Cardiac Rehabilitation Programs

**Title:** Cardiac Rehabilitation Programs

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**DESCRIPTION**
Cardiac rehabilitation refers to comprehensive medically supervised programs in the outpatient setting that aim to improve the function of patients with heart disease and prevent future cardiac events. National organizations have recently specified core components to be included in cardiac rehabilitation programs.

**Background**
Heart disease is the leading cause of mortality in the U.S., causing more than half of all deaths. Coronary artery disease (CAD) is the most common cause of heart disease. Annually, it is estimated that 785,000 Americans suffer a new myocardial infarction (MI), and 470,000 have a recurrent MI.(1) In addition, CAD can lead to the clinical syndrome of heart failure, which occurs in about 650,000 new cases in the U.S.
annually. (2) Heart failure may be secondary to or coexist with to CAD, but can also be related to structural heart disease and other genetic, metabolic, endocrine, toxic, inflammatory, and infectious causes. Given the disease burden of heart disease, preventing secondary cardiac events and treating the symptoms of heart disease and heart failure have received much attention from national organizations.

In 1995, the U.S. Public Health Service (USPHS) defined cardiac rehabilitation services as, in part, “comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. These programs are designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients.” (3) This USPHS guideline recommended cardiac rehabilitation services for patients with coronary heart disease (CHD) and with heart failure, including those awaiting or following cardiac transplantation. A 2010 definition of cardiac rehabilitation by the Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation is as follows: “Cardiac rehabilitation can be viewed as the clinical application of preventive care by means of a professional multi-disciplinary integrated approach for comprehensive risk reduction and global long-term care of cardiac patients.” (4) Since the release of the USPHS guideline, other societies, including the American Heart Association(5) and the Heart Failure Society of America(6) have developed guidelines about the role of cardiac rehabilitation in patient care.

Note: This policy does not address programs considered to be “Intensive Cardiac Rehabilitation Programs,” such as the Dean Ornish Program for Reversing Heart Disease and the Pritikin Program.

POLICY
A. Cardiac rehabilitation items and services are considered medically necessary for patients who have experienced one or more of the following:  
1. An acute myocardial infarction within the preceding 12 months; or  
2. A coronary artery bypass surgery; or  
3. Current stable angina pectoris; or  
4. Heart valve repair or replacement; or  
5. Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or  
6. A heart or heart-lung transplant.  
7. Compensated heart failure  
   (Stable congestive heart failure with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks)
B. Cardiac rehabilitation programs must include the following components:
   1. Physician-prescribed exercise each day cardiac rehabilitation items and services
      are furnished;
   2. Cardiac risk factor modification, including education, counseling, and
      behavioral intervention at least once during the program, tailored to patients’
      individual needs;
   3. Psychosocial assessment;
   4. Outcomes assessment; and
   5. An individualized treatment plan detailing how components are utilized for
      each patient.

C. Cardiac rehabilitation items and services must be furnished in a physician’s office or
   a hospital outpatient setting.

D. 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.

E. Duration of the Program:
   For BCBSKS members, services provided in connection with an approved cardiac
   rehabilitation exercise program may be considered reasonable and necessary for up
   to 18 sessions, usually 3 sessions a week in a single 6-week period. Coverage for
   continued participation would be allowed only on a case-by-case basis with exit
   criteria taken into consideration. It is preferable that programs start within 90 days
   of the cardiac event and be completed within 6 months of the cardiac event.

RATIONALE
The most recent literature review was from May 2013 through May 12, 2014. The following is a
description of the key literature to date.

Literature Review

*Does outpatient cardiac rehabilitation improve outcomes for patients with heart disease?*

