



SelectHealth Medical Policies

Cardiovascular Policies

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AUTOLOGOUS STEM CELL INFUSION FOR MYOCARDIAL INFARCTION

Policy # 394

Implementation Date: 3/5/08

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2/5/19, 2/11/20, 2/18/21, 5/5/22

Revision Dates: 2/18/10

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1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Acute myocardial infarction (AMI) is the death of heart muscle secondary to prolonged lack of oxygen due to blockage of the artery supplying the muscle. Approximately 1.5 million cases of AMI occur each year in the United States and cardiovascular disease is the leading cause of death in the U.S; approximately 500,000–700,000 deaths related to coronary artery disease (CAD) occur each year.

Dead heart muscle reduces the heart's ability to function properly which can result in congestive heart failure or other complications which impair an individual's ability to function and may ultimately lead to an early death.

Various therapies have been attempted to improve heart function in cases of ischemic heart disease. These include medical therapy, surgical excision of dead heart muscle, placement of left ventricular devices (LVD), and even heart transplantation or placement of a temporary artificial heart. Recently, stem cell transplantation has been tried to replace damaged heart cells with healthy viable cells. A relatively new concept of adult stem cell therapy predicts that stem cells can differentiate into cell types outside of their original lineage. Results from studies have suggested that blood line stem cells can change into heart muscle cells and vascular cells after transplantation into damaged heart tissue.

Many studies have been done investigating stem cell infusions for the replacement of damaged heart cells. Various methods of administering this therapy have been used with cells being implanted directly into heart muscle externally through the chest wall, through the veins leading to the heart and via heart catheterization into the coronary. Additionally, various cell lines have been used for this treatment including bone marrow cells, undifferentiated muscle cells, and peripheral blood cells, further clouding the question of efficacy. The exact mechanism in which stem cell transfer can improve perfusion and contractile performance of the injured heart remains unknown, and the controversies surrounding the ability of these cells to undergo this change continues to exist. However, irrespective of the mechanism, there appears to be a general agreement that stem cell transplantation has some impact on heart function post-MI. Questions remain, though, as to whether there is a significant clinical impact on patients.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

SelectHealth does NOT cover autologous stem cell infusion for myocardial infarction due to the lack of evidence proving clinical efficacy; and there are many unanswered questions related to the optimal progenitor cells and methods to deliver stem cells. This meets the plan's definition of investigational/experimental.

Cardiovascular Policies, Continued

Autologous Stem Cell Infusion for Myocardial Infarction, continued

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or the [manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

A Medical Technology Assessment performed in March 2008 identified 37 articles, including many randomized controlled trials, with most controls receiving normal saline injections or standard therapy. Most of these were small sample studies reporting outcomes over 3–6 months, and there was substantial heterogeneity in criteria for sample selection and infusion method. Of these studies, 28 studies focused on stem cells derived from bone marrow, 7 utilized circulating progenitor cells, and 2 used cells from skeletal myoblasts. A variety of cardiac outcomes were measured including change in left ventricular ejection fraction, global ejection fraction, various blood volume measures contractility, infarct size, and oxygen intake.

Many of these studies suggest potential for stem-cell infusion to improve cardiac function. For example, the largest study to date, REPAIR-AMI, is a multi-site randomized controlled trial of 204 patients with acute myocardial infarction successfully re-perfused with stent implantation. Patients were infused with either bone-marrow-derived progenitor cells or placebo. At 4 months, global LVEF was significantly higher in the treatment group, having increased from a mean of $48.3 \pm 9.2\%$ to $53.8 \pm 10.2\%$, compared with a change from $46.9 \pm 10.4\%$ to $49.9 \pm 13.0\%$, in the placebo group. The treatment group also experienced greater improvement in regional contractility.

In contrast, the ASTAMI randomized controlled trial of 100 patients found no difference between the bone marrow and placebo groups at 6 months in LVEF, end-diastolic volume, or infarct size. Similarly, LVEF was no different between treated and placebo patients at 18 months in the BOOST study of 60 patients.

Far fewer studies measured important clinical outcomes such as mortality, additional cardiac events, and quality of life post-infusion. The REPAIR-AMI study reported fewer deaths, repeat myocardial infarctions, or revascularization procedures, in the treatment group compared with placebo at the one-year follow-up. Stem cell infusion resulted in improved exercise capacity at 6 months in the ASTAMI trial and at 12 months in a nonrandomized cohort of 20 patients. Treatment with stem-cells conferred no improvement in quality of life at 6 months in the ASTAMI trial. The TOPCARE-AMI study of 59 patients reported no additional cardiac events at 12 months in patients treated with circulating progenitor cells.

Overall, while these studies suggest that stem cell infusion confers statistical improvement in cardiac functioning in the short-term, additional longitudinal studies are needed to evaluate whether the treatment reliably improves quality of life and reduces mortality from future cardiac events. Moreover, standardized procedures are needed for extraction and infusion in addition to better data on the appropriate patient population for this procedure. Several clinical trials are ongoing, which should contribute important data towards addressing these issues.

A literature review in February 2010 identified a BCBS TEC Summary, concluding there was insufficient evidence to allow a conclusion on the benefits of progenitor cell therapy.

Billing/Coding Information

CPT CODES

Not Covered: Investigational/Experimental/Unproven for This Indication

Autologous Stem Cell Infusion for Myocardial Infarction, continued

33999 Unlisted procedure, cardiac surgery

HCPCS CODES

No specific codes identified

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Autologous Stem Cell Infusion for Myocardial Infarction, continued

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CAROTID PROCEDURES FOR STROKE PREVENTION

Policy # 461

Implementation Date: 9/28/10

Review Dates: 9/15/11, 11/29/12, 12/19/13, 12/18/14, 12/10/15, 12/15/16, 12/21/17, 12/11/18, 12/15/19, 1/6/21, 3/25/22, 1/13/23, 12/5/23

Revision Dates: 6/17/22, 2/9/24

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2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Carotid endarterectomy is a surgical procedure to remove a build-up of fatty deposits (plaque), which cause narrowing of a carotid artery. The carotid arteries are the main blood vessels that supply blood to the neck, face, and brain. Carotid endarterectomies are performed when one or both carotid arteries become narrowed because of a build-up of fatty deposits (plaque). This is known as carotid artery disease or carotid artery stenosis.

The effectiveness of carotid endarterectomy (CEA) for moderate-to-severe asymptomatic or symptomatic carotid artery stenosis has been established in large, randomized trials. For patients with indications for bilateral CEA, a staged rather than combined procedure is performed.

Carotid artery stenting (CAS) involves placing an angioplasty and a stent in the narrowed artery. The stent maintains artery patency and decreases the chance of it narrowing again. CAS is an option for selected patients with contraindications to CEA due to high-risk anatomical or physiological factors for symptomatic (≥ 50 percent) or asymptomatic high-grade (≥ 80 percent) internal carotid artery stenosis.

Transcarotid artery revascularization (TCAR) is a distinct hybrid approach to carotid stenting that requires surgical exposure of the common carotid artery at the base of the neck for stent deployment. TCAR uses a specialized arterial sheath through which the stent is deployed to treat the carotid stenosis. TCAR uses dynamic flow reversal for cerebral protection. The TCAR neuroprotection system consists of the arterial sheath, venous sheath, and a flow controller with a built-in filter.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers carotid procedures for stroke prevention in *limited* circumstances; carotid endarterectomy, carotid stenting, and transcarotid artery revascularization, as the current literature demonstrates improved outcomes in select populations. Must meet either A or B.

- A. Recommended by Intermountain Health Cardiovascular Clinical Provider; **OR**
- B. For all other clinicians, the following criteria must be met:
 - 1) Patients with symptomatic carotid artery stenosis $\geq 50\%$; or

Carotid Artery Stenting (CAS), continued

- 2) Patients with asymptomatic carotid artery stenosis $\geq 70\%$.

Select Health Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

Select Health Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

Several systematic reviews are available, and all describe the international studies comparing carotid artery stenting (CAS) and coronary artery endarterectomy (CEA). Most have concluded that CEA is the preferred method for symptomatic plaques over 50% and for asymptomatic patients with greater than 70% narrowing. The Carotid Revascularization Endarterectomy versus Stenting Trial (CREST) trial appears to have demonstrated a non-inferiority status for CAS compared with CEA. Previously, the international randomized studies have shown increased rates of intraoperative CVA during CAS limiting the role of CAS in CVD. CAS would be used only when there were strict contraindications for surgery.

CREST demonstrated low rates of periprocedural stroke and death in both treatment groups as compared with the other trials. For example, the rate of periprocedural stroke among symptomatic patients treated by carotid artery stenting was 6% in CREST but 9.6% in the EVA-3S. Compared with previous studies, CREST was the only trial which used MI (myocardial infarction) as an endpoint. CAS resulted in 1.1% risk of MI compared with CEA at 2.3%. Because MI was included as an endpoint along with CVA and death, the CREST trial results demonstrated that CAS showed comparative clinical outcomes compared with CEA. Critics have suggested that the increased rate of MI cannot be considered equivalent to CVA. They illustrate that both the increased economic and health status of the patient is much worse with a CVA. Thus, CEA should still be considered the standard of care for carotid revascularization.

Many factors are important to emphasize with CREST and previous studies. Besides the influence of choosing endpoints as discussed above, the following issues are significant in determining the clinical outcomes of the studies. These include:

- Technical proficiency of the proceduralist - Enhanced training improved results in CREST compared with previous studies where training for CAS was limited
- The age of the patient - Younger patients favored CAS
- Recent symptoms of either a TIA or CVA and the need for intervention favors CEA
- Associated co-morbid condition which could increase perioperative mortality favoring CAS.

Besides these factors, critics also illustrate there were different criteria to be included in the studies. For example, carotid ultrasound (US), magnetic resonance angiogram (MRA), and computed tomography (CT) carotid angiogram were the imaging techniques used for the diagnosis of carotid stenosis. International studies compared with CREST did not use the same thresholds, thus, direct comparisons of the studies, including their overall outcomes, are difficult to perform. Newer methods to avoid perioperative emboli have decreased the rate of stroke in CREST compared with previous studies. It is anticipated that future refinement will limit the events in the future.

Unfortunately, all randomized studies have excluded a medical arm. This omission, especially with enhanced hypertension and cholesterol control, could significantly influence the outcomes of invasive

Cardiovascular Policies, Continued

Carotid Artery Stenting (CAS), continued

trial. Overall, CREST challenges the prior international studies and suggests that in certain patient subgroups, equal or improved health outcomes may be achieved with CAS compared with CEA.

Billing/Coding Information

Covered: For the conditions outline above

CPT CODES

- 37215** Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous: with distal embolic protection
- 37217** Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation
- 37218** Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation
- 76937-26** Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)

HCPCS CODES

No specific codes identified

ICD-10 CODES

- X2AH336** Cerebral Embolic Filtration, Extracorporeal Flow Reversal Circuit from Right Common Carotid Artery, Percutaneous Approach, New Technology Group 6
- X2AJ336** Cerebral Embolic Filtration, Extracorporeal Flow Reversal Circuit from Left Common Carotid Artery, Percutaneous Approach, New Technology Group 6

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Cardiovascular Policies, Continued

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HEART TRANSPLANT: ADULT

Policy # 125

Implementation Date: 2/10/99

Review Dates: 1/4/00, 2/27/01, 5/21/01, 5/13/02, 5/25/03, 4/22/04, 4/17/06, 5/17/07, 4/24/08 4/23/09, 8/19/10, 9/15/11, 4/25/13, 2/20/14, 3/19/15, 2/16/17, 10/4/18, 10/15/19, 6/17/21, 8/2/22

Revision Dates: 5/30/04, 1/28/10, 2/14/12, 2/16/16, 10/12/17, 10/8/18, 12/10/21, 7/8/22

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Description

Cardiac transplantation remains the treatment of choice for many patients with end-stage heart failure (HF) with severely impaired functional capacity, despite optimal medical therapy. Although barriers to long-term survival remain, the outcome among transplant recipients has improved over several decades as a result of careful recipient and donor selection, advances in immunosuppression, and the prevention and treatment of opportunistic infections.

In the most recent registry report, the median survival for heart transplants performed between 1982 and June 2015 was 11 years for adult recipients and 16 years for pediatric recipients. Patient survival has steadily improved since the 1980s, with one-year survival rates now exceeding 85 percent for adult patients and 90 percent for pediatric patients transplanted in the most current era (2009 through June 2015). The major survival gains are limited to the first 6 to 12 months, with a long-term attrition rate of 3.4 percent per year thereafter, remaining largely unchanged. The improvement is probably larger than it appears since the risk profile of recipients and the age of donors continue to increase.

Commercial Plan Policy/CHIP (Children’s Health Insurance Program)

Application of coverage criteria is dependent upon an individual’s benefit coverage at the time of the request.

To qualify for coverage, adult candidates for transplant must meet **EITHER** of the following criteria (**A or B**) (except for special cardiac conditions*):

- A. Approved if recommended by Intermountain Transplant Services;

OR

- B. Must meet **ALL** the following criteria:

1. Provided by In-Network Providers in an In-Network Facility** unless otherwise approved in writing in advance by SelectHealth. ****This criterion does not apply to Idaho commercial plans. Members on Idaho commercial plans may use their out-of-network benefits with an out-of-network provider if all other criteria are met.**
2. The patient has end-stage cardiac disease that is irreversible and progressive, with limited life expectancy, and with no available reasonable alternative medical or surgical therapy; and
3. NYHA Class III or Class IV cardiac dysfunction (see below for definition of NYHA functional classifications); and

Cardiovascular Policies, Continued

Heart Transplant: Adult, continued

4. Must have at least **ONE** of the following diagnoses:
 - a. Coronary artery disease/ischemic cardiomyopathy
 - b. Idiopathic dilated cardiomyopathy
 - c. Valvular heart disease
 - d. Myocarditis
 - e. Restrictive cardiomyopathy
 - f. Congenital heart disease
 - g. Adriamycin cardiomyopathy
 - h. Peripartum cardiomyopathy
 - i. Hypertrophic cardiomyopathy
 - j. Infiltrative cardiomyopathy—only if confined to heart (if not, it is an absolute contraindication)
 - k. Chagas Disease
 - l. *Unresectable primary cardiac tumor
 - m. *Intractable life-threatening arrhythmias
 - n. *Severe cardiac allograft vasculopathy
 - o. When pulmonary hypertension exists, pulmonary vascular resistance less than or equal to 5 wood units, with or without afterload reduction (e.g., Nitroprusside, etc.)
5. A reasonable expectation that the patient's quality of life, i.e., physical and social function suited to activities of daily living, will be improved
6. Strong motivation by the patient to undergo the procedure and a thorough understanding by the patient and family of the magnitude of the operation, its risks, and sequelae, including lifetime follow-up
7. Medical assessment that the patient will have a tolerance for immunosuppressive therapy and that no other major system disease or anomaly is present which would preclude surgery or a reasonable chance of survival
8. Medical and social assessment that the patient has sufficient social stability to provide assurance that they will cooperate with the long-term follow-up and the immunosuppressive program, which is required
9. No uncontrolled and/or untreated psychiatric disorder or substance use disorder that would interfere with compliance to a treatment regimen
10. Age at time of transplant listing: > 18 and ≤ 70 years

Absolute Contraindications:

1. Severe, irreversible pulmonary hypertension
2. Pulmonary disease as listed below:
 - a. Cystic fibrosis
 - b. Obstructive pulmonary disease (FEV < 65% of predicted)
 - c. Restrictive pulmonary disease (FVC < 50% of predicted)
 - d. Unresolved pulmonary roentgenographic abnormalities of unclear etiology
 - e. Unresolved pulmonary infarction
3. Vascular disease
4. Unresolved GI bleeding
5. Unresolved diverticulitis

Cardiovascular Policies, Continued

Heart Transplant: Adult, continued

6. Irreversible liver disease
7. Hepatitis B antigen positivity
8. Untreated positive Hepatitis C serology with severe pathology on liver biopsy and/or elevated transaminases
9. Active malignant disease
10. Active infection
11. Neuromuscular disorders with physical limitations impacting survival/QOL post-transplant
12. History of medical non-compliance

Relative Contraindications:

13. History of psychiatric illness
14. Morbid obesity (Body Mass Index > 35 kg/m²)
15. Renal insufficiency as manifested a creatinine clearance below 30 mL/min. The concern in this setting is the superimposed nephrotoxicity of long-term cyclosporine therapy.
16. HIV positivity (can be considered if **ALL** the following):
 - a. No active or prior opportunistic infections or CNS lymphoma, or visceral Kaposi sarcoma,
 - b. Clinically stable and compliant on combination antiretroviral therapy (cART) for 3 months,
 - c. Have undetectable HIV RNA and have CD4 counts > 200 cells/μl for > 3 months).
17. Advanced hepatic disease. Cirrhosis, for example, can limit survival and increase perioperative morbidity, particularly if a coagulopathy is present.
18. Diabetes mellitus with end-organ dysfunction (other than non-proliferative retinopathy), chronic infections, leg ulcers, or persistent poor glycemic control (HbA1C > 7.5% despite optimal effort).
19. Peripheral vascular disease is a relative contraindication for transplantation when its presence limits rehabilitation and revascularization is not a viable option.

Several other conditions increase the rate of perioperative complications or interact poorly with immunosuppressive agents. Included in this group are advanced peripheral vascular disease, morbid obesity, active peptic ulcer disease, cholelithiasis, and diverticulosis.

All cardiac transplantation candidates should undergo a complete psychosocial evaluation during the initial screening process. This may identify social and behavioral factors that cause difficulty during the waiting period, convalescence, and long-term post-operative management. The patient must understand that full cooperation and compliance are critical to the safe and effective use of immunosuppressive agents.

New York Heart Association (NYHA) Functional Cardiac Classifications:

20. Patients with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain.
21. Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
22. Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.

Cardiovascular Policies, Continued

Heart Transplant: Adult, continued

23. Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or the [manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

In 2001, the Clinical Practice Committee of the American Society of Transplantation published recommendations for considering transplantation in patients with cardiac conditions that have not responded to maximal medical management.

Improved survival should be the primary indication for cardiac transplantation and the primary selection task is to predict the prognosis in severe heart failure. Many predictors of poor prognosis have been identified, including NYHA functional class III or IV, reduced left ventricular ejection fraction (LVEF), and hyponatremia. However, there is sufficient overlap that these factors are of limited use in a particular individual. This is not surprising in view of the complexity of HF and the multiple neurohumoral, hemodynamic, and electrophysiological factors that may contribute to morbidity and mortality.

