A (Levine, et al., 2011).

The updated 2011 AHA/ACCF secondary prevention and risk reduction therapy for patients with coronary and other atherosclerotic vascular disease guideline recommendations for cardiac rehabilitation states:

- All eligible patients with acute coronary syndrome (ACS) or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (Class I recommendation with Level of Evidence: A).
- All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (Class I recommendation with Level of Evidence: A), chronic angina (Class I recommendation with Level of Evidence: B), and/or peripheral artery disease (Class I recommendation with Level of Evidence: A) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.
- A home-based cardiac rehabilitation program can be substituted for a supervised, center-based program for low-risk patients (Class I recommendation with Level of Evidence: A).
- A comprehensive exercise-based outpatient cardiac rehabilitation program can be safe and beneficial for clinically stable outpatients with a history of heart failure (Class IIa recommendation with Level of Evidence: B).

The 2015 ACC/AHA/SCAI Focused Update on Primary Percutaneous Coronary Intervention for Patients With ST-Elevation Myocardial Infarction: An Update of the 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention and the 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction does not address cardiac rehabilitation (Levine, et al., 2015).

The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)/ACC/AHA 2007 performance measures on CR for referral to CR/secondary prevention services were updated in 2010 and most recently in 2018. The 2018 document retires the original “set b” measures while publishing six new performance measures and three quality measures. These measures focus on the opportunities to improve referrals to outpatient CR from both inpatient and outpatient presentations. The updated performance measures state all patients hospitalized and evaluated in outpatient setting with a primary diagnosis of an acute myocardial infarction (MI) or chronic stable angina (CSA), or who during hospitalization have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation are to be referred to an early outpatient cardiac rehabilitation/secondary prevention (CR) program. Furthermore; the performance measures state all patients evaluated inpatient and outpatient setting who within the past 12 months have a primary diagnosis of Heart Failure with reduced Ejection Fraction be referred to outpatient exercise training, typically delivered in an outpatient CR program. The remaining performance measures and quality measures focus on enrollment, adherence and clinical outcomes of the cardiac rehabilitation program. The authors noted that improved clinical outcomes are realized with a “full dose” of thirty six prescribed sessions. CR communication to healthcare providers is important and care coordination is considered standard of care. The patients who are appropriate for entry into a CR program include persons 18 years of age or older who, during the previous year, have had one or more of the qualifying diagnoses previously noted. (Thomas, et al., 2007, 2010, 2018).

In 2007, the AHA and the AACVPR updated their 2000 scientific statement addressing the core components of CR/secondary prevention programs. The update presents the current information on the evaluation, interventions, and expected outcomes in each of the core components of CR/secondary prevention programs which is in agreement with the 2006 AHA/American College of Cardiology (ACC) secondary prevention guidelines, including baseline patient assessment, nutritional counseling, risk factor management (lipids, blood pressure, weight, diabetes mellitus, and smoking), psychosocial interventions, and physical activity counseling and exercise training. 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 (Balady, et al., 2007).

The 2007 ACC/AHA focused update of the 2002 practice guideline for the management of patients with chronic stable angina recommends medically supervised programs (CR) for at-risk patients (e.g., recent coronary syndrome or revascularization, heart failure). It is recommended that the patient’s risk should be assessed with a physical activity history. Where appropriate, an exercise test is useful to guide the exercise prescription. Physical activity of 30–60 minutes, seven days per week (minimum five days per week) is recommended. All patients should be encouraged to obtain 30–60 minutes of moderate-intensity aerobic activity, such as brisk walking, on most, preferably all, days of the week, supplemented by an increase in daily activities (such as walking breaks at work, gardening, or household work) (Fraker, et al., 2007). There has been no update to this guideline since 2007.

Outpatient Intensive Cardiac Rehabilitation Programs

Several outpatient intensive cardiac rehabilitation (ICR) programs have been developed including, but not limited to, the Pritikin Program, the Ornish Program for Reversing Heart Disease and the Benson-Henry Institute Cardiac Wellness Program (Hayes, 2018, Updated 2019; CMS, 2010; 2014). ICR are comprehensive, long-term programs involving medical evaluation, exercise, cardiac risk factor modification, education, and counseling for patients with chronic or post-acute cardiovascular disease. According to CMS, intensive cardiac rehabilitation program sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks. There is a lack of comparative studies in the peer-reviewed published literature that outpatient intensive cardiac rehabilitation programs improve health outcomes compared to a program of traditional outpatient cardiac rehabilitation.

A 2018 Hayes (Updated 2019) Comparative Effectiveness Review evaluated the comparative effectiveness and safety of intensive cardiac rehabilitation (ICR) programs relative to usual care (UC) and conventional cardiac

rehabilitation (CCR) in patients with coronary artery disease. The evidence evaluation concluded that “there is limited and very-low quality evidence, which suggests some advantages of ICR over usual care but insufficient evidence to determine whether ICR has advantages compared with conventional cardiac rehabilitation. Most evidence is based on Ornish programs, and there is an insufficient quantity of data to inform which ICR program, if any, is associated with the best outcomes”.

Use Outside of the US

The European Association for Cardiovascular Prevention and Rehabilitation, The American Association of Cardiovascular and Pulmonary Rehabilitation, and The Canadian Association of Cardiac Rehabilitation joint position statement on Aerobic Exercise Intensity Assessment and Prescription in Cardiac Rehabilitation concludes that “In current cardiac rehabilitation practice, the choice of the aerobic training stimulus intensity in individual patients remains largely a matter of clinical judgement. This European, US and Canadian joint position statement provides evidence-based indications for a shift from a ‘range-based’ to a ‘threshold-based’ aerobic exercise intensity prescription, to be combined with thorough clinical evaluation and exercise-related risk assessment. The importance of functional evaluation through exercise testing prior to starting an aerobic training program is strongly emphasized, and an incremental cardiopulmonary exercise test, when available, is proposed as the gold standard for a physiologically comprehensive exercise intensity assessment and prescription. This would allow professionals to match the unique physiological responses of different exercise intensity domains to the individual patient pathophysiological and clinical status, maximizing the benefits obtainable from aerobic exercise training in cardiac rehabilitation” (Mezzani, et al., 2012).

Medicare Coverage Determinations

	Contractor	Determination Name/Number	Revision Effective Date
NCD	National	Cardiac Rehabilitation Programs (20.10)	02/22/2020
NCD	National	Cardiac Rehabilitation Programs for Chronic Heart Failure (20.10.1)	08/18/2014
NCD	National	Intensive Cardiac Rehabilitation (ICR) Programs (20.31)	08/12/2010
NCD	National	Benson-Henry Institute Cardiac Wellness Program (20.31.3)	05/06/2014
NCD	National	The Pritikin Program (20.31.1)	08/12/2010
NCD	National	Ornish Program for Reversing Heart Disease (20.31.2)	08/15/2010

Note: Please review the current Medicare Policy for the most up-to-date information.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
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)

Considered Not Medically Necessary:

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

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