Many randomized controlled trials (RCTs) have been published comparing cardiac rehabilitation
with usual care for patients with established heart disease, and a number of meta-analyses of
RCTs have been performed. In 2012, Oldridge identified 6 independent meta-analyses published
since 2000 that reported outcomes from RCTs after cardiac rehabilitation interventions. (7) The
RCTs included in the meta-analyses enrolled patients with myocardial infarction (MI), coronary
heart disease (CHD), angina, percutaneous coronary intervention (PCI) and/or coronary artery
bypass graft (CABG). RCTs compared cardiac rehabilitation programs (exercise only and/or
comprehensive rehabilitation) with usual care. Cardiac rehabilitation was associated with a
statistically significant (p<0.05) reduction in all-cause mortality in 4 of the 5 meta-analyses that
reported this outcome. In addition, cardiac rehabilitation was associated with a statistically
significant reduction in cardiac mortality in 3 of the 4 meta-analyses that reported disease-
specific mortality as an outcome.
Two of the meta-analyses on cardiac rehabilitation were conducted by the Cochrane collaboration. One of these included patients with CHD and the other focused on patients with systolic heart failure. Both reviews addressed exercise-based cardiac rehabilitation programs (exercise-alone or as part of comprehensive program). In 2011, Heran et al identified 47 RCTs with a total of 10,794 patients comparing cardiac rehabilitation with usual care in patients with CHD. Seventeen of the studies used exercise-only interventions, and 29 used comprehensive rehabilitation (ie, exercise plus psychosocial and/or educational interventions). Most studies (32 of 47, 68%) were conducted in Europe. Trial sample size ranged from 28 to 2304. The median duration of rehabilitation interventions was 3 months, and there was a median follow-up duration of 24 months. The investigators reported that most studies had limited information available on methodologic quality. Due to the nature of the intervention, patients were not blinded to treatment group in any of the studies. Only 4 studies reported that there was blinded assessment of study outcomes. In a pooled analysis of data from 17 trials reporting all-cause mortality after at least 12 months of follow-up, cardiac rehabilitation resulted in a significantly lower mortality rate compared with usual care (relative risk [RR]=0.87, 95% confidence interval [CI], 0.75 to 0.99). Similarly, a pooled analysis of findings from 12 trials with at least 12 months’ follow-up found a significantly lower rate of cardiovascular mortality in the cardiac rehabilitation compared with the usual care group (RR=0.74, 95% CI, 0.63 to 0.87). In sensitivity analyses of a priori defined variables, the investigators did not find a significant association between health outcomes and the type of cardiac rehabilitation (ie, exercise-only versus comprehensive cardiac rehabilitation), length of the intervention or study publication date (ie, published before 1995 or 1995 and later).

The 2010 Cochrane review by Davies et al identified a total of 19 trials with 3647 heart failure patients; 1 large trial, HF-ACTION, contributed 2331 (60%) patients. The overall quality of the studies was judged to be poor; for example, only 3 studies adequately described their randomization process, and only 3 studies had blinded outcome assessment. A pooled analysis of the 13 studies reporting all-cause mortality with up to 12 months’ follow-up, did not find a statistically significant difference in mortality between groups (RR=1.02, 95% CI, 0.70 to 1.51). Similarly, there was not a significant difference between groups in all-cause mortality in a pooled analysis of the 4 studies reporting more than 12 months’ follow-up (RR=0.88, 95% CI, 0.73 to 1.07). No significant between-group differences were found for the other primary outcome variable, hospital admissions. For example, when findings from 5 studies reporting hospital admissions up to 12 months were pooled, the relative risk was 0.79 (95% CI, 0.58 to 1.07). Most of the studies included in the Cochrane review, including the HF-ACTION trial, were exercise-only interventions; thus, conclusions cannot be drawn from this review regarding the impact of comprehensive cardiac rehabilitation programs on mortality or hospital admissions in patients with heart failure. The Cochrane review did not require that studies only included patients with compensated heart failure.

A 2011 meta-analysis by Lawler et al addressed exercise-based cardiac rehabilitation programs for patients who had a recent MI. To be included in the review, trials needed to include a minimum intervention duration of 2 weeks and a minimum of 12 weeks of follow-up. Interventions could involve any form of exercise program, with or without other interventions. A total of 34 RCTs with 6111 patients met the review’s inclusion criteria. In a pooled analysis of data from 18 trials, patients randomized to cardiac rehabilitation had a significantly lower risk of reinfarction than patients randomized to a control condition (odds ratio [OR]=0.53, 95% CI, 0.38 to 0.76). There was also a lower risk of all-cause mortality (OR=0.74, 95% CI, 0.58 to 0.95) and
cardiovascular mortality (OR=0.60, 95% CI, 0.40 to 0.76) in the group randomized to cardiac rehabilitation compared with a control intervention.