In general, the peak VO₂ appears to provide the most objective assessment of functional capacity in patients with HF, and may be the best predictor of when to list an individual patient for cardiac transplantation. The 2002 task force of the ACC/AHA has given a class I recommendation to the use of exercise testing with ventilator gas analysis for this purpose.

The value of using the peak VO₂ for this purpose is illustrated by a study of 114 consecutive ambulatory patients with advanced disease referred for possible cardiac transplantation. Three groups of patients were prospectively divided and had their outcomes compared based on their VO₂ outcomes. They were comparable with regards to other clinical parameters of disease severity, including NYHA functional class, LVEF, and cardiac index. The 1-year survival of the healthier patients in group 2 was 94%, an outcome that was similar to that in transplanted patients in group 1. The prognosis was poorest in group 3, although survival varied with the peak VO₂ in this group. Patients with a value less than or equal to 10 mL/kg per min had the lowest survival, while those between 10–14 mL/kg per min had an outcome that was only slightly worse than patients in group 1. Thus, patients with a profoundly reduced exercise capacity of 10 mL/kg per min are likely to experience the most pronounced improvement in survival with transplantation.

The small survival benefit seen for group 3 patients with a peak VO₂ of 10–14 mL/kg per min illustrates the difficulty in selection of patients for transplantation. Many of these patients will benefit from transplantation, particularly those with a peak VO₂ of 12 mL/kg per min. Patients in this intermediate range of peak VO₂ who are initially considered too well for transplantation should have several measurements of exercise capacity over a period. Some will improve on repeated testing, but those with persistent values of 10–12 mL/kg per min and poor exercise tolerance should generally be considered for



HEART TRANSPLANT: ADULT

Policy # 125

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3. NYHA Class III or Class IV cardiac dysfunction (see below for definition of NYHA functional classifications); and

Heart Transplant: Adult, continued

previously poor survival of such patients. However, the advent of highly active antiretroviral therapy has changed the prognosis of HIV. As a result, the view has been expressed that HIV infection itself should not be sufficient reason to refuse transplantation.

Among the relative contraindications to cardiac transplantation, age has historically been a major factor. Many programs have routinely excluded patients over the age of 60–65. However, carefully selected patients in this age group or older have a survival rate comparable to that in younger patients. One report compared 63 patients transplanted at 65 years of age or older (mean age 67) to 63 matched younger patients (mean age 48). Survival was comparable for both groups at 1, 3, 5, and 10 years; there was also no significant difference in the incidence of rejection or infection. As a result, most centers now focus on the patient's "physiologic" age, with emphasis on the functional integrity of major organ systems and the absence of exclusionary comorbid diseases.

Diabetes mellitus, even without evidence of significant end-organ damage (neuropathy, retinopathy, or nephropathy), is a relative contraindication to heart transplantation. However, the outcome in properly selected patients is comparable to that in nondiabetics. This was illustrated in an analysis of 345 consecutive heart transplant recipients, 101 with diabetes. Diabetics, compared to nondiabetics, had a non-significant trend toward decreased survival at one year (85% vs. 91%) but comparable survival at 5 years (82%). Rates of infection severe enough to require hospitalization were higher among diabetics at 90 days (14% vs. 3%) and 4 years (29% vs. 15%). There were no differences in the incidence of rejection, transplant coronary disease, or renal dysfunction.

Advanced obstructive and/or restrictive lung disease is associated with a higher incidence of postoperative lung complications, including infection associated with immunosuppressive therapy. Objective exclusion criteria include a forced one-second expiratory volume of less than 1.0 liter; a forced vital capacity of less than 50% of predicted; or a forced expiratory volume-to-vital capacity ratio of less than 1.0. In addition, recent pulmonary embolism with or without infarction should delay transplantation, because secondary infection in the affected lobe may occur postoperatively. Before putting the patient on the transplant list, most centers treat this disorder with systemic anticoagulants for 6–8 weeks or until radiographic evidence of resolution is seen.

A January 2012 Medical Technology Assessment focused on the maximum age at transplant. Nine primary literature articles and no systematic reviews were identified regarding heart transplantation as it relates to upper age limitations. A total of 16,892 patients reported in these studies underwent heart transplantation. Though the articles, in general, did well to report follow-up times and age ranges of participants, few appropriately matched patients for age, sex, weight, or presence of comorbidities such as diabetes mellitus. Only 2 of the 9 papers (Crespo-Leiro et al. and Morgan et al.) specifically addressed the safety and efficacy of heart transplantation in patients > 65 years of age and < 65 years of age. Both groups noted that among carefully selected patients aged more than 65 years, heart transplantation can be performed without incurring a greater risk of rejection or death than in patients aged less than 65 years.

From the literature, it is notable that among the relative contraindications to cardiac transplantation, age has historically been a major factor. Many programs have routinely excluded patients over the age of 60–65 while advocating the view that physiologic age is more important than chronological age.

Speaking to the issue of the outcomes related to transplanting a more mature population, a report based on United Network for Organ Sharing (UNOS) data for 14,401 first-time transplant recipients between 1999 and 2006 demonstrated that patients ≥ 60 years of age more frequently had comorbidities than younger patients and that their overall survival post-transplant was lower than in younger patients. However, cumulative five-year survival for patients ≥ 60 years of age was only slightly lower than that for younger patients (69% vs. 75%). There is no data to suggest that this disparity is a direct result of the heart transplantation itself. Multivariate analysis revealed recipient age ≥ 60 years, donor age, ischemic time, creatinine, hypertension, and diabetes to be independent predictors of mortality.

One of the most significant studies demonstrating the lack of age as being a significant variable affecting outcome was the 2006 ISHLT update on the listing criteria and management of cardiac transplantation candidates. This study suggested that most patients 70 years of age or younger and carefully selected patients over age 70 can be considered for cardiac transplantation. This finding is supported by most additional references cited in this report.

Billing/Coding Information

CPT CODES

Heart Transplant: Adult, continued

- 33940** Donor cardiectomy (including cold preservation)
- 33944** Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation
- 33945** Heart transplant, with or without recipient cardiectomy

HCPCS CODES

Not covered: Investigational/Experimental/Unproven for this indication

- S2152** Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition
- S9975** Transplant related lodging, meals and transportation, per diem

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Heart Transplant: Adult, continued

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Cardiovascular Policies, Continued

Heart Transplant: Adult, continued

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HEART TRANSPLANT: CHILDREN (UNDER AGE 18)

Policy # 126

Implementation Date: 2/10/99

Review Dates: 1/4/00, 2/27/01, 5/21/01, 5/13/02, 6/25/03, 4/22/04, 4/19/05, 4/20/06, 8/23/07, 8/21/08, 8/13/09, 9/15/11, 11/29/12, 10/24/13, 10/23/14, 10/15/15, 2/16/17, 2/15/18, 2/5/19, 2/13/20, 2/18/21, 1/13/22, 3/21/23

Revision Dates: 9/15/06, 8/19/10, 2/16/16, 2/26/20, 1/27/22, 8/10/23

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Worldwide, > 700 pediatric heart transplantation procedures are performed each year, representing about 12% of the total number of heart transplants performed. Most pediatric heart transplantation programs now have 5-year survival rates in excess of 80%.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers heart transplant in children under age 18 who meet EITHER of the following criteria (A or B).

- A. Approved if recommended by Intermountain Health Transplant Team;
- OR**
- B. For services being requested outside of Intermountain Health, guidelines for coverage include **ALL** the following:
1. The patient was evaluated and accepted for transplant by a paneled transplant team; and
 2. The patient has end-stage cardiac disease, which is irreversible and progressive, a limited life expectancy or documented progressive (but partially reversible) pulmonary hypertension, or both, and no available reasonable alternative medical or surgical therapy; and
 3. The patient suffers from New York Heart Association (NYHA) Class III or Class IV cardiac dysfunction - when criteria can be applied (see below for definition of NYHA Classes) despite maximal medical therapy; and
 4. **ONE** of the following diagnoses:
 - a. Cardiomyopathy
 - b. Inoperable congenital heart disease, for which there is no reasonable corrective operation
 - c. Myocarditis

Cardiovascular Policies, Continued

Heart Transplant Children: Under Age 18, continued

- d. Cardiac tumor
5. Pulmonary vascular resistance < 6 wood units with Nitroprusside or other vasodilators. (does not apply to infancy); and
6. A reasonable expectation that the patient's quality of life, i.e., physical and social function suited to activities of daily living, will be improved; and
7. Strong motivation and emotional stability of parent/guardian, a thorough understanding by the patient and family of the magnitude of the operation and its sequelae, including lifetime follow-up; and
8. Medical assessment that the patient will have a tolerance for immunosuppressive therapy and that no other major system disease or anomaly is present which would preclude surgery or a reasonable survival; and
9. Medical and social assessment that the parent/guardian and child have sufficient social stability to provide assurance that he/she will cooperate with the long-term follow-up and the immunosuppressive program which is required; and
10. No uncontrolled and/or untreated psychiatric disorder that would interfere with compliance to a treatment regimen; and
11. Child is > 36 weeks gestational age and weight > 2.2 kilograms.

Absolute Contraindications

1. Severe pulmonary hypertension (PA pressure) or pulmonary vascular resistance (PVR) greater than 6 Wood units/m², with inability of medications to reduce PVR and PA pressure to acceptable levels
2. Recent pulmonary infarct
3. Persistent acidosis with pH less than 7.1
4. Irreversible and severe renal, hepatic, CNS or pulmonary dysfunction.
5. Active/unresolved alcohol or drug abuse.
6. Active malignancy or history of malignancy with high rate of recurrence
7. Unclear cardiac diagnosis
8. Active, uncontrolled infection

Relative Contraindications

1. Psychosocial considerations as listed below:
 - a. Strong history of parent/guardian alcohol and/or substance abuse.
 - b. Documented parent/guardian child abuse or neglect.
 - c. Family unable to support long-term medical needs of recipient.
 - d. Parent/guardian with cognitive/psychiatric impairment severe enough to limit comprehension of medical regimen.
 - e. Documented parent/guardian and/or patient noncompliance with previous medical care.
2. HIV positivity (transplant can be considered if ALL the following)
 - a. No active or prior opportunistic infections or CNS lymphoma, or visceral Kaposi sarcoma,
 - b. Clinically stable and compliant on combination antiretroviral therapy (cART)
 - c. Have undetectable HIV RNA and have CD4 counts > 200 cells/μl for > 3 months.
3. Diabetes mellitus, with A1C levels > 8

Cardiovascular Policies, Continued

Heart Transplant Children: Under Age 18, continued

Select Health Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or the [manual website](#)

Select Health Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

The 4 main etiologies leading to conditions that might require heart transplantation are errors in the formation of the heart, cardiac tumors, infections, and toxins (either endogenous or exogenous), leading to damage to the myocardium. Many of the congenital anomalies, including congenital cardiomyopathy, are now known to have specific chromosomal abnormalities associated with them.

Conditions considered for pediatric heart transplantation include the following:

- Cardiomyopathy (i.e., dilated, hypertrophic, restrictive)
- Anatomically uncorrectable congenital heart disease (e.g., HLHS, pulmonary atresia with intact ventricular septum plus sinusoids, congenitally corrected transposition of the great arteries with single ventricle and heart block, severely unbalanced atrioventricular septal defects)
- Congenital heart disease at high risk for repair (e.g., severe Shone complex, interrupted aortic arch and severe subaortic stenosis, critical aortic stenosis with severe endocardial fibroelastosis, Ebstein anomaly in a symptomatic newborn)
- Refractory heart failure
- Unresectable symptomatic cardiac neoplasms

Billing/Coding Information

CPT CODES

33940	Donor cardiectomy (including cold preservation)
33944	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation
33945	Heart transplant, with or without recipient cardiectomy

HCPCS CODES

S2152	Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition
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Heart Transplant Children: Under Age 18, continued

Key References

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HEART-LUNG TRANSPLANT

Policy # 127

Implementation Date: 2/10/99

Review Dates: 1/4/00, 2/27/01, 5/21/01, 5/13/02, 6/25/03, 4/22/04, 4/22/05, 8/23/07, 8/21/08, 8/13/09, 8/19/10, 9/15/11, 7/18/13, 6/11/15, 6/16/16, 6/15/17, 7/20/18, 6/13/19, 6/18/20, 3/15/22, 4/20/23

Revision Dates: 9/15/06, 3/29/22

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2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Cardiopulmonary transplantation (heart and lung transplantation) is the simultaneous surgical replacement of the heart and lungs in patients with end-stage cardiac and pulmonary disease. This procedure remains a viable therapeutic alternative for patients in specific disease states, although the frequency of application has substantially diminished in recent years.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers heart-lung transplantation *with limitations as outlined below* (either A or B must be met).

- A. Heart-Lung Transplantation will be approved if recommended by Intermountain Health Cardiovascular Clinical Program, **or**
- B. For clinicians outside of Intermountain Health, all the following criteria must be met:
 - 1) Provided by In-Network Providers in an In-Network Facility* unless otherwise approved in writing in advance by Select Health; and
 - 2) Review of the transplant team demonstrates that patient has a significant and reasonable probability for improved health post-transplant; and
 - 3) Transplant is not being performed as part of an investigational trial; and
 - 4) Patient has severe cardiopulmonary disease which is refractory to standard-of-care therapy.

**This criterion does not apply to Idaho commercial plans. Members on Idaho commercial plans may use their out-of-network benefits with an out-of-network provider if all other criteria are met.*

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For this policy, specifically, there are no CMS criteria available; therefore, the Select Health Commercial policy or InterQual criteria apply. Select Health

Cardiovascular Policies, Continued

Heart-Lung Transplant, continued

applies these requirements after careful review of the evidence that supports the clinical benefits outweigh the clinical risks. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

The International Society Heart and Lung Transplantation (ISHLT) summarized the distribution of diagnoses leading to heart-lung transplantation from 1988 to 2019. The 3 leading indications were:

- Nonidiopathic pulmonary arterial hypertension due to congenital heart disease or cardiomyopathy: 38 %: 32%
- Idiopathic pulmonary arterial hypertension: 28.4%
- Cystic fibrosis: 15%

Heart-lung transplantation may also be required in patients with end-stage parenchymal lung disease who also have severely compromised left ventricular function (e.g., sarcoidosis).

The updated joint guidelines from the American Thoracic Society/American Society for Transplant Physicians/European Respiratory Society and the ISHLT guidelines does not suggest an age limit for heart-lung transplantation. Among patients with severe lung disease, referral for heart-lung transplantation should be made if the patient is a New York Heart Association (NYHA) class III or IV heart failure despite optimal surgical and medical treatment. Malignant ventricular arrhythmias not amenable to pharmacologic or electrophysiologic interventions (including an implantable cardioverter-defibrillator) in patients with end-stage lung disease are rare indications for the combined procedure.

Patients with idiopathic pulmonary arterial hypertension with preserved left ventricular function are best treated with double-lung transplantation. Combined heart-lung transplantation is the preferred procedure for patients with complex congenital heart disease with Eisenmenger syndrome, including those with single ventricle anatomy, unsuccessfully repaired or uncorrectable lesions, and/or severely depressed left ventricular function.

On the other hand, bilateral lung transplantation with repair of the congenital defect is the recommended procedure in patients with simple congenital heart disease. These lesions include:

- Atrial or ventricular septal defect
- Scimitar syndrome
- Pulmonary venous stenosis
- A functionally inadequate vascular bed as with multiple peripheral pulmonary arterial stenoses or pulmonary arteriovenous malformations.

Orthotopic heart transplantation alone has been performed in patients with congenital heart disease and a physiologic single lung (e.g., unilateral pulmonary venous stenosis, or due to previous aortopulmonary shunt procedure). Heart-lung transplant recipients receive an "en bloc" harvested heart and lung allograft and can be listed under both the lung and heart allocation systems. The lung allocation system in the United States was changed by United Network for Organ Sharing (UNOS) in 2018 (<https://optn.transplant.hrsa.gov/policies-bylaws/policies/>).

Billing/Coding Information

CPT CODES

33930 Donor cardiectomy-pneumonectomy (including cold preservation)

Cardiovascular Policies, Continued

Heart-Lung Transplant, continued

- 33933** Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation
- 33935** Heart-lung transplant with recipient cardiectomy-pneumonectomy
- 33940** Donor cardiectomy (including cold preservation)
- 33944** Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation
- 33945** Heart transplant, with or without recipient cardiectomy

HCPCS CODES

- S2054** Transplantation of multivisceral organs
- S2055** Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor
- S2060** Lobar lung transplantation
- S2061** Donor lobectomy (lung) for transplantation, living donor
- S2152** Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition

Key References

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IMPLANTABLE LOOP RECORDERS (ILR)

Policy # 131

Implementation Date: 7/15/03

Review Dates: 2/26/04, 1/13/05, 1/3/06, 2/16/07, 2/21/08, 2/19/09, 2/18/10, 2/17/11, 2/16/12, 4/25/13, 2/20/14, 3/19/15, 2/11/16, 2/16/17, 2/15/18, 2/5/19, 2/11/20, 2/18/21, 4/18/22

Revision Dates:

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2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

The implantable loop recorder (ILR) is an implantable, self-sensing, and/or patient-activated monitoring system that records electrocardiography data. It is designed to diagnose a cardiac cause of syncope when the standard work-up, including non-invasive tests, is not diagnostic. Electrodes in the device sense the heart's activity through human tissue, so there is no need for any intravenous leads. When symptoms occur, the patient uses an external activator device to record electrocardiogram (ECG) data for analysis by a physician; the Reveal® Plus device has an autosensing feature that can be programmed to automatically begin recording when it senses an arrhythmia. The monitor can store up to 40 minutes of preceding signals after an episode of spontaneous syncope. The device is removed after the battery has failed, or earlier, if a definitive diagnosis has been established.

The ILR is implanted subcutaneously under local anesthetic in a single incision procedure in a left pectoral or mammary location. The projected life of the battery is approximately 24 to 36 months. The manufacturer recommends that the device be explanted (removed) when it is no longer clinically necessary, or when the battery is depleted. The electrodes are self-contained within the recorder. The ILR system consists of the following elements:

1. A subcutaneously placed, programmable cardiac event recorder with looping memory.
2. A handheld telemetry unit, which is used by the patient to activate electrocardiographic storage.
3. A programmer, which is used to program the event recorder and retrieve, display, and print stored data.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

SelectHealth **covers implantable loop recorders.**

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

Implantable Loop Recorder (ILR), continued

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

Syncope is the abrupt and transient loss of consciousness associated with absence of postural tone, followed by a rapid and usually complete recovery. This symptom is alarming for the individual, witnesses, family, and physicians. Although syncope can be a harbinger of a multitude of disease processes and can mimic the appearance of a cardiac arrest, it is most often benign and self-limited. Nevertheless, injuries associated with syncopal attacks occur in 35% of patients, and recurrent episodes can be psychologically devastating. In addition, syncope can be a premonitory sign of sudden cardiac death, especially in patients with organic heart disease.

The common pathway of all forms of syncope is a sudden decrease or brief cessation of cerebral blood flow. The causes can be classified into 7 main groups: unknown origin (estimated 34% of total), neurally-mediated (24%), cardiac (18%), neurological (10%), orthostatic hypotension (8%), medication-related (3%), and psychiatric disorders (2%). Since a syncopal episode can occur without warning, it sometimes causes injuries due to falls and other accidents.

Syncope is common and accounts for around 6% of all hospital admissions and 3% of emergency room visits. Forty-three percent of patients experience recurrent syncope with an approximate 5% first year mortality in patients with unexplained syncope. Moreover, it does not always have a benign course, with mortality rates up to 33% at one year in patients with a structural cardiac disorder. In addition, costs for investigation for syncope ("diagnostic odysseys") are substantial, and about 25% of all patients remain undiagnosed.

A major problem in the diagnosis of the underlying cause is that syncope is a transient symptom and not a disease. Typically, patients are asymptomatic at the time of assessment, and thus, the likelihood of capturing a spontaneous event during diagnostic testing is low. The cause of syncope is not determined after history, physical examination, or surface ECG, in 38–47% of patients. Even after further referral for tilt-table and electrophysiological testing, 10%–26% of patients will remain undiagnosed. Other tests that can be employed include 24–48-hour halter or prolonged cardiac monitoring.

Ambulatory event monitors (AEMs) were developed to provide longer periods of monitoring and may be useful when the initial evaluation is non-diagnostic or when symptoms are infrequent. Ambulatory event monitors (AEMs) are intermittent recorders that can be used for longer periods (weeks to months) of monitoring to provide briefer, intermittent recordings to investigate events that occur infrequently. Intermittent recorders can be worn continuously or be attached by the patient when symptoms occur. They are activated after the onset of symptoms. Some recorders are implanted under the skin for long-term recordings (Medtronic's Reveal implantable loop recorder). Ambulatory event monitors are useful if symptoms are quite brief, or if symptoms include only very brief or no patient incapacitations, so that the patient, or a companion, can activate the recorder. These devices are often capable of downloading data trans-telephonically.

There are several types of AEMs available:

1. Noncontinuous devices with memory. These devices are carried by the patient and applied to the precordial area when symptoms occur (e.g., HeartCard Cardiac Event Recorder). The limitations are that an arrhythmia may be of short duration and not captured by the device or the patient may be incapacitated and unable to apply the device while symptomatic.
2. Continuous memory loop devices. These devices are worn continuously and can continuously store EKG data so that when symptoms occur, the patient activates the device, and the EKG is recorded from the memory loop for the preceding 30–90 seconds and approximately 1 minute after.
3. Implantable continuous memory loop devices. These devices are inserted under the skin in the chest area during an outpatient surgical procedure. When symptoms occur, the patient activates the handheld activator over the recorder to activate the storage of cardiac rhythms; the newest

Cardiovascular Policies, Continued

Implantable Loop Recorder (ILR), continued

generation of this device (Medtronic's Reveal Plus) also has an autosensing feature. The device may be used for more than 1 year's duration and has a projected battery life of 14 months, at which time the device must be surgically removed.

Current published evidence consists of numerous case series and studies and several controlled trials; and at least 1 economic study. Additionally, there is an abstract of a relatively large (n = 201) randomized trial (EaSyAS) reported at the European Society of Cardiology annual meeting in 2002.

Except for the EaSyAS trial, virtually all the biggest available trials and several smaller series, including the economic trial, were sponsored by the manufacturer (Medtronic) and the authors are part of the (Medtronic) Reveal Investigators group. Additionally, these studies are not without flaws. Both the RCTs and case studies consistently demonstrate substantial improvements in diagnostic yield (i.e., of recurrent, unexplained syncope), in an assortment of patient populations. However, both the Krahn randomized trial and the EaSyAS trial demonstrated no difference in patient outcomes and the EaSyAS trial also demonstrated increased treatment costs (without a significant difference in outcomes). Krahn et al. demonstrated dramatic improvements in costs per diagnosis; however, this trial must be interpreted with caution due to the authors' affiliations with Medtronic. The EaSyAS trial demonstrated increased costs for treatment in the ILR group vs. conventional work-up of a recurrent, unexplained syncope population. Thus, there are probable substantial improvements in diagnostic yield, possible reductions in diagnostic costs in, yet, ill-defined patient populations; but little direct evidence of improved patient outcomes and some evidence of increased costs for treatment (without improvements in patient outcomes). Many questions remain, however, about just who these patients are, and which of them would benefit from a diagnosis. As Noll stated in Internal Medicine News: "We have a diagnosis in these patients, but we are not able to treat them appropriately. This raises the question, then, of whether we really need to diagnose these patients if there are no good methods to influence outcome."

Billing/Coding Information

CPT CODES

33282	Implantation of patient-activated cardiac event recorder
33284	Removal of an implantable, patient-activated cardiac event recorder
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system
93291	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

HCPCS CODES

C1764	Event recorder, cardiac (implantable)
E0616	Implantable cardiac event recorder with memory, activator, and programmer

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Implantable Loop Recorder (ILR), continued

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INTIMA-MEDIA THICKNESS (IMT) TESTING FOR THE ASSESSMENT OF HEART DISEASE RISK (HEART SCAN)

Policy # 238

Implementation Date: 9/14/04

Review Dates: 10/18/05, 10/19/06, 10/18/07, 12/18/08, 12/17/09, 12/16/10, 12/15/11, 7/18/13, 6/19/14, 6/11/15, 6/16/16, 6/15/17, 7/20/18, 6/13/19, 6/18/20, 6/17/21, 5/19/22

Revision Dates:

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Intima-media testing involves the application of B-mode ultrasound to the carotid artery to determine quantitative arterial intima-media wall thickness (IMT) of the artery. This is used as a surrogate to estimate intima-media wall-thickening in the coronary arteries. A relationship between common carotid artery intima-media thickness and angiographic presence and extent of coronary artery disease has been reported in several studies. These studies suggest that patients at high risk for an adverse coronary event can be identified early, before the patient is symptomatic through use of these surrogate markers. Data from a National Heart Lung and Blood Institute study indicates that carotid arterial IMT incorporates additional, independent information on prediction of coronary events beyond angiographic measurements of lumen narrowing.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

SelectHealth **does NOT cover intima-media thickness (IMT) testing to assess cardiovascular risk** in any population. This meets the plan's definition of experimental/investigational.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Intima Media Thickness (IMT) Testing for the Assessment of Heart Disease Risk (Heart Scan), continued

Summary of Medical Information

The current state of the literature has clearly established that carotid IMT, with its numerous methods and sub sites (e.g., common, internal, bifurcation, maximal, mean/average), is highly correlated with a variety of traditional risk factors for coronary artery disease (CAD) as well as for CAD-related events (i.e., MI, stroke). The evidence supporting the belief that carotid IMT provides additional predictive capability beyond traditional risk factors is mixed; however, the weight of the evidence seems to suggest that indeed carotid IMT does provide some additional predictive capability beyond traditional risk factor assessment. One report suggests that IMT is equal in weight/value to nine separate traditional risk factors.

However, the predictive ability of carotid IMT seems to vary widely between subpopulations of people at elevated risk for CAD without a history of CAD-related events as a function of age, gender, and the presence and degree of other risk factors. Additionally, it is not clear whether the additional predictive capacity of carotid IMT would persist when adjusted for the entire risk factor profile now being proposed by Intermountain's Cardiovascular Services group (which includes c-reactive protein and serum homocysteine in addition to the more traditional Framingham risk factors). To date, there have been no studies that have prospectively followed appropriate patient groups to determine whether the addition of carotid IMT to a standard and complete battery of risk factors (comparable to the profile now being advocated by Intermountain's Cardiovascular Services group) changes treatment decisions and/or leads to meaningful improvements in patient outcomes.

Current literature evaluates IMT as a risk factor. However, no studies are available to assess IMT and treatment outcomes to reduce coronary cerebrovascular events or death from atherosclerosis.

Additional concerns/issues include:

- IMT "... is complex and expensive ..." (Nichols et al., 1999)
- "The differences in carotid-artery intima-media thickness between patients at high risk and those at low risk are too small for common clinical use (Nichols et al., 1999)."
- There seems to be consensus suggesting that carotid IMT is an early-to-intermediate or late-intermediate marker when atherosclerosis is still limited to the arterial wall, whereas coronary angiography measures atherosclerosis in its late stages. Traditional risk factors generally are measures (albeit indirect and sometimes weak) of the numerous factors at play throughout the process but their predictive capacity may diminish with age and advanced disease. Thus, the value of carotid IMT may be at its highest during the early-to-late "intermediate" period of atherosclerosis and less useful in the earliest and possibly latest stages of disease.
- "The association between IMT and risk of MI did not show a clearly linear pattern (Bots et al., Circulation 1997)." Thus, use of a linear algorithm may not be valid for this indication.
- IMT measurement protocols have yet to be standardized and concerns remain about quality control of IMT facilities outside of tightly-controlled clinical trials.
- Atherosclerosis is a focal, patchy disease, thus, measures of carotid IMT may not reflect the process in other vessels.
- "Whether increased common carotid intima-media thickness itself reflects local atherosclerosis is still a subject of debate. It may merely reflect an adaptive response of the vessel wall to changes in shear stress, tensile stress, and blood flow and subsequent changes in lumen diameter (Bots et al., Circulation 1997)."
- "We believe that the primary ill effect is not the increase in carotid-artery thickness in itself, but rather the increase in the stiffness of the vessel that results from increased wall thickness and content (Nichols et al., 1999)."

Billing/Coding Information

Not covered: Investigational/Experimental/Unproven for this indication

CPT CODES

0126T Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment

HCPCS CODES

Intima Media Thickness (IMT) Testing for the Assessment of Heart Disease Risk (Heart Scan), continued

No specific codes identified

Key References

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INTRAVASCULAR LITHOTRIPSY (IVL)

Policy # 647

Implementation Date: 4/23/21

Review Dates: 5/5/22, 4/20/23

Revision Dates: 5/11/23

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Intravascular lithotripsy (IVL) is a technology derived from renal lithotripsy, in which multiple emitters mounted on a traditional balloon catheter provide circumferential pulsatile energy to disrupt calcified plaque and improve acute gain while minimizing vessel injury. Over the last 40 years, despite multiple advancements in percutaneous coronary interventions, calcified lesions remain a challenge for even the most experienced operators, leading to an increase in morbidity and mortality. Most recently, intravascular lithotripsy (IVL) has been shown to be an innovative technology that is designed to address heavily calcified lesions.

The Shockwave Medical Peripheral IVL System (Shockwave Medical, Fremont, CA) received U.S. Food and Drug Administration (FDA) approval in 2016. This system is a single-use sterile disposable catheter that contains multiple lithotripsy emitters enclosed in an integrated balloon. The emitters create sonic pressure waves in the shape of a sphere, creating a field effect to treat circumferential vascular calcium. These sonic pressure waves selectively disrupt and fracture calcium in situ, altering vessel compliance, while minimizing injury and maintaining the integrity of the fibro-elastic components of the vessel wall.

In addition, Shockwave C2 coronary intravascular Lithotripsy (IVL) catheter has been FDA approved in 2021, for the dilation of a severely stenotic and heavily calcified coronary lesion; its technology is the same as the peripheral IVL system.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth covers Intravascular Lithotripsy (IVL) for patients undergoing transfemoral aortic valve replacement (TAVR) with calcified peripheral arterial disease.

SelectHealth covers IVL for patients undergoing percutaneous coronary intervention with stenotic and heavily calcified coronary lesions.

All other indications utilizing IVL are considered experimental/investigational.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date

Cardiovascular Policies, Continued

Intravascular Lithotripsy (IVL), continued

Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

IVL, by disrupting intimal and medial calcification, alters vessel compliance to allow for the safe passage of large-bore delivery sheaths. This expands the patient cohort that could be eligible for transfemoral access for TAVR procedures. IVL-enabled transfemoral access offers several advantages. First, it preserves the established benefits of TAVR: decreased morbidity and mortality, fewer hospital days, and reduced cost. Second, although alternative access options exist, they are more invasive and have a significant learning curve (1,5). IVL leverages the familiarity of a balloon-based intervention, minimizing the learning curve, regardless of a center's volume.

IVL may represent a straightforward technique to preserve the benefits of reduced morbidity and mortality of transfemoral TAVR in patients with calcified peripheral arterial disease.

IVL in the coronary artery is based on the same technology, as above, but is applied by a specific catheter designed for the coronary artery and is designed to dilate the recalcitrant coronary lesion prior to stenting.

Billing/Coding Information

CPT CODES

- C9764** Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed
- C9765** Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed
- C9766** Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed
- C9767** Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed
- C9772** Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed
- C9773** Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed
- C9774** Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed

Cardiovascular Policies, Continued

Intravascular Lithotripsy (IVL), continued

- C9775** Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with the intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within same vessel(s), when performed
- 0715T** Percutaneous transluminal coronary lithotripsy (list separately in addition the code for the primary procedure)

Key References

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4. Safety and efficacy data: https://www.accessdata.fda.gov/cdrh_docs/pdf20/P200039B.pdf
5. Shockwave IVL coronary catheter indication for use: https://www.accessdata.fda.gov/cdrh_docs/pdf20/P200039C.pdf

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LDL APHERESIS (LIPOSORBER DEVICE, HELP SYSTEM)

Policy # 207

Implementation Date: 12/9/03

Review Dates: 2/9/05, 2/16/06, 5/17/07, 4/24/08, 4/23/09, 4/12/12, 6/20/13, 4/17/14, 5/7/15, 4/14/16, 4/27/17, 8/16/18, 4/27/19, 4/15/20, 4/15/21, 3/18/22, 4/18/23

Revision Dates: 2/18/10, 4/21/11, 8/19/15, 5/9/19, 7/12/23

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2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Heart disease is the number one cause of morbidity and mortality in the adult US population. Lowering total and LDL cholesterol has been shown to reduce the development and recurrence of heart disease. Consequently, great emphasis is placed on the treatment of elevated total and LDL cholesterol by many physicians. Treatment including diet and multiple medications are used to reach goals published by the National Cholesterol Education Program (NCEP). However, some patients, primarily those with familial hypercholesterolemia (FH), may require additional therapy.

The dextran sulfate cellulose adsorption system (LipoSorber) uses columns containing dextran sulfate immobilized on cellulose beads to remove LDL from the plasma. Typically, there are 2 such columns in the plasma circuit, which are regenerated automatically during LDL apheresis. The system has a high selectivity for the removal of apolipoprotein B (apo B)-containing lipoproteins, removing LDL, very low-density lipoprotein, and lipoprotein (a). Binding of LDL appears to depend on electrostatic interaction between dextran sulfate and apo B and is inhibited by acetylation of LDL. Interestingly, dextran sulfate columns can remove LDL of patients with familial defective apo B-100 with equal efficacy. Although some molecules with similar properties are absorbed to the column, this is not associated with any adverse clinical consequences. The columns are discarded after each apheresis procedure, and this contributes to the high running costs of this system.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers LDL apheresis in *limited* circumstances when certain criteria have been met.

A. Patients must meet ALL the following criteria (1–5):

1. Patient has one of the following diagnoses and associated LDL cholesterol levels:
 - a) Functional homozygous FH patients with LDL-C \geq 300 mg/dL (or non-high density lipoprotein cholesterol [HDL-C] 330 mg/dL); or
 - b) Functional heterozygous FH patients with LDL-C \geq 300 mg/dL (or non-HDL cholesterol 330 mg/dL and 0 to 1 risk factors); or

Cardiovascular Policies, Continued

LDL Apheresis (Liposorber Device, Help System), continued

- c) Functional heterozygous FH patients with LDL-C \geq 200 mg/dL (or non-HDL cholesterol 230 mg/dL) and high-risk characteristics such as \geq 2 risk factors or high lipoprotein (a) \geq 50 mg/dL using an isoform insensitive assay; or
- d) Functional heterozygous FH patients with LDL-C \geq 160 mg/dL* (or non-HDL cholesterol \geq 190 mg/dL) and very high-risk characteristics, such as established coronary heart disease or other cardiovascular disease.

AND

- 2. Patient has documented medical nutritional therapy consultation and has shown active efforts at appropriate lifestyle modifications.

AND

- 3. Supporting documentation demonstrates the patient to have attempted or is currently on maximal medical therapy. Maximal medical therapy is defined as the following:
 - a) Maximal doses, for at least 6 months, of high-potency HMG-CoA reductase inhibitor (statin) therapy (unless intolerant or detrimental side effects are documented) with ezetimibe and a PCSK-9 agent, with compliance to that therapy.

AND

- 4. Absence of other severe co-morbid conditions such as end-stage renal disease, emphysema, or other life-threatening conditions.

AND

- 5. LDL apheresis is to be performed with an FDA approved device.

*Patients with familial heterozygous traits with LDL cholesterol \geq 160 must have documented atherosclerosis. The patient should have known coronary artery disease, cerebrovascular disease, or peripheral vascular disease documented prior to apheresis therapy.