Findings of a large, multicenter RCT from the U.K. that evaluated the effectiveness of cardiac rehabilitation in a ‘real-life’ setting were published by West et al in 2012. (11) Called the Rehabilitation After Myocardial Infarction Trial (RAMIT), the study included patients from centers with established cardiac rehabilitation programs that were multifactorial (including exercise, education, counseling), involved more than 1 discipline, and provided an intervention lasting a minimum of 10 hours. A total of 1813 patients from 14 centers were randomized, 903 to cardiac rehabilitation and 910 to a control condition. Vital status was obtained at 2 years for 99.9% of participants (all but 1 patient) and at 7 to 9 years for 99.4% of participants. By 2 years, 166 patients had died, 82 (9.1%) in the cardiac rehabilitation group and 84 (9.2%) in the control group. The between-group difference in mortality at 2 years (the primary study outcome) was not statistically significant (RR=0.98, 95% CI, 0.74 to 1.30). After 7 to 9 years, 488 patients had died, 245 (27%) in the cardiac rehabilitation group and 243 (26.7%) in the control group (RR=0.99, 95% CI, 0.85 to 1.15). In addition, at 2 years, cardiovascular morbidity did not differ significantly between groups. For a combined end point including death, non-fatal MI, stroke or revascularization, the relative risk was 0.96 (95% CI, 0.88 to 1.07). In discussing the study’s negative findings, the trial authors noted that medical management of heart disease has improved over time, and patients in the control group may have had better outcomes than in earlier RCTs on this topic. Moreover, an editorial accompanying publication of study findings emphasized that RAMIT was not an efficacy trial but instead a trial evaluating the effectiveness of actual cardiac rehabilitation programs in the U.K. (12) Finally, these results may in part reflect the degree to which clinically based cardiac rehabilitation programs in the U.K. differ from the treatment protocols used in RCTs that were based in research settings.

A concern raised by the negative findings in the RAMIT trial is that most of the RCTs evaluating cardiac rehabilitation were conducted in an earlier era of heart disease management and may not be relevant to current care. Although no new RCT evidence was identified, several newer nonrandomized studies have been published since the RAMIT trial that corroborate prior RCT evidence about the benefit of cardiac rehabilitation after MI. Two examples of such studies are provided here.

In 2013, Pack et al assessed the association between cardiac rehabilitation attendance and outcomes among 846 patients in a single Minnesota county who underwent CABG from 1996 to 2007. (13) After propensity score adjustment, attending cardiac rehabilitation was associated with a reduced risk of 10-year mortality (hazard ratio [HR]=0.54, 95% CI, 0.01 to 0.74, p<0.001).

In a longitudinal observational study, Coll-Fernandez et al compared mortality and subsequent ischemic event rates after acute MI between patients who underwent cardiac rehabilitation (n=521) and those who did not (n=522). (14) In multivariate analysis, patients who underwent cardiac rehabilitation had lower mortality than those who did not (adjusted HR=0.08, 95% CI, 0.01 to 0.63, p=0.016).

Although these nonrandomized studies published since the RAMIT trial are limited by the potential for residual confounding by unobserved variables even after propensity-score adjustment or multivariable adjustment, they provide some additional evidence supporting the use of cardiac rehabilitation in the current era of cardiac care.
Does repeat outpatient cardiac rehabilitation improve outcomes?
No studies were identified that evaluated the effectiveness of repeat participation in a cardiac rehabilitation program.

Ongoing Clinical Trials
A search of online database ClinicalTrials.gov on May 15, 2014 using the term “cardiac rehabilitation” as the intervention identified the following randomized studies that are currently enrolling patients:

Enhancing Standard Cardiac Rehabilitation With Stress Management Training in Patients With Heart Disease (ENHANCE) (NCT00981253) - This is a randomized, open-label trial designed to evaluate whether cardiac rehabilitation incorporating exercise and stress management is more effective than standard cardiac rehabilitation at improving cardiac biomarkers among patients with a diagnosis of CHD who are eligible for cardiac rehabilitation. Enrollment is planned for 150 subjects; the planned study completion date is May 2014.

Multi-Disciplinary Rehabilitation Program in Recently Hospitalized Patients With Preserved Ejection Fraction Heart Failure (NCT01914315) – This is a randomized, single-blinded (outcomes assessor-blinded) study to evaluate whether comprehensive cardiac rehabilitation is superior to standard care for patients with heart failure with preserved systolic function who are discharged after an acute heart failure event. Enrollment is planned for 1100 subjects; the planned study completion date is January 2016.

OPTImal CArdiac REhabilitation (OPTICARE) Following Acute Coronary Syndromes: A Randomized, Controlled Trial to Investigate the Benefits of an Expanded Educational and Behavioural Intervention Program (NCT01395095) – This is a randomized, open-label trial designed to compare 2 extended cardiac rehabilitation programs to a standard cardiac rehabilitation program among patients with acute coronary syndrome treated with primary or elective percutaneous coronary intervention or coronary surgery. Enrollment is planned for 1200 subjects; the planned study completion date is March 2016.

Effects of Homebased Training With Telemonitoring Guidance in Low to Moderate Risk Patients Entering Cardiac Rehabilitation (NCT01732419) - This is a randomized, open label trial to compare home-based cardiac rehabilitation with center-based cardiac rehabilitation among patients with acute coronary syndrome or a cardiac revascularization procedure. Enrollment is planned for 90 subjects; the planned study completion date is October 2014.

Efficacy of Physical Exercise in Cardiac Rehabilitation (NCT01617850) – This is a randomized, single-blinded trial to compare an “optimized” (higher-intensity” exercise program to a conventional program for improvement in exercise-related parameters among patients with angina pectoris, acute MI, and chronic heart failure. Enrollment is planned for 70 subjects; the study completion date was listed as December 13, 2013. No results have been published.

Cardiopulmonary Rehabilitation for Adolescents and Adults With Congenital Heart Disease (NCT01822769) – This is a randomized, single-blinded trial to compare a formal 12-week outpatient cardiac rehabilitation program with standard care for adults and children with congenital heart disease and impaired aerobic capacity. Enrollment is planned for 60 subjects; the planned study completion date is December 2014.
Summary
Cardiac rehabilitation refers to comprehensive medically supervised programs in the outpatient setting that aim to improve the function of patients with heart disease and prevent future cardiac events. A joint national U.S. guideline has specified core components of cardiac rehabilitation programs. Numerous randomized controlled trials (RCTs) have been performed, and meta-analyses of RCTs have found that cardiac rehabilitation improves health outcomes for selected patients. The evidence is insufficient to support repeat participation in cardiac rehabilitation programs.

Practice Guidelines and Position Statements
In 2013, the American College of Cardiology Foundation and the American Heart Association published updated guidelines on the management of heart failure.(2) These guidelines include the following Class IIA recommendation related to cardiac rehabilitation (Level of Evidence: B): Cardiac rehabilitation can be useful in clinically stable patients with HF [heart failure] to improve functional capacity, exercise duration, HRQOL [health-related quality of life], and mortality.

In 2012, the American College of Physicians, American College of Cardiology Foundation, American Heart Association/American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association and Society of Thoracic Surgeons published a joint guideline on management of stable ischemic heart disease. (15) The guideline included the following statement on cardiac rehabilitation:
Medically supervised exercise programs, i.e., cardiac rehabilitation and physician-directed home-based programs, are recommended for at-risk patients at first diagnosis of stable ischemic heart disease.

In 2007, the American Heart Association and American Association of Cardiovascular and Pulmonary Rehabilitation issued an updated consensus statement on the core components of cardiac rehabilitation programs. (16) The 10 core components are: patient assessment prior to beginning the program, nutritional counseling, weight management, blood pressure management, lipid management, diabetes management, tobacco cessation, psychosocial management, physical activity counseling, and exercise training. Programs that only offer supervised exercise training are not considered to be cardiac rehabilitation. The updated guidelines specify the assessment, interventions, and expected outcomes for each of the core components. For example, symptom-limited exercise testing before exercise training is strongly recommended. The national guideline does not specify the optimal overall length of programs or number or duration of sessions.