Select Health Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp> or the manual website

Select Health Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

The evidence permits the conclusion that lipid apheresis consistently reduces total cholesterol and LDL cholesterol. Three randomized, controlled trials (RCTs) report that the reductions in LDL cholesterol are clinically and statistically significantly greater than those achieved by medication alone for patients with refractory hypercholesterolemia. The evidence suggests that lipid apheresis may reduce arterial morphologic change and improve hemodynamic flow in diseased arteries; however, this has not been consistently demonstrated in RCTs. The RCTs are insufficient to provide direct evidence that lipid apheresis reduces adverse cardiovascular events as compared to maximal medical management. The results of these RCTs are also limited by the fact that 2 of the 3 trials included some patients who may have been responsive to medical management, rather than limiting the population to those patients who are truly refractory to maximal medical management.

LDL Apheresis (Liposorber Device, Help System), continued

In most of the nonrandomized studies, the patients had failed diet and drug therapy, and correspond more closely to the target group of refractory patients. The efficacy of LDL lowering is of similar magnitude in these studies as compared to the RCTs. In uncontrolled studies using pre-and post-treatment coronary angiography, the reductions in cholesterol appear to be associated with non-progression of atherosclerosis. Therefore, the evidence supports the effectiveness of lipid apheresis for providing a long-term lipid-lowering benefit and suggests that lipid apheresis may be associated with non-progression of coronary artery disease. Given the established causal relationship between LDL cholesterol and cardiac events, it is likely that lipid apheresis will reduce cardiovascular events for patients with hypercholesterolemia who are refractory or intolerant to maximal drug therapy.

Lipid apheresis improves health outcomes by lowering cholesterol in patients with refractory hypercholesterolemia, leading to a reduction in adverse cardiovascular events. However, the available evidence has not quantified the magnitude of this benefit. Given that the magnitude of LDL lowering by apheresis is large, 50%–70% or greater, the magnitude of reduction in adverse cardiovascular events is also likely to be clinically meaningful.

Lipid apheresis is a relatively safe treatment, although it occasionally may be associated with significant hypotension and anaphylactic reactions. Most adverse effects are minor. Hypotension may be more likely with dextran sulfate chemo adsorption, especially in patients receiving concomitant angiotensin-converting enzyme (ACE) inhibitors. There are no adequate trials of direct comparison of the techniques to quantitatively determine treatment or safety advantages. All 3 techniques are relatively selective for LDL cholesterol but may remove some other molecules non-selectively. The clinical effect of removal of other factors such as HDL, fibrinogen, and bradykinin are unclear at this time, but there is no evidence to suggest that adverse effects have resulted from this phenomenon.

For the indicated patient group with refractory hypercholesterolemia despite maximal medical therapy, the alternatives are very limited. Radical treatments such as portocaval shunt or liver transplantation have been tried but are not yet established in clinical practice. Intensification of medical therapy is an option as newer and more potent cholesterol lowering agents are introduced, but only a minority of patients will remain refractory. Lipid apheresis is likely the best option for many of these patients.

Billing/Coding Information

Covered: For the conditions outlined above

CPT CODES

- | | |
|--------------|---|
| 0342T | Therapeutic apheresis with selective HDL delipidation and plasma reinfusion |
| 36516 | Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion |

HCPCS CODES

- | | |
|---------------|--|
| S2120 | Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation |
| E88.89 | Other specified metabolic disorders |

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Acute Inpatient Rehabilitation LDL Apheresis (Liposorber Device, Help System), continued

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LEADLESS PACEMAKERS

Policy # 670

Implementation Date: 8/21/23

Review Dates:

Revision Dates: 11/20/23

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Bradycardia (defined as resting heart rate < 60 beats per minute [bpm] on electrocardiography [ECG]) due to AV node dysfunction or sinus node dysfunction (SND), commonly called sick sinus syndrome, may result in hemodynamic consequences. A permanent cardiac pacemaker (PM) is the definitive treatment for symptomatic bradycardia that is not caused by underlying disorders or medication. More than 1 million PMs are implanted annually worldwide, with 200,000 implanted in the United States each year. Up to 12% of patients with TVPMs experience a complication, including lead- and pocket-related events, within 2 months of implantation, and nearly 20% of patients experience a complication within 5 years. The transvenous leads are the most common source of complication, removal, and revision surgery.

The Micra transcatheter pacing system (TPS) (Medtronic) is a single-chamber right ventricular pacing device. The device senses electrical activity of the heart via electrodes within the device's titanium capsule. Heart rhythm is monitored for bradycardia. Rate-adaptive pacing therapy is provided based on programmed pacing parameters. The Micra TPS is self-contained and does not require a surgical incision in the chest or intravascular leads. It is inserted via a 23-French catheter placed in the femoral vein and held in place within the right ventricle of the heart via nitinol tines that attach to the myocardium.

The Aveir VR Leadless Pacemaker (Abbott) is designed to provide bradycardia pacing as a pulse generator with built-in battery and electrodes for implantation in the right ventricle. The leadless pacemaker is intended to provide sensing of intrinsic cardiac signals and delivery of cardiac pacing therapy to the target patient population. Using the power of leadless technology, the Aveir VR Leadless Pacemaker is implanted in the heart through a minimally invasive catheter procedure. The mapping capability is designed to help reduce the number of repositioning attempts (Aveir VR Brochure). A protective sleeve fully covers the Aveir VR Leadless Pacemaker's helix during catheter navigation to reduce the risk of damaging the helix or an injury to cardiovascular structures. The Aveir VR Leadless Pacemaker's active fixation helix uses a screw-in mechanism to enable both implantation and chronic retrieval of the leadless pacemaker.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health considers the Micra single-chamber transcatheter pacing system or the Aveir single-chamber VR leadless pacemaker system as medically necessary for members who meet both of the following criteria:

Cardiovascular Policies, Continued

Leadless Pacemakers, continued

1. Has symptomatic paroxysmal or permanent high-grade arteriovenous block, or symptomatic bradycardia-tachycardia syndrome or sinus node dysfunction (sinus bradycardia or sinus pauses); and
2. Has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads, such as any of the following:
 - a) History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection; or
 - b) Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins, or planned use of such veins for a semi-permanent catheter; or current or planned use of an AV fistula for hemodialysis; or
 - c) Presence of a bioprosthetic tricuspid valve.

Select Health considers the Micra single-chamber transcatheter pacing system and the Aveir single-chamber VR leadless pacemaker system as experimental/investigational in all other situations in which the above criteria are not met.

Select Health Advantage (Medicare/CMS)

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Select Health Community Care (Medicaid)

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Billing/Coding Information

Covered when the above criteria are met

CPT CODES

- 33274** Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed

Key References

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2. Hayes, Inc. Health Technology Assessment. Micra Transcatheter Pacing System (Medtronic Inc.) for Single-Chamber Pacemaker Indications. Jun 3, 2022.

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Cardiovascular Policies, Continued

Leadless Pacemakers, continued

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LEFT ATRIAL APPENDAGE CLOSURE (LAAC) DEVICES

Policy # 430

Implementation Date: 12/28/09

Review Dates: 5/19/11, 6/19/14, 10/20/16, 10/19/17, 10/3/18, 10/15/19, 10/15/20, 11/18/21, 5/1/22

Revision Dates: 6/21/12, 4/13/13, 8/6/15, 6/3/22

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Atrial fibrillation (AF) is a common dysrhythmia. It is characterized as paroxysmal if the duration is less than one week, persistent if the duration is between 7 days, and 1 year and permanent if greater than one year in duration with failure of conversion. AF can have adverse consequences related to a reduction in cardiac output and thrombus formation that can lead to systemic embolization and strokes.

Most embolized thrombi are felt to develop in the left atrial appendage (LAA). In patients with atrial fibrillation, blood tends to pool and form clots in this appendage. To prevent clot formation and subsequent embolization in patients with AF, current guidelines recommend anticoagulation with warfarin. Management of anticoagulation with warfarin is cumbersome due to the need for frequent monitoring as warfarin is subject to significant drug-drug and drug-food interactions which can result in excessive or inadequate anticoagulation. Though warfarin is the long-term oral antithrombotic of choice in patients at high risk of embolism in association with non-valvular atrial fibrillation, especially after an ischemic cerebrovascular event, many patients cannot achieve anticoagulation targets. It is estimated that therapeutic INRs are reached less than 60% of the time, and only 50% of high-risk atrial fibrillation patients are treated with warfarin. In some of these instances, alternative treatment with medications such as aspirin or clopidogrel are used, though, studies have shown these therapies to be inferior to warfarin.

To overcome many of the alternative issues surrounding anticoagulation therapy, the WATCHMAN LAA Closure Technology (Boston Scientific Corporation, Maple Grove, MN) consists of a delivery catheter and a device that is permanently implanted in the left atrial appendage (LAA) of the heart. The device, often referred to as the WATCHMAN, which received FDA approval on March 13, 2015, prevents LAA blood clots from entering the bloodstream and potentially causing a stroke. It is made of a self-expanding, nickel-titanium (Nitinol) frame with an attached woven plastic cap. The physician inserts the delivery catheter into the body through a vein in the leg. The catheter is advanced through the bloodstream until it reaches the upper right chamber of the heart (right atrium). The physician makes a small hole through the wall between the two upper chambers of the heart (atrial septum) so that the catheter reaches the LAA. The physician then pushes the WATCHMAN through the delivery catheter into the LAA where it opens like an umbrella and is permanently implanted. Once the WATCHMAN is in place, a thin layer of tissue grows over it in about 45 days. This keeps blood clots in the LAA from entering the bloodstream.

The Amplatzer Amulet Left Atrial Appendage Occluder (LAAO) is a permanent implant that is placed in the patient's left atrial appendage, which is a pouch-like part of the heart. The device is intended to prevent blood clots formed in the LAA from entering the bloodstream and potentially causing a stroke. The device is made of a Nitinol (nickel-titanium) mesh with polyester fabric cover.

Percutaneous LAA closure with Watchman or Amulet may reduce the risk of stroke in some patients with AF and high risk of stroke with contraindications to oral anticoagulation (OAC) or unwillingness to adhere to long-term OAC therapy.

Cardiovascular Policies, Continued

Left Atrial Appendage Closure (LAAC) Devices (e.g., Watchman®), continued

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth covers left atrial appendage closure with an FDA approved device (e.g., Watchman or Amulet) in *limited* circumstances as outlined below. SelectHealth covers this procedure when either A or B are met.

- A. Will be approved if recommended by Intermountain Healthcare Cardiovascular Clinical Program,

OR

- B. For all other clinicians, criteria for coverage must be met (Must meet 1 and 2 **AND** either 3, 4, or 5).

1. Patients with $CHA_2DS_2VAsc \geq 2$ who have contraindications to anticoagulation therapy.
2. Patient does not have rheumatic mitral stenosis.
3. Patients are unable to take long-term oral anticoagulation occupational or intolerance of anticoagulation due to side effects or prior bleeding experience.
4. Patients in whom administering oral anticoagulation long-term is deemed clinically high risk, or contraindicated, because of fall-risk or other predisposition to bleeding complications.
5. Patients in need of secondary prevention who had a therapeutic INR or verified medication compliance with novel oral anticoagulation (NOAC) medications at the time of their embolic event.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or the [manual website](#)

SelectHealth Community Care (Medicaid)

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Summary of Medical Information

The WATCHMAN was evaluated in four clinical studies, in which two studies compared the WATCHMAN to warfarin. Many patients with atrial fibrillation take warfarin or other FDA approved blood thinning

Left Atrial Appendage Closure (LAAC) Devices (e.g., Watchman®), continued

medicines to prevent a stroke caused by a blood clot in the brain. However, warfarin can increase the risk of bleeding anywhere in the body. If bleeding happens in the brain, this can also cause a stroke.

These two clinical studies suggested that warfarin was better than the WATCHMAN in preventing strokes caused by a blocked blood vessel in the brain. However, the number of strokes caused by bleeding in the brain was lower in the WATCHMAN patients compared to the warfarin patients.

The overall rate of serious bleeding was similar in the WATCHMAN and warfarin patients. Within several months after the device was implanted, the rate of serious bleeding was higher in the WATCHMAN patients as compared to warfarin patients. However, beginning six months after the device implant procedure, the rate of serious bleeding was lower in WATCHMAN patients.

In one of the clinical studies that evaluated the WATCHMAN, 226 out of 246 WATCHMAN patients (approximately 92%) were able to stop taking their warfarin 45 days after the device was implanted. Within a year after the implant procedure, 231 out of 234 patients remaining in the study (over 99%) were able to stop taking warfarin.

To prevent strokes, most atrial fibrillation patients can safely take blood thinning medicines (like warfarin) without serious side effects. However, in some patients, blood thinning medicines can be difficult to use due to bleeding concerns. In choosing a treatment, physicians should consider the risks and benefits of blood thinning medicines compared to the WATCHMAN or Amulet for each individual patient. This includes the risk that either kind of stroke (caused by a blocked blood vessel or by bleeding) might occur.

Billing/Coding Information

Covered: For the conditions outlined above

CPT CODES

33340 Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

HCPCS CODES

No specific codes identified

Key References

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PECTUS EXCAVATUM SURGERY

Policy # 160

Implementation Date: 4/22/02

Review Dates: 6/25/03, 6/24/04, 5/20/05, 5/4/06, 7/12/07, 6/19/08, 6/11/09, 5/19/11, 7/18/13, 6/19/14, 6/11/15, 6/16/16, 6/15/17, 6/21/18, 6/19/19, 6/18/20, 10/15/21, 11/10/22, 4/20/23

Revision Dates: 4/22/02, 7/24/06, 1/12/10, 11/17/21, 6/30/22

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2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Pectus excavatum deformity is a congenitally acquired deformity of the front portion of the chest wall caused by the backward displacement of the xiphoid cartilage. In this condition, the anterior chest wall cartilages develop abnormally, leaving a "dent" in the chest wall. Though it causes a cosmetic deformity, it can also cause reduced function of an individual if the depression in the chest wall impairs the ability of the lungs or heart to work normally. Surgery can be done to correct the deformity while the child is still growing. Surgery is usually done prior to puberty with its associated bone growth and maturing of the child's skeletal structure.

The degree of anticipated functional impairment a patient with pectus excavatum deformity may expect is measured indirectly with the Haller Index. This value reflects the ratio of the transverse diameter (the horizontal distance of the inside of the ribcage) to the anterior-posterior diameter (the shortest distance between the vertebrae and sternum) of the chest and is calculated from a single CT scan of the chest performed through the deepest portion of a pectus excavatum deformity.

Haller Index

The Haller index (HI), also known as the pectus index, is a simple mathematical way to assess and describe the chest cage on CT of the thorax and is used in the detection and pre/postoperative assessment of pectus excavatum.

The Haller index is calculated by dividing the transverse diameter of the chest by the anterior-posterior distance on CT of the chest on the axial slice that demonstrates the smallest distance between the anterior surface of the vertebral body and the posterior surface of the sternum. Some authors have found that both radiographic- and CT-calculated Haller indices are strongly correlated and thus recommend the use of chest radiography instead of CT to minimize the radiation exposure.

The Haller index is affected by the vertebral level at which it is measured and is largest cranially. For consistency, therefore, it is recommended to calculate the largest Haller index in pectus excavatum patients by obtaining the AP diameter at the deepest point of the sternum.

The following values are used:

normal chest: < 2.0 cm
mild excavatum: 2.0–3.2 cm
moderate excavatum: 3.2–3.5 cm
severe excavatum: > 3.5 cm

Cardiovascular Policies, Continued

Pectus Excavatum Surgery, continued

Corrective pectus excavatum surgery is considered with a Haller index ≥ 3.25 cm.

Correction Index

To assess a correction index (CI), a virtual correction of the pectus is performed, and a horizontal line is drawn across the posterior aspect of the corrected sternum. CIs are calculated by measuring the distance between the posterior aspect of the corrected sternum and anterior aspect of the vertebra. This number is subtracted by the distance between the posterior aspect of the sternum at the site of deepest depression and anterior vertebra. This difference is divided by the first measurement and multiplied by 100 to represent the percentage of chest depression and, therefore, potential correction.

The CI provides an accurate assessment of pectus severity, and by the nature of the measurement, reflects the potential degree of operative repair. The Haller index correlates well with the correction index in pectus patients with standard chest wall dimensions, but is quite discrepant in the nonstandard chest. We recommend operative repair for pectus excavatum with a correction index of 28% or more, because this value correlates with the long-accepted standard (Haller index ≥ 3.25 cm) and this index remains accurate even in nonstandard chest morphologies.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers repair of pectus excavatum deformities when the following criteria are met:

1. Patient is > 7 years of age; **AND** one of the following:
2. Haller index ≥ 3.25 cm or correction index $\geq 28\%$ by non-contrast chest CT; **OR**
3. Serial PA and lateral chest x-rays taken at mid-respiration and at least 6 months apart revealing a persistent ratio of the external skeletal AP diameter of the chest at the angle of Lewis compared to the distance between the anterior surface of the vertebral body and the gladiolas-xiphoid junction is < 0.3 cm; **OR**
4. Serial PA and lateral chest x-rays taken at mid-respiration and at least 6 months apart revealing a persistent ratio of the external skeletal AP diameter of the chest at the angle of Lewis compared to the distance between the anterior surface of the vertebral body and the gladiolas-xiphoid junction is < 0.5 cm and > 0.3 cm, **AND either of the following:**
 - a) Pulmonary function tests consistent with restrictive lung disease without other underlying lung disease which explains the abnormalities; **OR**
 - b) An echocardiogram performed within the last 3 months reveals reduced cardiovascular function attributable to the chest wall deformity.

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. Select Health applies this policy after careful review of the evidence that supports the clinical benefits outweigh the clinical risks. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

Cardiovascular Policies, Continued

Pectus Excavatum Surgery, continued

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

Patients with chest wall deformities often have poor body image and self-esteem. Some individuals attempt to cover the defect with clothing and avoid activities that may require exposure of the chest. Indications for surgical correction are controversial and vary widely. Surgical repair is offered primarily as a method of improving cosmesis and psychological factors but may be necessary to improve cardiopulmonary function in some patients, as the disfigurement may be accompanied by physiologic impairment.

The scientific literature is controversial as to whether pectus excavatum is primarily cosmetic or whether it results in actual physiological impairment of function. Patients with mild pectus excavatum deformity may be treated with posture and exercise. Most surgical corrections are performed for cosmetic reasons, and in some cases to improve functional impairment. Authors agree that if patients with severe deformities do not undergo surgical repair in childhood, their symptoms worsen in adulthood.

If surgical repair is performed at an early age it has been reported there is a high recurrence rate due to periods of rapid bone growth. While the optimal age for surgical repair is generally between the ages of 11 and 18 years, each case must be reviewed individually for the presence of impaired cardiopulmonary symptoms. In some cases, surgery may be performed in adults to correct pectus deformities. Adults who have uncorrected pectus excavatum deformity and experience symptoms of activity limitation may undergo surgical repair with low morbidity, short-term limitation of activities, and improvement of symptoms.

Surgery for pectus excavatum may be performed using any of several techniques, including a sternal osteotomy (i.e., a modified osteotomy that involves supporting, removing and repositioning the sternum) or implantation of a Silastic mold in the subcutaneous space to fill the defect without altering the thoracic cage. Surgical correction often employs a metal bar behind the sternum; the bar may be removed in 1 to 2 years, after remodeling has occurred. The standard surgical procedure is the open Ravitch procedure, which involves extensive dissection, cartilage resection, and sternal osteotomy. More recently, minimally invasive techniques, including the Nuss procedure (i.e., a minimally invasive repair of pectus excavatum [MIR pectus excavatum]), have been utilized that involve the insertion of a convex steel bar beneath the sternum through small thoracic incisions. These recently developed minimally invasive methods do not require cartilage resection or osteotomy.

Billing/Coding Information

CPT CODES

- 21740** Reconstructive repair of pectus excavatum or carinatum; open
- 21742** ; minimally invasive approach (Nuss procedure), without thoracoscopy
- 21743** ; minimally invasive approach (Nuss procedure), with thoracoscopy

HCPCS CODES

No specific codes identified

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Cardiovascular Policies, Continued

Pectus Excavatum Surgery, continued

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TRANSCATHETER EDGE-TO-EDGE REPAIR (TEER)

Policy # 464

Implementation Date: 10/19/10

Review Dates: 12/15/11, 10/20/16, 10/19/17, 10/3/18, 10/15/19, 10/15/20, 11/25/21, 9/14/22

Revision Dates: 5/30/13, 1/10/14, 1/23/14, 12/13/21, 1/10/22, 10/1/22, 7/3/23

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Description

The mitral valve insufficiency occurs when the mitral valve fails to close properly causing blood to flow backward into the atrium (regurgitation), leaving the left ventricle, the heart's primary pumping chamber, with too little blood. To compensate, the ventricle stretches and overworks. Over time, it becomes enlarged, distorted, and weak.

Historically, 3 options have been available to treat symptomatic mitral valve regurgitation: medications (such as diuretics to alleviate fluid retention), valve repair, and valve replacement. Valve surgery is a highly invasive procedure which many fragile patients may not be able to undertake due to their associated comorbidities. Consequently, new approaches to mitral valve repair/replacement are under development.

One such development is the MitraClip (Abbott Laboratories, Chicago, IL). The MitraClip procedure is performed in a cardiac catheterization laboratory with the patient under general anesthesia. A thin catheter is inserted through a small incision in the groin and guided through the femoral vein to the affected area of the heart. A smaller catheter holding the clip is slipped through the first catheter. After the clip is attached to the valve leaflets, the catheters are removed. The patient is released from the hospital within a day or two. If the clip is not placed ideally on the first attempt, it can be reset. If it does not sufficiently correct the regurgitation, surgical repair or replacement of the valve remains an option.

The MitraClip system received FDA approval on October 24, 2013, for use in the United States. The FDA approved indication is for the percutaneous reduction of significant symptomatic mitral regurgitation (MR is for the percutaneous reduction of significant symptomatic mitral regurgitation (> 3+) due to primary abnormality of the mitral apparatus [degenerative MR] in patients who have been determined to be at a prohibitive risk for mitral valve surgery by a heart team. This team includes a cardiac surgeon experienced in mitral valve surgery and a cardiologist experienced in mitral valve disease, and this procedure is intended for patients in whom existing comorbidities would not preclude the expected benefit from the reduction of the mitral regurgitation.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers transcatheter edge-to-edge repair (TEER) for patients who meet *specific* coverage criteria.

Coverage criteria:

- A. Mitral Valve

Cardiovascular Policies, Continued

Transcatheter Edge-to-Edge Repair, continued

Must meet one of the following:

1. Primary degenerative mitral valve disease*, moderate-to-severe, or severe mitral regurgitation with high operative risk; or
2. Secondary moderate-to-severe or severe mitral regurgitation**, regardless of operative risk.

B. Tricuspid Valve

1. Select Health will cover transcatheter tricuspid valve implantation for prior failed tricuspid valve implantation with clinical worsening.

*Degenerative mitral valve disease is classified as degeneration of the mitral valve due to changes in the connective tissue of the valve or mitral chordae causing weakness and redundancy of the leaflets and their supporting structures. Degenerative mitral valve disease does not include infective causes, or mitral regurgitation due to ischemia or problems intrinsic with the left ventricle causing the mitral annulus to dilate and creating the mitral insufficiency. The most common finding in patients with degenerative valve disease is leaflet prolapse due to elongation or rupture of the chordal apparatus.

**Secondary means patients with normal mitral valves, who develop heart failure symptoms with moderate-to-severe or severe functional mitral regurgitation (MR), when the patient remains symptomatic despite stable doses of maximally tolerated guideline-directed medical therapy (GDMT).

Select Health Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or the [manual website](#)

Select Health Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

In December 2013, an updated review of this technology was undertaken. This review identified one systematic review and 41 primary literature articles which met the inclusion criteria for review. Most of the authors conducted and published their results after the EVEREST I Trial, EVEREST II RCT, EVEREST II HRR, and REALISM HR trials were completed. The only systematic review included only 12 studies and stated that no RCTs comparing MitraClip to non-surgical therapies were identified. This is the same finding illustrated in this report. They also noted that only one paper published between 2000 and 2013 reported outcomes beyond 12 months; however, 11 papers identified for this review followed-up with patients after 12 months between only 2010 and 2013; with regards to the primary literature articles, 5,575 patients have been enrolled in published studies in the last three years. Outcomes from the studies showed successful implantation ranging from 85% to 100% with reduction in mitral regurgitation ranging from a low 41.4% to 65%. These studies also showed improvement in NYHA categorization of at least 1 grade, ranging from 34.4% to 66.7%. In the 9 studies which assessed patients out to at least 12 months post-procedure, survival ranged from 71.1% to 87.5%. Like the findings reported in the systematic review, the average follow-up time was just over a year in the primary literature. Dissimilar to that review, however, 5 papers followed patients for 2 years and one paper followed patients out to 4 years.

Cardiovascular Policies, Continued

Transcatheter Edge-to-Edge Repair, continued

An important observation from the studies relates to the number of MitraClips used. 11 of the 41 studies used either more than 2 clips or no clip at all in each procedure. Paranskaya et al., for example, reported that 19 patients (22.3%) received 3 clips, 4 patients (4.7%) received 4 clips, and 1 patient (1.2%) received 5 clips. For studies where clips had to be removed because of perioperative complications, the authors reported that zero clips were used. Also, some of the 11 studies did not report what number of clips over 2 were used during the procedure so it is difficult to estimate what number of procedures used 3, 4, or 5 clips.

Feldman et al. and Mauri et al. were the only two to have randomized their surgical repair patients from their MitraClip patients. This is important to note as the remaining three studies explicitly note that MitraClip patients were significantly older, had lower LVEF, had a higher EuroSCORE I, had higher LV diameter, and had more comorbidities in general.

Five studies compared MitraClip surgery to standard valvular surgery. Feldman et al. and Mauri et al. were the only two to have randomized their surgical repair patients from their MitraClip patients. This is important to note, as the remaining three studies explicitly note that MitraClip patients were significantly older, had lower LVEF, had a higher EuroSCORE I, had higher LV diameter, and had more comorbidities in general. These studies did not demonstrate a statistically significant difference between percutaneous MitraClip procedures to valvular surgery for endpoints which included 30-day survival, longer term mortality, and improvement in cardiovascular function.

In conclusion, the current body of evidence regarding MitraClip demonstrates that MitraClip may reasonably improve patient outcomes, especially for patients who otherwise could not undergo surgery. Though only a few papers thoroughly examine patient outcomes in the long-term (> 2 years), what evidence does exist, shows similar outcomes as compared to standard surgical methods in appropriately selected patients. (GRADE 1B).

Billing/Coding Information

Covered: for the conditions outlined above

CPT CODES

0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus [MitraClip]
0646T	Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis
33419	; additional prosthesis (es) during the same session (List separately in addition to code for primary procedure)
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)

HCPCS CODES

No specific codes identified

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Transcatheter Edge-to-Edge Repair, continued

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Cardiovascular Policies, Continued

Transcatheter Edge-to-Edge Repair, continued

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PERCUTANEOUS TRANSCATHETER CLOSURE FOR THE TREATMENT OF ATRIAL SEPTAL DEFECTS (ASD) AND PATENT FORAMEN OVALE (PFO)

Policy # 174

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Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Atrial septal defect (ASD) is the most common congenital lesion in adults after bicuspid aortic valve. Although the defect is often asymptomatic until adulthood, potential complications of an undetected ASD include right ventricular failure, atrial arrhythmias, paradoxical embolization, cerebral abscess, and pulmonary hypertension that can become irreversible and lead to right-to-left shunting (Eisenmenger syndrome).

In approximately 70% of individuals, the primum and secundum septa fuse after birth, creating an intact interatrial septum. However, in a significant proportion of the population, the septae do not fuse. If the foramen ovale is completely covered but not sealed, it is called a "probe patent" or simply "patent" foramen ovale (PFO), indicating that the foramen can be opened by a reversal of the interatrial pressure gradient or by an intracardiac catheter. Less commonly, an open communication persists between the atria after septation. Such a communication is called an atrial septal defect (ASD).

The various types of ASDs are classified according to their location and the nature of the embryologic defect. Isolated ASDs include: PFO, ASD at the fossa ovalis (secundum ASD), a defect superior to the fossa ovalis (superior sinus venosus type ASD, superior vena caval defect), a defect inferior to the fossa ovalis (inferior sinus venosus type ASD, inferior vena caval defect), and coronary sinus defects.

The standard of care for the treatment of significant or symptomatic ASDs is percutaneous closure using several FDA-approved devices. Recently, this same therapy has been investigated for closure of physiologically significant PFOs. No devices are currently FDA approved that are specific to PFO-closure, however, this therapy is being performed using devices that are FDA approved for ASD-closure in patients with cryptogenic stroke. PFO-closure is also being investigated as a treatment of migraine headaches.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth covers percutaneous transcatheter closure of symptomatic atrial septal defect (ASD) in secundum position or for the closure of the fenestration in individuals who have undergone a fenestrated Fontan procedure. These procedures are considered medically necessary when using a device that has been FDA approved for that purpose and used according to the labeled indications.

Cardiovascular Policies, Continued

Percutaneous Transcatheter Closure for the Treatment of Atrial Septal Defects (ASD) and Patent Foramen Ovale (PFO), continued

SelectHealth covers percutaneous transcatheter closure of patent foramen ovale (PFO) using FDA approved closure devices *in limited circumstances*.

Criteria for coverage:

1. Patient has a documented history of recurrent, cryptogenic, clinically-evident transient ischemic episode or stroke, which has been verified by an independent, qualified neurologic specialist.
2. Patient has demonstrated the PFO to be hemodynamically significant as defined by EITHER one of the following:
 - a. Right-sided pressure or volume overload changes on imaging studies along with evidence of a large shunt (typically permanent right-to-left shunt); or
 - b. Documented orthodeoxia-platypnea (resting or exercise induced)

SelectHealth **does NOT cover percutaneous transcatheter closure of PFO for migraine prophylaxis or for any other indications** because its effectiveness for these indications has not been established. It is considered experimental and investigational in these circumstances.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp> or [the manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

There are several devices approved by the FDA for closure of ASDs. These include the AMPLATZER Septal Occluder, HELEX Septal Occluder, and the NMT Medical CardioSEAL STARFlex Septal Occlusion System. All these devices are inserted via a catheter in collapsed form, then once at the defect, the device opens, and occludes the defect.

Prior to October 31, 2006, the FDA approved 2 catheter systems under the Human Device Exemption (HDE) for patients with patent foramen ovale (PFO) and cryptogenic stroke due to presumed paradoxical embolism through a PFO and who have failed conventional drug therapy. The previously approved devices were the NMT Medical CardioSEAL STARFlex Septal Occlusion System and the AGA Medical Amplatzer PFO Occluder. As it was felt that these devices no longer met the criteria for the HDE exemption and needed to prove their efficacy through the PMA approval process, both manufacturers agreed to cease marketing their devices effective October 31, 2006.

Though no randomized, controlled trials have proven the PFO specific percutaneous devices to be safe and effective, the literature suggests that currently approved FDA devices are effective in closing both ASD and PFO. Anzola et al., for example, studied 140 patients who underwent percutaneous closure for PFO. At the 12-month follow-up, 91% had not detectable right-to-left shunt and only one CVA-like event

Percutaneous Transcatheter Closure for the Treatment of Atrial Septal Defects (ASD) and Patent Foramen Ovale (PFO), continued

had occurred. Bruch et al. reported on 66 patients with ASD, none of whom had residual shunting after 12 months. No evidence of recurrent thromboembolic events was observed in this population.

A 2004 study of 28 patients with ASD by Khositseth et al. found a 7% residual shunt rate at 12 months. A 3.6% recurrence rate for recurrent thromboembolic events was observed at 23 months. Yew et al. reported 5-year data on patients who underwent percutaneous ASD-closure. All patients experienced complete closure.

Subsequently, as the questions around the similarity between PFO and ASD physiology have been addressed in the above literature, one may be able to extrapolate that use of ASD-closure approved devices will be effective in PFOs. Supporting this supposition, several conference abstracts provide additional support for ASD-closure devices for treating PFO. In 58 patients, closed with either the Amplatzer PFO device or the Amplatzer Septal Occluder, residual shunt at 3 months was lower in the latter group. In 1000 patients treated with either device, serious adverse events were uncommon and the relative risk of CVA was 0.15 compared with historical controls.

It was noted that a Hayes Directory published in 2002 gave percutaneous closure of PFO and ASD a 'B' rating indicating a device with some proven benefit (i.e., use of the technology is supported by a moderate level of published evidence but further research is required to fully clarify clinical indications, contraindications, treatment parameters, comparison with other technologies, and/or impact on health outcomes). The report cited a lack of long-term follow-up data as a weakness in the literature.

These data suggest that ASD devices are effective at closing PFO and reducing risk for recurrent stroke, at least in the short-term. Long-term data are still lacking as well as comparative trials to examine the relative efficacy between percutaneous devices and medical therapy on stroke outcomes. Ongoing clinical trials may provide additional insight pertinent to this question.

In 2011, a literature review was performed, and guidelines provided by the Intermountain Medical Center Heart Institute identified a science advisory from the American College of Cardiology Foundation (ACCF), American Heart Association (AHA), American Stroke Association (ASA), and the American Academy of Neurology published in 2010. The advisory concluded the optimal therapy for prevention of recurrent stroke or transient ischemic attack in patients with cryptogenic stroke and PFO has not been defined. Although numerous observational studies have suggested a strong association between PFO and cryptogenic stroke, a causal relationship has not been convincingly established for the majority of affected patients. Treatment choices include medical therapy with antiplatelet agents or vitamin K antagonists, percutaneous device closure, or open surgical repair. Whereas suture closure of an incidental PFO is performed routinely during an operation undertaken for another indication, primary surgical repair is rarely advocated in the current era. The choice between medical therapy and percutaneous device closure has been the subject of intense debate over the past several years, albeit one that has not been adequately informed by randomized, prospective clinical trial data to permit an objective comparison of the relative safety and efficacy of these respective approaches. Enrollment in clinical trials has lagged considerably despite frequent calls for participation from the US Food and Drug Administration and major professional societies. Completion and peer review of ongoing trials are critical steps to establish an evidence base from which clinicians can make informed decisions regarding the best therapy for individual patients. The present advisory strongly encourages all clinicians involved in the care of appropriate patients with cryptogenic stroke and patent foramen ovale—cardiologists, neurologists, internists, radiologists, and surgeons—to consider referral for enrollment in these landmark trials to expedite their completion and help resolve the uncertainty regarding optimal care for this condition.

Based on a guideline for healthcare professionals from the American Heart Association/American Stroke Association published in 2011, the importance of PFO with or without atrial septal aneurysm for a first stroke or recurrent cryptogenic stroke, remains in question. No randomized controlled clinical trials comparing different medical therapies, medical versus surgical closure, or medical versus transcatheter closure, have been reported, although several studies are ongoing. Non-randomized comparisons of various closure techniques with medical therapy have generally shown reasonable complication rates and recurrence risk with closure at or below those reported with medical therapy. One study suggested a particular benefit in patients with > 1 stroke at baseline.

There is still debate on the possible mechanism of formation of WMLs in migraine. Subjects with migraine with aura (MA) have a two-fold risk of being a carrier of a cardiac right-to-left shunt (RILES) due to PFO compared with the general population. Patent foramen ovale, which can be detected by transcranial Doppler (TCD), is a risk factor for cryptogenic ischemic stroke in young patients, and its prevalence in patients with MA is about 45%.

Percutaneous Transcatheter Closure for the Treatment of Atrial Septal Defects (ASD) and Patent Foramen Ovale (PFO), continued

In 2010, Ueno et al. assessed the contribution of embolic etiologies, PFO and atrial septal aneurysm (ASA), to cerebral white matter lesions (WMLs) in ischemic stroke patients. They enrolled 115 patients (age, 69 +/- 11 years; 41 females); 49 (43%) were in the PFO group, 4 (3%) were in the ASA group, 23 (20%) were in the PFO-ASA group, and 39 (34%) were in the non-SA group. The PFO-ASA group had significantly increased WMLs compared to the other three groups ($p = 0.004$). On multiple logistic regression analysis, the coexistence of PFO and ASA was significantly associated with the degree of WMLs (odds ratio: 2.40; 95% confidence interval: 1.11-5.17; $p = 0.026$) when the PFO-ASA and non-SA groups were compared. They concluded that coexistence of PFO with ASA could play an important pathogenic role in WML severity.