In 2010, Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation published a position paper on cardiac rehabilitation.(4) Recommendations were based on a review of national guidelines from the U.S. and Europe. They stated that core components of cardiac rehabilitation are patient assessment, physical activity counseling, exercise training, diet/nutritional counseling, weight-control management, lipid management, blood pressure monitoring, smoking cessation, and psychosocial management. The recommended criteria for adequate exercise training are:
- Mode: Continuous endurance e.g., walking, jogging, cycling, swimming, etc.
- Duration: At least 20-30 minutes (preferably 45-60 minutes)
- Frequency: Most days (at least 3 days per week and preferably 6-7 days per week)
- Intensity: 50-80% of peak oxygen consumption or of peak heart rate or 40-60% of heart rate reserve.
The position paper did not address repeat participation in cardiac rehabilitation programs.

**BENEFIT APPLICATION**
Cardiac rehabilitation must be performed in a facility approved by Blue Cross and Blue Shield of Kansas.

**CODING**
The following codes for treatment and procedures applicable to this policy 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. 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.

**CPT/HCPCS**
- 93797 Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
- 93798 Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

- A single initial visit with the physician for referral to a program may be allowed under CPT code 99215.

**ICD-9 Diagnoses**
- 410.00-410.92 Acute myocardial infarction (code range)
- 411.1 Intermediate coronary syndrome
- 412 Old myocardial infarction
- 413.9 Other and unspecified angina pectoris
- 428.0 Congestive heart failure, unspecified

**ICD-10 Diagnoses (Effective October 1, 2015)**
- I20.0 Unstable angina
- I20.8 Other forms of angina pectoris
- I20.9 Angina pectoris, unspecified
- I21.01 ST elevation (STEMI) myocardial infarction involving left main coronary artery
- I21.02 ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
- I21.09 ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
- I21.11 ST elevation (STEMI) myocardial infarction involving right coronary artery
- I21.19 ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
- I21.21 ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
- I21.29 ST elevation (STEMI) myocardial infarction involving other sites
- I21.3 ST elevation (STEMI) myocardial infarction of unspecified site
- I21.4 Non-ST elevation (NSTEMI) myocardial infarction
- I22.0 Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I22.1  Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.2  Subsequent non-ST elevation (NSTEMI) myocardial infarction
I22.8  Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.9  Subsequent ST elevation (STEMI) myocardial infarction of unspecified site
I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
I25.2  Old myocardial infarction
I25.700 Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris
I25.701 Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm
I25.708 Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris
I25.709 Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris
I25.710 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris
I25.711 Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.718 Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris
I25.719 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris
I25.720 Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris
I25.721 Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.728 Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris
I25.729 Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris
I25.730 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris
I25.731 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.738 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris
I25.739 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris
I25.750 Atherosclerosis of native coronary artery of transplanted heart with unstable angina
I25.751 Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm
I25.758 Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris
I25.759  Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris
I25.760  Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina
I25.761  Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm
I25.768  Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris
I25.769  Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris
I25.790  Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris
I25.791  Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm
I25.798  Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris
I25.799  Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris
I50.20   Unspecified systolic (congestive) heart failure
I50.21   Acute systolic (congestive) heart failure
I50.22   Chronic systolic (congestive) heart failure
I50.23   Acute on chronic systolic (congestive) heart failure
I50.30   Unspecified diastolic (congestive) heart failure
I50.31   Acute diastolic (congestive) heart failure
I50.32   Chronic diastolic (congestive) heart failure
I50.33   Acute on chronic diastolic (congestive) heart failure
I50.40   Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.41   Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42   Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43   Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.9    Heart failure, unspecified

**REVISIONS**

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<th>Description</th>
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<td>08-17-2010</td>
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<tr>
<td>09-24-2012</td>
<td>Description section updated.</td>
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<td>o In Item E, added &quot;It is preferable that programs start within 90 days of the cardiac event and be completed within 6 months of the cardiac event.&quot;</td>
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<td>Rationale section updated.</td>
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<td>12-11-2013</td>
<td>Added Medical Policy and Coding Disclaimers.</td>
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<td>o Added ICD-10 Diagnosis codes <em>(Effective October 1, 2014)</em></td>
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Updated Reference section.

07-15-2014 Description section updated

In Policy section:
▪ Added to A 7 "(Stable congestive heart failure with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks)\n\ndefine compensated heart failure.

Revision section updated

References updated

REFERENCES


**Other References:**

1. Blue Cross and Blue Shield of Kansas Cardiology Liaison Committee, April 2010, May 2014.