Adami et al. performed the Shunt Associated Migraine (SAM) study. One hundred eighty-five patients (77% women) underwent a standardized headache and vascular risk factors questionnaire, contrast-enhanced transcranial Doppler, blood coagulation tests, and brain MRI. RLS was categorized into four grades: no shunt, < 10 microbubbles (mb), > 10 mb single spikes pattern, and > 10 mb shower/curtain pattern. Standard and fluid-attenuated inversion recovery T2-weighted MRI sequences were inspected for WMLs by three independent raters blinded to RLS grade. WML load was scored in the periventricular areas (PV-WMLs) with the Fazekas scale and in the deep white matter (D-WMLs) with the Scheltens scale. Interobserver agreement was good to excellent ($k = 0.64$ to 0.96 , $p < 0.0001$). WML load was then correlated between patients with and without RLS. They concluded that the presence of right-to-left shunt does not increase white matter lesion load in patients who have migraine with aura.

In summary, these studies provide new information on options for closure of PFO and generally indicate that short-term complications with these procedures are rare and for the most part minor. Unfortunately, long-term follow-up is lacking. Event rates over 1–2 years after transcatheter closure ranged from 0%–3.4%. Studies in which closure was compared with medical treatment alone indicate trends toward better outcomes with closure. Windecker et al. reported a very high 3-year event rate of 33.2% in 44 medically treated patients compared with 7.3% in 59 similar patients treated with PFO-closure. The generally low rates of stroke in the closure series, the lack of robust outcome differences in the 3 non-randomized comparison studies, and the overall absence of controlled comparisons of closure strategies with medical treatment alone, reinforce the need to complete randomized clinical trials comparing closure with medical therapy. A 2009 statement from the AHA/ASA/ACC strongly encourages all clinicians involved in the care of appropriate patients with cryptogenic stroke and PFO—cardiologists, neurologists, internists, radiologists, and surgeons, to consider referral for enrollment in these landmark trials to expedite their completion and help resolve the uncertainty regarding optimal care for this condition.

Billing/Coding Information

CPT CODES

Covered: For the indications outlined above

93580 Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant

HCCPS CODES

C1760 Closure device, vascular (implantable/insertable)

C1817 Septal defect implant system, intracardiac

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Cardiovascular Policies, Continued

Percutaneous Transcatheter Closure for the Treatment of Atrial Septal Defects (ASD) and Patent Foramen Ovale (PFO). continued

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PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY STENTING (PTAS) FOR THE TREATMENT OF INTRACEREBRAL DISEASE

Policy # 495

Implementation Date: 12/5/11

Review Dates: 7/18/13, 6/19/14, 6/11/15, 6/16/16, 6/15/17, 9/18/18, 8/7/19, 8/20/20, 8/19/21, 7/21/22

Revision Dates:

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Cerebrovascular disease (CVD) refers to a group of conditions that affect the circulation of blood to the brain, potentially limiting blood flow to affected areas of the brain. This can manifest itself as either a stroke or transient ischemic attack (TIA).

Standard therapy for patients with atherosclerotic disease is antiplatelet therapy with aspirin or other antiplatelet agents and control of other risk factors. Intracerebral stenting of identified atherosclerotic lesions is also offered to some patients. The stent and delivery catheter consist of an expandable stainless-steel device that provides structural support for a blood vessel, helping to keep it open. The stent is a self-expanding, metal (nitinol) mesh in the shape of a tube. It is intended for use in the treatment of patients with recurrent intracranial stroke due to atherosclerotic disease who did not respond to medical therapy.

Commercial Plan Policy/CHIP (Children's Health Insurance Policy)

SelectHealth **does NOT cover percutaneous transluminal angioplasty stenting (PTAS) in the treatment of intracranial disease.** The current evidence has not demonstrated this treatment as a clinical benefit for the initial therapy of intracerebral atherosclerotic disease.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp> or [the manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Percutaneous Transluminal Angioplasty Stenting (PTAS) for the Treatment of Intracerebral Disease, continued

Summary of Medical Information

A Medical Technology Assessment performed in October 2011 identified 4 systematic reviews. All systematic reviews were published in 2006 or 2007 and no updates are available and long-term outcomes were not presented. Questions concerning durability and success of 2 different stents were raised. All concluded that current evidence at the time of their reviews was insufficient to warrant broad coverage outside an investigational setting.

Seventeen peer-reviewed papers studying PTAS were identified. These studies were small in size and supported the use of stenting in patients with > 50% atherosclerotic narrowing of any intracerebral vessel with significant success and relatively low risk of complications. For example, the largest study by Jiang, involved 637 patients and 670 lesions. It was a retrospective study comparing 2 different stents. A relatively low risk of complications, 6.1% within 30 days of the procedure was demonstrated. This study's limitations include the short duration of follow-up (1 month), and the lack of randomization or blinding.

The most recent article on this topic was a randomized controlled multi-centered study published in September 2011 by Chimowitz et al. This study compared percutaneous transluminal angioplasty and stenting (PTAS) with aggressive medical management in patients with 70%–99% narrowing. The 2 groups had similar initial clinical findings, and both achieved similar outcomes to medical management including improved blood pressure control, LDL reduction, and diabetic control. Aspirin and clopidogrel were used. The interventional group developed a much higher rate of complications including hemorrhagic stroke and death within the first 30 days. The medical group also achieved a lower rate of stroke reduction than what was expected compared with previous studies evaluating the role of medical therapy in the prevention of recurrent stroke. "The 30-day rate of stroke or death in the PTAS group (14.7) is substantially higher than the rates previously reported with the use of the Wingspan stent in the Phase I trial and in 2 registries (rates ranging from 4.4-9.6)." The rate of stroke was much lower at 5.5% with expected rate of 10.7%. The expected 1-year rate of stroke or death was 25% and realized rate in this study was 12.2%. These results were carefully analyzed to attempt to explain the difference in realized and expected outcomes.

Despite experienced interventional radiologists, similar initial clinical parameters, and similar results in aggressive medical management between the 2 groups, the much higher complication rate within the first 30 days of the procedure which included stroke and death led to the early suspension of this trial.

Also discouraging was that 4% of patients (total of 9) who crossed over from the medical group to the PTAS group due to recurrent strokes also had a high rate of complications. Three of the 9 patients suffered a stroke after PTAS within 30 days. Despite attempts from stent manufacturers to minimize restenosis the rate of restenosis occurs "23%-30% within 6 months after intracranial PTAS and could also lead to later stroke."

In conclusion, the most recent large clinical trial, Stenting and Aggressive Medical Management for Preventing Recurrent stroke in Intracranial Stenosis (SAMMPRIS), 14% of patients treated with angioplasty combined with stenting experienced a stroke or died within the first 30 days after enrollment compared with 5.8% of patients treated with medical therapy alone. Even though there have been many studies dating back to 2002, the literature has shown for patients with intracranial arterial stenosis, aggressive medical management was superior to PTAS with the use of either the Wingspan or the Neurolink stent systems. The risks of early stroke after PTAS were high and the risk of stroke with aggressive medical therapy alone was lower than expected. Therefore, the use of PTAS with or without medical management does not seem to be a reliable form of treatment for intracranial stroke.

Billing/Coding Information

Not covered: Investigational/Experimental/Unproven for this indication

CPT CODES

61635 Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed

HCPCS CODES

C1874 Stent, coated/covered, with delivery system

C1875 Stent, coated/covered, without delivery system

C1876 Stent, non-coated/non-covered, with delivery system

C1877 Stent, non-coated/non-covered, without delivery system

Percutaneous Transluminal Angioplasty Stenting (PTAS) for the Treatment of Intracerebral Disease, continued

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SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR

Policy # 535

Implementation Date: 8/9/13

Review Dates: 8/28/14, 8/20/15, 8/25/16, 8/17/17, 7/25/18, 6/13/19, 6/18/20, 8/11/21, 7/21/22

Revision Dates: 8/24/21

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2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/ CMS), and SelectHealth Community Care (Medicaid/ CHIP) plans. Refer to the "Policy" section for more information.

Description

Tachyarrhythmias are broadly characterized as supraventricular tachycardia (SVT), defined as a tachycardia in which the driving circuit or focus originates, at least in part, in tissue above the level of the ventricle (i.e., sinus node, atria, AV node, or the bundle of His) and ventricular tachycardia (VT), defined as a tachycardia in which the driving circuit or focus solely originates in ventricular tissue or Purkinje fibers. Sustained arrhythmias are an important cause of sudden death. Ventricular arrhythmias that occur in the absence of structural heart disease or a defined ion channel abnormality are referred to as *idiopathic* and are usually benign. Ventricular arrhythmias are responsible for most of the 150,000 to 350,000 sudden deaths that occur annually in the United States and account for approximately 13% of all mortality. Without immediate action, ventricular tachycardia can degenerate to ventricular fibrillation and lead to sudden death. Short-term goals of treatment are to stabilize hemodynamically unstable patients, transfer them to a hospital immediately, and stop ventricular tachycardia.

Transvenous implantable cardiac defibrillators (ICDs) have been used for years and are designed to detect a life-threatening, rapid heartbeat emanating from the lower chamber of the heart, and then deliver an electrical discharge intended to terminate the rhythm so that it is converted back to normal.

Conventional ICDs consist of a generator, which is usually implanted in a pocket in the pectoral region below the left shoulder. The transvenous right ventricular lead contains the shock coils and pacing electrode. Additional leads may be connected for right atrial or left ventricular pacing, sensing, and defibrillation. The ICD can be implanted under local anesthesia with the leads inserted through an incision into a vein and guided to the heart under fluoroscopy. The lead is attached to the heart muscle, while the other end of the lead is attached to the pulse generator.

Subcutaneous implantable defibrillators (S-ICD) have recently been approved in an effort to reduce morbidity and procedure-related complications. The S-ICD consists of an electrically active pulse generator, which is implanted near the left mid-axillary line and a subcutaneous lead, consisting of sensing electrodes and a shocking coil, which is tunneled 1 to 2 cm to the left of the mid-sternal line. The current FDA approved S-ICD weighs 145 grams and has a lithium battery with a projected life of 5 years; therapy consists of 80-joule biphasic transthoracic shocks and 30 seconds of post-shock pacing.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth covers subcutaneous implantable defibrillators for members 10 years of age and older who would require a transvenous cardiac defibrillator for ventricular tachyarrhythmias for the treatment of life-threatening ventricular tachyarrhythmias.

SelectHealth does not cover subcutaneous implantable defibrillators for patients who have symptomatic bradycardia, incessant ventricular tachycardia, or spontaneous,

Cardiovascular Policies, Continued

Subcutaneous Implantable Defibrillator, continued

frequently recurring ventricular tachycardia, that is reliably terminated with antitachycardia pacing.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

A recent review of subcutaneous implantable cardiac defibrillators (S-ICDs) identified eight peer-reviewed published studies that met inclusion criteria for this report. No systematic reviews on the safety, efficacy, or cost-effectiveness of subcutaneous implantable defibrillators have been published. These studies had a mean duration ranging from 7.2 to 22.3 months. The studies documented efficacy of 89.6% to 100% in aborting dysrhythmias. These studies also identified inappropriate shocks occurring from 0% to 22% of the time. These numbers compare favorably to historical rates for efficacy and inappropriate shocks for transvenous ICDs which have demonstrated inappropriate shock rates as high as 30%.

In general, single shocks, whether preceded by symptoms or not, are most often caused by the appropriate detection and treatment of a ventricular tachyarrhythmia. Conversely, multiple transvenous ICD discharges often result from the detection of other arrhythmias or signals that are inaccurately classified as a ventricular tachyarrhythmia. Thus, transvenous ICD therapy often is inappropriately delivered for sinus tachycardia, or other supraventricular tachycardias with rapid AV conduction. To this point, Jarman et al., Kobe et al., and Olde Nordkamp et al., all noted that inappropriate shocks (5.6% of all shocks) were associated with T-wave oversensing in patients with S-ICDs. During the MADIT II Trial of transvenous ICDs, Daubert et al. found that one or more inappropriate shocks occurred in 11.5% of the 719 patients enrolled.

No cost-effectiveness studies have been completed comparing S-ICD to either transvenous ICD or to medical treatment.

Using the Grade evidence system, which rates the body of evidence Grade 1–3, with additional rankings of A–C, the current body of evidence has a Grade evidence level of 2B. This is primarily due to the limitations in evidence, where risks and magnitude of benefits appear to be finely balanced in comparison to medical treatment, or conventional ICD placement, and where the quality of evidence is moderate (cohort studies with short follow-up times).

Billing/Coding Information

CPT CODES

33240	Insertion of implantable defibrillator pulse generator only; with existing single lead
33241	Removal of implantable defibrillator pulse generator only
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system

Cardiovascular Policies, Continued

Subcutaneous Implantable Defibrillator, continued

33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed
33271	Insertion of subcutaneous implantable defibrillator electrode
33272	Removal of subcutaneous implantable defibrillator electrode
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system

HCPCS CODES

C1721	Cardioverter-defibrillator, dual chamber (implantable)
C1722	Cardioverter-defibrillator, single chamber (implantable)
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)
C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)
G0448	Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing

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TOTAL ARTIFICIAL HEART

Policy # 436

Implementation Date: 3/22/10

Review Dates: 8/16/11, 8/15/13, 8/28/14, 8/20/15, 8/25/16, 12/15/16, 8/17/17, 7/20/18, 6/13/19, 6/18/20, 7/12/21, 7/21/22

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Description

Heart failure (HF) is a common complex clinical syndrome that can result from any structural or functional cardiac disorder that impairs the ability of the ventricle to fill with or eject blood.

Heart failure is classified based upon the history, including assessment of New York Heart Association (NYHA) functional class, and physical examination in conjunction with certain diagnostic tests. Both establish the primary cause of the heart failure and provide a reasonable estimate of its severity. The NYHA classification system, most used to quantify the degree of functional limitation imposed by HF, was first developed by the New York Heart Association (NYHA). This system assigns patients to one of four functional classes, depending on the degree of effort needed to elicit symptoms.

- Class I - symptoms of HF only at activity levels that would limit normal individuals
- Class II - symptoms of HF with ordinary exertion
- Class III - symptoms of HF with less than ordinary exertion
- Class IV - symptoms of HF at rest

Additionally, heart failure has 4 stages (Stage A – Stage D) that reflect the development and progression of the condition:

- Stage A: at high risk for HF but without structural heart disease or symptoms of HF, recommended treatment to control the risk factor and close monitoring.
- Stage B: Structural heart disease but without signs or symptoms of HF, recommended treatment is to start heart failure guided medical therapies.
- Stage C: Structural heart disease with prior or current symptoms of HF, recommended treatment is guided medical therapies and devices therapy if indicated.
- Stage D: Refractory HF requiring specialized interventions, recommended treatments are Heart transplantation and mechanical circulatory support in selected patients and palliative care.

In addition to left ventricular assist devices, total artificial heart transplants (TAH-t) are used in patients with end-stage heart disease who need a heart transplant, who have failed optimal medical therapy, and for who no other reasonable medical or surgical treatment options are available. TAH-t is typically chosen in patients with biventricular failure rather than left ventricular failure only or who are ineligible for other ventricular devices when a donor organ is not immediately available. Total artificial hearts have been used as a bridge to transplant (temporary) or as a destination therapy (permanent).

The SynCardia Total Artificial Heart (SynCardia Systems Inc., Tucson, AZ) is a pulsating is a pneumatically driven, biventricular replacement device with 2 mechanical valves in each ventricle and 2

Cardiovascular Policies, Continued

Total Artificial Heart, continued

exiting drivelines. large power-generating console, which operates and monitors the device. A smaller portable controller, the Freedom Driver, is also available to help to discharge selected patients.

The total artificial heart continues to be studied extensively, as both a bridge to transplant and a destination therapy in patients with intractable (stage 4) heart failure, failing on medication therapy alone.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth covers the SynCardia total artificial heart as a bridge to transplant in limited circumstances.

Members must meet ALL the following criteria:

1. Intractable biventricular failure unresponsive to maximal medical therapy; **AND**
2. Member is an approved candidate for donor heart transplantation and has been registered as a transplant candidate; **AND**
3. Member is not a candidate for left ventricular assist device (LVAD) implantation; **AND**
4. Member has adequate space in the chest area where the ventricles will be removed. This is generally defined as a body surface area (BSA) > 1.7 m² and a distance between the sternum and the 10th anterior vertebral body measured by CT is > or = 10 cm.

SelectHealth does NOT cover any other total artificial heart device (e.g., AbioCor).

The lack of evidence does not support adequate safety or efficacy. This meets the plan's definition of investigational/experimental.

SelectHealth does NOT cover any total artificial heart device as destination therapy.

The lack of evidence does not support adequate safety or efficacy. This meets the plan's definition of investigational/experimental.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

The number of studies available assessing total artificial heart transplant (TAH-t) as a bridge to transplant or destination therapy is quite limited. Only 3 studies met the inclusion criteria for review, and none were randomized to include an arm comparing the efficacy and safety of TAH-t to left ventricular assist device (LVAD) implantation. None of the reviews assessed the AbioCor device.

Cardiovascular Policies, Continued

Total Artificial Heart, continued

These studies, as expected, tended to have small study numbers, though, the largest by Platis et al. published in 2009 assessed the outcomes of 715 SynCardia transplants over 16 years. Overall, the studies demonstrated improved mortality as compared to watchful waiting but also demonstrated significant complications. From the studies included in this report, the table below provides a parallel comparison of the various trials and the outcomes as they compare to LVAD used as a bridge to transplant.

Characteristic	Total Artificial Heart Device	Left Ventricular Assist Device
Survival to transplant post-implantation	71.5%–79%	69%–86.9%
1-year survival post donor heart transplant	57%–90%	63%–66.6%
5-year survival post donor heart transplant	34%–81%	
Re-exploration for bleeding	47%	15.6%–33.3%
Respiratory failure	4.7%–44%	
Renal failure requiring temporary dialysis	40%	
Infection	33%–85%	8%–19%
Neurological event	7%–16%	4.8%–8.0%
GI bleeding		15.6%
Device failure	2.3%	0%–3.1%

The most recent update was from Interagency Registry for Mechanically Assisted Circulatory Support (INTERMACS) report, of 450 implants, 266 were transplanted and 162 died on support. One-year survival depended on center experience; for centers that had implanted more than 10 TAHs, survival was near 70%, vs. 40% for centers with 10 or less. Combining all centers, competing outcomes analysis demonstrated an overall likelihood of transplantation of 53%, mortality of 34%, and 13% alive on a device by 12 months. The most common cause of death was multisystem organ failure (36% of deaths), followed by neurologic injury (18%) and elective withdrawal of support (12%).

Billing/Coding Information

Covered: For the conditions outlined above

CPT CODES

- 33927** Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy
- 33928** Removal and replacement of total replacement heart system (artificial heart)
- 33929** Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)

HCPCS CODES

No specific codes identified

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Cardiovascular Policies, Continued

Total Artificial Heart, continued

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TRANSCATHETER AORTIC VALVE IMPLANT (TAVI) TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR)

Policy # 444

Implementation Date: 5/26/10

Review Dates: 4/21/11, 12/18/14, 10/20/16, 9/19/18, 12/1/18, 12/18/19, 12/23/20, 12/18/21, 1/14/23, 12/21/23

Revision Dates: 8/5/13, 11/06/13, 4/3/15, 7/10/15, 12/9/16, 1/20/17, 12/21/17, 9/24/18, 8/23/19, 1/4/22

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

There are 3 primary causes of valvular aortic stenosis (AS): a congenitally abnormal valve with superimposed calcification (unicuspid or bicuspid), calcific disease of a trileaflet valve, and rheumatic valve disease. In North America and Europe, aortic valve disease is primarily due to calcific disease of a native trileaflet or a congenital bicuspid valve. Worldwide, rheumatic valve disease is most common; mitral valve involvement invariably accompanies rheumatic aortic valve disease.

Many patients do not develop symptoms until severe valve obstruction (valve area < 1.0 cm²) is present, while some patients become symptomatic when the stenosis is less severe (1.5–2.0 cm²), particularly, if there is coexisting aortic regurgitation. Replacement of the aortic valve is the only effective treatment for severe AS. Standard aortic valve replacement surgery involves the patient undergoing a sternotomy and being placed on cardio bypass. Not all patients can tolerate such an extensive procedure.

Less invasive transcatheter techniques for aortic valve replacements have been developed. Currently, FDA approved transcatheter valves include the balloon expandable Sapien valve and self-expandable CoreValve systems. Both Sapien and CoreValve consist of metal frames which support tissue valves. In June 2015, the first repositionable transcatheter valve, the CoreValve Evolut R received FDA approval. This is the first valve which can be repositioned after initial deployment, so as to reduce valve leakage or other issues.

Approaches to transcatheter aortic valve replacement include retrograde delivery with transfemoral, transaortic, and subclavian access, as well as antegrade delivery with the transapical approach.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers FDA approved transcatheter aortic valve implants/replacements when EITHER of the following criteria are met (A or B).

- A. TAVR will be approved if recommended by Intermountain Health Cardiovascular Clinical Program,

OR

- B. For all other clinicians, TAVR will be approved when **ALL** the following criteria are met:

Cardiovascular Policies, Continued

Transcatheter Aortic Valve Implant (TAVI), Transcatheter Aortic Valve Replacement (TAVR), continued

Criteria for Coverage (Must meet ALL):

1. Device has been approved by the FDA [PMA or 510(k)]
2. Patient has one of the following conditions:
 - a. Severe native calcific aortic stenosis demonstrated by at least 1 of the following:
 - 1) An aortic valve area $\leq 1.0\text{cm}^2$
 - 2) A mean aortic valve gradient greater than 40mmHg
 - 3) A jet velocity greater than 4.0m/sec
 - b. Failure (stenosed, insufficient, or combined) of a surgical bioprosthetic aortic valve
 - c. Severe aortic regurgitation with justification from a cardiothoracic surgeon
3. Patient has documented New York Heart Association (NYHA) functional class II or greater
4. Patient has been evaluated face-to-face for open heart surgery by at least 1 cardiologist and 1 cardiothoracic surgeon, with full documentation, and determined to be a candidate for TAVR
5. Patient does not have a life expectancy < 12 months due to non-cardiac co-morbid conditions

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For this policy, specifically, there are no CMS criteria available; therefore, the Select Health Commercial policy or InterQual criteria apply. Select Health applies these requirements after careful review of the evidence that supports the clinical benefits outweigh the clinical risks. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

TAVR for Aortic Stenosis: A May 2010 Medical Technology Assessment found the published literature available on this topic was limited. Only 1 technology assessment and 4 primary studies were identified. However, it is important to note the 1 technology assessment was published in June 2006 and was performed by a highly respected organization—the National Institute for Health and Clinical Excellence (NICE) out of the U.K. This technology assessment aimed to provide conclusions concerning current evidence of transcatheter aortic valve implantation. Aortic regurgitation and transvalvular gradient both appeared to decrease significantly in postoperative follow-up. Most of the literature focused on the implementation of these 2 devices. These are 2 major indicators/complications associated with diseased aortic valves.

A Medical Technology Assessment performed in June 2012 identified 23 new papers published since the last review in 2010, reflecting data at least 2 years post-procedure. In February 2012, Bleiziffer et al. reported 2-year results in 227 patients who received TAVI/TAVR. Clinical and echocardiographic investigations were performed at 6 months, 1 year, and 2 years. Survival was 88.5% at 30 days, 75.9% at 6 months, 74.5% at 1 year, and 64.4% at 2 years. Patients improved significantly in New York Heart Association class after 6 months (from 3.2 +/- 0.5 to 1.7 +/- 0.7, $p < .001$) and up to 2 years (1.9 +/- 0.7). Cumulative incidences of myocardial infarction, stroke, and life-threatening or major bleeding were 2.7%, 6.2%, and 16.2% at 2 years, respectively. Moderate or severe prosthetic regurgitation was present in 8% of patients at 2 years. In 6% of patients, the paravalvular or valvular regurgitation grade increased

Transcatheter Aortic Valve Implant (TAVI), Transcatheter Aortic Valve Replacement (TAVR), continued

significantly over time. They concluded transcatheter aortic valve implantation may be considered the treatment of choice for aortic valve stenosis in elderly patients with an increased risk for surgery with a heart-lung machine.

A prospective multicenter observational study published in 2011 by D'Onofrio et al. assessed early and 2-year outcomes after TAVI/TAVR in 179 patients. Patients underwent clinical and echocardiographic follow-up visits at hospital discharge, 3 and 6 months after TAVI/TAVR, and every 6 months thereafter. Seventeen severe intraoperative complications occurred in 13 (7.3%) patients. Thirty-day mortality was 3.9% (7 patients). Mean follow-up was 9.2 +/- 6.5 months. Late mortality occurred in 9 patients. Two-year survival was 88% +/- 3%. An intraoperative severe complication was identified as the only significant independent predictor of 1-year mortality. A significant benefit was found when comparing 2-year survival of the second versus the first 50% patients at each center (93% +/- 2% vs. 84% +/- 3%; $p = 0.046$). A significant reduction of both mean and peak gradients from the preoperative to the postoperative period, which remained stable during follow-up, was found.

In May 2012, the Centers for Medicare and Medicaid (CMS) issued a national coverage determination (NCD) outlining criteria under which it would provide coverage of TAVR/TAVI. Current evidence demonstrates improved mortality for patients who are ineligible for standard AVR, though, some increased morbidity risks exist especially for early stroke problems. Nonetheless, several studies identify this therapy to meet current standards for cost-effectiveness as defined by QALY's.

Transcatheter aortic valve replacement (TAVR) has emerged as a therapeutic alternative for patients with severe aortic stenosis whose surgical risk is very high or prohibitively high, in part due to findings of the PARTNER trials (inoperable patients: *NEJM JW Cardiology May 2012* and *N Engl J Med 2012*; 366:1696; high-risk patients: *NEJM JW Cardiology May 2012* and *N Engl J Med 2012*; 366:1686). Two manufacturer-sponsored analyses from PARTNER provide insights into the long-term survival patterns of such patients.

Kapadia and colleagues focused on 358 patients with severe aortic stenosis (mean age, 83; mean Society of Thoracic Surgeons estimated risk of 30-day mortality after operative AVR [STS], 11.7%; women, 54%) who were deemed inoperable because of mortality risk or anatomical factors. Individuals were randomized to TAVR or nonoperative standard therapy. At 5 years, mortality was 71.8% in the TAVR group and 93.6% in the standard therapy group. There were six standard-therapy survivors with follow-up data; five received AVR outside the study. Of 49 survivors in the TAVR group, 86% had modest symptom burden (New York Heart Association class I or II symptoms). Prosthetic valve deterioration was not evident in the TAVR group.

Mack and colleagues followed 699 patients with severe aortic stenosis (mean age, 84; mean STS score, 11.7%; women, 43%) who were considered at high but not prohibitive risk for surgery. Individuals were randomized to TAVR or surgical AVR (SAVR). At 5 years, the two groups had statistically similar mortality—67.8% with TAVR and 62.4% with SAVR. No postprocedural events requiring repeat valve replacement were reported. Moderate-to-severe aortic regurgitation 30 days after the procedure occurred in 14% of the TAVR group and 1% of the SAVR group ($P < 0.0001$) and was identified as a risk factor for death.

Aortic Stenosis with Aortic Insufficiency: A literature review completed in November 2016 reviewed the evidence as it relates to TAVR use in aortic insufficiency. This review identified one systematic review and 3 primary studies were identified which met inclusion criteria. In all, 159 patients were studied, of which, 92 (57.9%) received TAVR for aortic insufficiency. The systematic review by Phan et al., though, specific to AI, investigated the use of TAVR in patients with a left ventricular assist device. Though the report showed promise for the procedure, it does not generally address the question of the procedure's clinical utility in most patients with traditional AI symptoms.

The 3 primary studies were all published since 2013. They consist of multi-center, prospective, or retrospective patient populations. No long-term data has been published to date on the use of this intervention for the treatment of AI. Only 1 of the 3 (33%, Wilder et al.) compared outcomes to other surgical methods. Survival outcomes from studies by Roy et al. and Testa et al. varied widely even with use of the same device (CoreValve) likely due to differing patient populations and inclusion criteria. Mortality from AI/AR in symptomatic patients is > 10% per year. The assessed studies show greater than double the mortality rate in patients treated with TAVR for AI than previously published outcomes from patients not undergoing surgical management for the treatment of AI. One obvious limitation of this

Transcatheter Aortic Valve Implant (TAVI), Transcatheter Aortic Valve Replacement (TAVR), continued

conclusion is the lack of randomized, controlled published data regarding TAVR in patients with primary symptomatic AI.

Though the evidence regarding TAVR in aortic insufficiency is weak, it demonstrates net benefit in high-risk patients who are otherwise not surgical candidates. In addition, the FDA has approved the Edwards Sapien XT for use in aortic insufficiency in patients with a bioprosthetic valve (valve-in-valve procedure).

As experience with TAVR continues to grow, potential candidates for TAVR continue to be explored. Whereas initial candidates were either ineligible for surgery or have serious surgery risk for post-operative morbidity or mortality. A body of literature has been published related to performing TAVR in patients with intermediate surgical risk (STS score ≥ 3 and ≤ 10). A review of the published literature recently completed identified four systematic reviews and 14 primary studies related to patients with intermediate surgical risk undergoing TAVR. All 4 systematic reviews were published in 2016 and the primary studies have all been published since 2012. These studies represent assessment of > 17,000 intermediate risk patients, of which, > 8,800 received TAVR.

The four systematic reviews by Arora et al., Khan et al., Siemieniuk et al., and Zhou et al., reached similar conclusions that all-cause mortality rates did not differ to a statistically significant degree between SAVR and TAVR-treated intermediate-risk patients. From the primary literature studies by Abdul-Jawad Altisent et al., D'Errigo et al., Fanning et al., Kodali et al., Leon et al., and Thourani et al., it was also suggested the rate of stroke was lower in TAVR than in SAVR.

One concern noted from the studies was related to the need for permanent cardiac pacemaker placement. Nine of the primary studies and the four systematic reviews reported on pacemaker implantation. All the systematic reviews reported an increased incidence of pacemaker implantation in TAVR vs. SAVR patients. This rate varied in the studies, from 2 to 15 times the incidence of pacemaker placement TAVR compared to SAVR.

Conclusions drawn from the recently published data on TAVR for intermediate risk patients from 2012 has illustrated mortality and pacemaker implantation rates in nearly 8,000 patients. Most of the literature compared TAVR to SAVR and illustrated comparable mortality rates at follow-up periods between 1 and 24 months. However, substantially more pacemakers are implanted in TAVR patients than in those receiving standard surgical treatment.

Billing/Coding Information

Covered: For the circumstances outlined above

CPT CODES

- | | |
|--------------|---|
| 33361 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach |
| 33362 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach |
| 33363 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach |
| 33364 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach |
| 33365 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy) |
| 33366 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy) |
| 33367 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure) |

Transcatheter Aortic Valve Implant (TAVI), Transcatheter Aortic Valve Replacement (TAVR), continued

- 33368** Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)
- 33369** Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)
- 33405** Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
- 93355** Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D

Not Covered: Considered investigational

- 93591** Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve

HCPCS CODES

No specific codes identified

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The codes for treatments and procedures applicable to this policy are included 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.



TRANSCATHETER PULMONARY VALVE REPLACEMENT

Policy # 483

Implementation Date: 4/11/11

Review Dates: 6/21/12, 6/20/13, 4/17/14, 5/7/15, 4/14/16, 4/27/17, 7/25/18, 4/27/19, 11/11/19, 5/26/21, 9/15/22, 10/17/23

Revision Dates: 5/21/16, 2/13/20, 6/17/21

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

The pulmonary valve is made up of 3 thin pieces of tissue called leaflets that are arranged in a circle, much like a 3-piece pie. With each heartbeat, the valve opens in the direction of blood flow, into the pulmonary artery and continuing to the lungs, and then closes to prevent blood from flowing backward into the right ventricle of the heart. In pulmonary valve stenosis, 1 or more of the leaflets may be defective or too thick, or the leaflets may not separate from each other properly. If this happens, the valve doesn't open correctly, restricting blood flow. Pulmonary valve stenosis usually occurs when the pulmonary valve doesn't grow properly during fetal development. It's not known what causes the valve to develop abnormally. Adults occasionally have the condition as a complication of another illness, but most of the time pulmonary valve stenosis develops before birth.

As the condition advances, patients may develop symptoms of shortness of breath or fluid retention. In these instances, medications may be prescribed to control shortness of breath, reduce the heart's workload, or regulate the heart's rhythm. For most people, medication alone cannot slow the progression of pulmonary valve disease. Once severe or moderately severe stenosis develops, patients will often require surgical intervention. The 2006 ACC/AHA guidelines recommend balloon valvotomy in symptomatic patients with a peak systolic gradient > 30 mmHg and in asymptomatic patients with peak systolic gradient > 40 mmHg (moderate-to-severe disease). Standard surgery involves open sternotomy with inherent risks to cardiovascular, pulmonary, and infectious complications.

A newer approach has been developed which avoids the necessity of open-heart surgery. Transcatheter valve implantation involves placement of an artificial valve in the affected valve via a catheter inserted through a vein such as the femoral vein or jugular vein. Currently, only two valves have obtained FDA approval, the Medtronic Melody Transcatheter Pulmonary Valve (Medtronic, Inc., Santa Ana, CA) and the Edwards SAPIEN XT Transcatheter Heart Valve (Edwards Lifesciences Corporation Irvine, CA). With both these valves, the heart valve is first crimped down onto the catheter's balloon and then is fished through a vein in the groin and into the right side of the heart where it is placed into position within the pulmonary valve. The small balloon is then inflated to open the valve into position, the catheter is removed from the body, and then immediately becomes the new pulmonary valve.

Harmony TPV is the first FDA-approved transcatheter valve system specifically designed to treat severe pulmonary regurgitation in patients with a native or surgically-repaired right ventricular outflow tract (RVOT); offering patients a minimally invasive treatment option.

The Harmony TPV was designed in an effort to offer a treatment alternative for patients with Congenital Heart Disease (CHD), specifically the 80 percent of CHD patients born with right ventricular outflow tract anomalies who undergo a surgical repair early in life. For these patients, the Harmony TPV provides a less invasive option to restore normal valve function later in life. The minimally invasive TPV therapy

Cardiovascular Policies, Continued

Transcatheter Pulmonary Valve Replacement, continued

builds off of the proven Melody TPV technology, the first transcatheter heart valve available anywhere in the world, which has been implanted in more than 10,000 patients worldwide.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

Select Health covers Transcatheter Pulmonary Valve Replacement with an FDA approved device when either A or B are met:

A. Will be approved if recommended by Intermountain Health Cardiovascular Clinical Program,

OR

B. For all other clinicians, will be approved when either of the following criteria are met:

1. Select Health covers Transcatheter Pulmonary Valve Replacement with an FDA approved device (e.g., Harmony valve) for pediatric and adult patients who meet the following conditions:
 - i) Severe pulmonary regurgitation (i.e., severe pulmonary regurgitation as determined by echocardiography and/or pulmonary regurgitant fraction \geq 30% as determined by cardiac magnetic resonance imaging)
 - ii) Who have a native or surgically-repaired right ventricular outflow tract and are clinically indicated for surgical pulmonary valve replacement; or
2. Select Health covers Transcatheter Pulmonary Valve Replacement with an FDA approved device (e.g., Melody Transcatheter Pulmonary Valve or Sapien XT) for the management of pediatric and adult patients with prior surgical valve replacement when the following criteria are met:
 - i) Dysfunctional RVOT conduits with a clinical indication for intervention, **and** either of the following:
 - a) \geq Moderate pulmonary stenosis, **or**
 - b) \geq Moderate pulmonary regurgitation

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For this policy, specifically, there are no CMS criteria available; therefore, the Select Health Commercial policy or InterQual criteria apply. Select Health applies these requirements after careful review of the evidence that supports the clinical benefits outweigh the clinical risks. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp> or [the manual website](#)

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit

Transcatheter Pulmonary Valve Replacement, continued

their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

A Medical Technology Assessment performed in March 2011 identified 3 systematic reviews and 8 peer-reviewed journal articles related to percutaneous transcatheter pulmonary valve implantation. Notable, is the fact that the 3 systematic reviews were completed by well-respected organizations: Hayes, NICE, and the Australia and New Zealand Horizon Scanning Network.

Though the Hayes systematic review completed in 2010 was a “Prognosis Notes” rather than a “Directory Report,” this reflects the limited evidence currently available on the Melody device; it provided insight into the current state of the evidence, specifically regarding the Melody device. It reported: “PPVI with the Melody Valve system is feasible and may delay open heart surgery in selected patients with failing RVOT conduits, but the long-term efficacy of this intervention to reduce the lifetime risk for exposure to multiple pulmonary valve surgeries is still being evaluated.” It also noted, importantly, that long-term durability remains unknown and the appropriate patient selection criteria remain undefined.

The NICE guidance, though completed in 2007, holds remarkably similar findings to that of Hayes’ “Prognosis Notes.” It notes most of the evidence was derived from a small number of patients, but short-term efficacy was good. It too, noted little evidence related to long-term efficacy; safety was also noted to not be a concern.

The Australia and New Zealand Horizon Scanning Network compared bare-metal stenting (BMS) to percutaneous pulmonary valve implantation (PPVI). Though use of BMS to treat pulmonary stenosis is not commonly performed in the US, this review noted no major complications for BMS or PPVI in the perioperative period, and a complication rate of 9% over the median 28.4-month follow-up period. Additionally, it observed the mean pulmonary artery diastolic pressure increased significantly after PPVI compared to BMS, indicating that pulmonary valvular competence was restored (9 mmHg before BMS vs. 11 mmHg after PPVI; $p = 0.048$). Pulmonary regurgitation was virtually eliminated following PPVI as indicated by measurements of pulmonary regurgitation fraction (41.4% after BMS vs. 3.6% after PPVI; $p < 0.001$). Right ventricular end diastolic volume was also significantly lower (98.3 mL/m² vs. 85.3 mL/m², $p = 0.021$) and there was a significant improvement in effective right ventricular stroke volume after PPVI, compared with the post-BMS state (32.6 mL/m² vs. 41.0 mL/m²; $p = 0.004$). All indications were for correction of the underlying hemodynamic issues related to the pulmonary valve stenosis. Again, a lack of long-term outcomes was noted.

Seven of these were considered major complications: device instability in 5 patients, which included dislodgement of the device ($n = 2$) and homograft rupture ($n = 3$); compression of the left main coronary artery ($n = 1$); and obstruction of the origin of the right pulmonary artery ($n = 1$). Five of the patients with major complications required surgical RVOT revision. During the follow-up period, 5 patients were diagnosed with endocarditis, a median 4.9 months after PPVI, which led to valve removal in 3 patients. A stent fracture led to stent embolization in the right pulmonary valve in 1 patient, requiring surgical removal of the Melody valve.

BMS achieved significant reduction in mean right ventricular systolic pressure, mean pulmonary artery to right ventricular pullback gradient, and the mean ratio of right ventricular to systemic pressure. However, PPVI did not produce any statistically significant changes in these measurements.

The primary studies, as could be imagined (as they are the basis for the systematic reviews), demonstrate the same outcomes. They show adequate safety and good short-term efficacy. These studies all suffer from the lack of randomization and short-term endpoints, and for the most part, are small in size. One large case series study indicated that PPVI is a feasible procedure (in a select group of patients) and that most patients who underwent PPVI avoided surgical RVOT revision. Nevertheless, the proportion of patients who required re-do procedures (surgical or transcatheter) was quite substantial and increased over time. The results also indicated that patient outcomes improved substantially with operator experience.

In conclusion, current evidence supports transcatheter pulmonary valve implantation to be safe and efficacious, at least in the short-term. Long-term evidence is lacking related to efficacy and durability of the procedure and the optimal patient candidates are poorly defined.

Cardiovascular Policies, Continued

Transcatheter Pulmonary Valve Replacement, continued

Billing/Coding Information

Covered: For the indications outlined above

CPT CODES

33477 Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed

HCPCS CODES

No specific codes identified

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Cardiovascular Policies, Continued

Transcatheter Pulmonary Valve Replacement, continued

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TRANSTHORACIC ELECTRICAL BIOIMPEDANCE (TEB) TESTING

Policy # 335

Implementation Date: 12/21/06

Review Dates: 12/20/07, 12/18/08, 12/19/09, 12/16/10, 12/15/11, 7/18/13, 6/19/14, 6/11/15, 6/16/16, 6/15/17, 7/20/18, 6/13/19, 6/18/20, 6/17/21, 5/19/22

Revision Dates: 1/17/14

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2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Transthoracic electrical bioimpedance (TEB), also referred to as plethysmography or bioimpedance cardiography, has been investigated as a non-invasive method for the determination of cardiac output. TEB relies on the conductivity of blood and the fact that resistance to electrical current in the thorax varies in relation to the amount of blood in the aorta. Blood pumped into the aorta causes a decrease in electrical impedance (resistance) that is inversely proportional to the volume of blood pumped.

Transthoracic electrical bioimpedance measures cardiac output by introducing a low voltage alternating current between 2 sets of electrodes placed on the skin over the thorax. The outer sensors, attached to the neck and chest, transmit a high-frequency, low-amplitude electric current through the thoracic cavity. The inner sensors, placed adjacent to the first set, detect impedance of the electric current in the thoracic cavity. The difference between the initial voltage and that which the device senses moving through the thorax provides a measure of electrical impedance. The magnitude of the decrease in impedance in conjunction with electrocardiographic results allows stroke volume to be estimated, which can be used to calculate cardiac output.

Multiple uses for TEB have been proposed: these include non-invasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease, differentiation of cardiogenic from pulmonary causes of acute dyspnea, optimization of atrioventricular interval for patients with A/V sequential cardiac pacemakers, patients with need of determination for intravenous inotropic therapy, early identification of rejection in post-heart transplant myocardial biopsy patients, cardiac patients with a need for fluid management (excluding patients on dialysis and with cirrhosis of the liver), and management of hypertension.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

SelectHealth **does NOT cover transthoracic electrical bioimpedance (TEB) testing.** This testing is not found to be medically necessary to manage patients with various cardiac conditions in an outpatient setting.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

Transthoracic Electrical Bioimpedance (TEB) Testing, continued

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

In a 2003 Hayes Review, Thoracic Electrical Bioimpedance was given a rating of 'C,' reflecting a technology with potential but unproven benefit. The review concluded that the literature suggests that TEB provides accurate measurement of cardiac output in properly selected patients, but that the appropriate clinical role of cardiac output measurement in patient management and its impact on clinical outcomes were poorly defined. Similarly, the Agency for Healthcare Research and Quality's (AHRQ) 2002 review concluded that TEB may have potential value in patient care. However, the accuracy of TEB relative to other measures of hemodynamic parameters could not be evaluated because limited literature and that a focus on clinical outcomes of TEB measurement was needed to evaluate its role in clinical care. The literature published since 2003 is fairly consistent with the observations made in these two reviews, and TEB measurements of hemodynamic parameters also correlate fairly well with those from other invasive or noninvasive techniques, though one study by Leslie et al., found poor agreement between TEB and thermodilution on measures of cardiac output.

A few studies provide some data to address the question of the clinical role of TEB and the impact of measuring cardiac output on changing patient outcomes. Several of these have application to outpatient uses. In Packer et al. for example, 212 patients with chronic heart failure attributable to an ischemic or non-ischemic cause underwent clinical assessment and TEB every 2 weeks for 26 weeks. Three clinical variables (patient visual analog rating of symptoms, NYHA functional class, and systolic blood pressure) and three TEB parameters (thoracic fluid content index, velocity index, and left ventricular ejection time) were independently associated with the occurrence of a heart failure event within 14 days following their measurement. A composite ICG score based on these 3 variables grouped patients into low- (0–3), intermediate- (4–6), and high-risk categories (7–10). Patients in the high-risk group had an 8.4% event rate compared with vs. 3.5% and 1.0% for intermediate- and low-risk patients, respectively. High-risk patients accounted for 41.6% of heart-failure events. While the study suggests that TEB may provide some prognostic information pertinent to treatment planning in this population, the authors caution that TEB parameters should not be used to titrate therapeutic agents or to monitor therapy. Moreover, they noted that the study could not determine whether TEB contributed any unique information to the clinical data already available to clinicians. They indicate that large-scale trials are needed to evaluate whether treatment guided by TEB would have any impact on clinical outcomes.

Peacock et al. examined the use of TEB with patients presenting with dyspnea to an emergency department. After conducting their routine history and physical, and indicating their working diagnosis, physicians reviewed each patient's TEB data and reconsidered their working diagnosis. Of the 89 patients evaluated, the initial diagnosis for 12 (13%) was changed after the physician had reviewed the TEB data. Physicians made changes to the medication plan in 35 patients (39%) after the initial assessment and review of TEB.

A 2004 study by Sharman et al. enrolled 21 patients with uncontrolled hypertension on a treatment protocol that was guided by TEB measurements of hemodynamic parameters. After 215 ± 85 days, average blood pressure had declined from approximately 157/78 mmHg to 142/77 mmHg. Moreover, 57% of participants achieved sustained blood pressure control. A prospective randomized controlled trial in 2006 by Smith et al. also evaluated use of TEB to inform treatment in patients with essential hypertension. Patients ($n = 164$) underwent a 2-week anti-hypertensive medication washout period and were randomized to a standard care or TEB-informed treatment group. Physicians treating patients in the standard group prescribed anti-hypertensives according to published guidelines, usual practice patterns, and patient characteristics. Physicians treating patients in the TEB-informed group were also provided TEB measurements about their patients and were encouraged to use a hemodynamic treatment algorithm to guide decisions about pharmacologic agents and dosing. Compared with standard care, patients in the TEB group were more likely to achieve blood pressure reduction at or below the target goal of $< 140/90$ mmHg (77% vs. 57%). A greater percentage of TEB patients also achieved reductions below 130/85mmHg (55% vs. 27%).

Transthoracic Electrical Bioimpedance (TEB) Testing, continued

These studies suggest some novel clinical applications for TEB in the outpatient setting and that TEB may impact physicians' treatment decisions. However, small sample sizes and lack of replication suggest that these findings should be considered preliminary. Future research is needed to define specific TEB-informed treatment protocols in addition to replicating these findings in larger patient samples.

Literature reviews performed in December 2008, 2009, and 2010 did not identify any new information.

Billing/Coding Information

Not Covered: Investigational/Experimental/Unproven for this indication

CPT CODES

93701 Bioimpedance-derived physiologic cardiovascular analysis

HCPCS CODES

No specific codes identified

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Transthoracic Electrical Bioimpedance (TEB) Testing, continued

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VENTRICULAR ASSIST DEVICES

Policy # 187

Implementation Date: 7/98

Review Dates: 1/4/00, 2/27/01, 4/16/02, 10/23/03, 11/18/04, 3/25/05, 4/20/06, 10/18/07, 10/22/09, 10/22/10, 2/16/12, 4/25/13, 2/20/14, 3/19/15, 2/11/16, 2/16/17, 2/15/18, 2/5/19, 2/11/20, 2/18/21, 3/21/22

Revision Dates: 8/22/06, 10/30/06, 10/23/08

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Description

A ventricular assist device (VAD) is a mechanical pump that relieves the native ventricle by assisting in pumping blood through the body. The VAD requires a control system and a power source that are maintained outside the body. The VAD pump may be placed internally or externally but the control system and power source are maintained outside the body. Sometimes called, "bridge-to-transplant" (BTT), VADs were originally intended for use in patients awaiting heart transplant who required additional assistance for survival. As VAD technology has improved and the supply of transplantable hearts remains limited, VADs are now sometimes used for long-term (destination) therapy in severe heart-failure patients.

The first FDA approval of a VAD for this indication was in 1994. A variety of devices have received approval from the U.S. Food and Drug Administration (FDA), encompassing both biventricular and left ventricular devices, as well as devices that are intended to be used in the hospital setting alone and those that can be used as an outpatient. Devices that can be used in an outpatient setting while the patient awaits a heart transplantation, as destination therapy or bridge to recovery include Second generation LVAD; Abbott HeartMate II LVAD and third generation LVAD; Abbott HeartMate 3 LVAD and Medtronic HeartWare LVAD (HVAD). In these systems, the device is surgically placed entirely within the thoracic except for HeartMate II pump is placed under the diaphragm and connected to the power source by a percutaneous drive line.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth covers all FDA approved* ventricular assist devices in the following **limited circumstances**.

1. Members with ventricular dysfunction secondary to post cardiectomy syndrome, post myocardial infarct ventricular dysfunction, and chronic ischemic and non-ischemic cardiomyopathy that have undergone advance heart failure evaluation and treatment that may include but is not limited to inotropic therapy or temporary mechanical support; or
2. As a bridge to transplant for members who are awaiting heart transplantation; or
3. As destination therapy for members with severe (NYHA Class IV) heart failure, and who are ineligible for heart transplantation due to age or co-morbidities.

*FDA approved is defined as devices that have been granted approval through a Pre-Marketing Approval (PMA) process or have gained FDA approval as Investigational Exempt Devices (IDE) and are categorized as Category "B" devices by the FDA.

Cardiovascular Policies, Continued

Ventricular Assist Devices, continued

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or the [manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

There are two type of Mechanical Circulatory Support (MCS) devices: Short-term and intermediate to long-term devices.

1) Short-Term devices:

These devices are designed to provide hemodynamic support for a wide range of clinical conditions, ranging from prophylactic insertion for high-risk invasive coronary artery procedures to the management of cardiogenic shock, acute decompensated heart failure, or cardiopulmonary arrest. Each of these devices provides circulatory support by performing work for a failing left or right ventricle or both and are used as bridge to recovery, transplantation and intermediate to long terms MCS or facilitating very high risk percutaneous coronary artery intervention, valve procedure and electrophysiologic procedures.

- a) Intra-Aortic Balloon Pump (IABP): Uses the counterpulsation system to displace the blood to the proximal aorta by inflation during diastole and reduce the afterload during systole by rapid balloon deflation. It can provide up to 0.5 L/min flow and be inserted via femoral or axillary arteries.
- b) Percutaneous Short-Term Left Ventricular Assist Devices
 - i) **Impella (Abiomed):** Intravascular micro-axial continuous flow pump that is inserted via femoral or axillary artery and positioned across the aortic valve. Currently four versions are available: Impella (2.5, CP, 5.0, 5.5) with flow 2.5- 5 L/min.
 - ii) **TandemHeart (TandemLife):** Centrifugal continuous pump inserted in the left atrium using transseptal approach from the femoral vein (max flow 4.0L/min).
- c) Percutaneous Short-Term Right Ventricular Assist Devices:
 - i) **Impella RP (Abiomed):** Like other Impella devices. It is inserted in an antegrade fashion via the femoral vein, crossing the tricuspid and pulmonary valves (4.0 L/min)
 - ii) **Protek Duo (TandemLife):** A dual Lumen cannula, draining right atrium and superior vena cava blood via proximal vents into an extracorporeal centrifugal pump, which is then delivered back directly to the Pulmonary artery. It is inserted via the right internal jugular vein and crosses the tricuspid and pulmonary valve and connected to an extracorporeal centrifugal pump. (Flow 4.0 L/min).

2) Intermediate to Long-Term MCS Devices

These devices are designed to support the patient while waiting for heart transplantation or as permanent therapy (Destination Therapy). Currently there is one LVAD that FDA approved for Bridge to Transplantation (BT) and Destination Therapy (DT):

- a) Third Generation LVADs: These are continuous centrifugal flow and the most used. These are durable LVADs and have similar basic design to the second generation LVADs however they are placed in the pericardium and attached to the LV apex with swing ring.

Cardiovascular Policies, Continued

Ventricular Assist Devices, continued

- i) **HeartWare HVAD (Medtronic):** (Currently is not FDA approved) is a continuous flow, centrifugal pump utilizing passive magnetic and hydrodynamic forces to levitate and rotate an impeller designed to support the left ventricle and provide flows up to 10 L/min. is implanted in the pericardial space with the inflow conduit in the apex of the LV and outflow graft attached to the ascending aorta and is capable of providing 3 - 10 liters/minute of blood flow.
 - ii) **HeartMate 3 LVAD (Abbott):** is a fully magnetic levitated continuous centrifugal flow pump that uses magnetic fields to float the device's rotor, creating a contact-free, friction-free environment. The pump is designed for intrapericardial and can provide blood flows from 2.5 to 10 L/min. *It is currently the only FDA approved LVAD.*
- 3) **Total Artificial Heart:**
- a) The SynCardia temporary Total Artificial Heart (TAH) is intended as a cardiac replacement device for bridging to transplantation for patients with severe biventricular failure, intractable arrhythmias or complex congenital heart disease.
 - b) The artificial heart consists of two ventricles, each with two Medtronic-Hall tilting disc valves. The ventricles are orthotopically positioned and attach to the patient's remnant atria and great vessels with atrial sewing cuffs and vascular graft material.
 - c) The TAH is driven by metered pulses of compressed air delivered by a C2 hospital driver that adjusts the pumping rate, driveline inflation pressures and percent systole. A flexing diaphragm is found in each ventricle to pump the blood from the ventricle when the diaphragms are inflated.
 - d) The driveline from the base of each ventricle exits near the patient's waist and connects to an 8-foot driveline extension that goes to a controller in the console.
 - e) The TAH can pump up to 9.5 L/min of flow through both ventricles. With careful control of the console, the patient can ambulate around the hospital and hospital grounds for 1 to 2 hours on the C2 driver and battery supplies.
 - f) TAH patients are not permitted to leave the hospital while on the larger C2 console; however, the portable, 13.5-pound Freedom Driver is available for use outside the hospital. Participation in a cardiac rehabilitation program is possible while on the TAH. The 70 cc TAH can only be used in patients with a body surface area (BSA) of 1.7 m² or greater and an A-P distance from posterior sternum to anterior vertebral body at T-10 on CT scan of ≥ 10 cm.

Billing/Coding Information

Covered: For the conditions outlined above

CPT CODES

0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)
0452T	; aortic counterpulsation device and vascular hemostatic seal
0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)
0456T	; aortic counterpulsation device and vascular hemostatic seal
0458T	; subcutaneous electrode
0459T	Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano-electrical skin interface and electrodes
0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode
0461T	; aortic counterpulsation device
0463T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day
33975	Insertion of ventricular assist device; extracorporeal, single ventricle

Cardiovascular Policies, Continued

Ventricular Assist Devices, continued

33976	; extracorporeal, biventricular
33977	Removal of ventricular assist device; extracorporeal, single ventricle
33978	; extracorporeal, biventricular
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump
33990	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture
33992	Removal of percutaneous ventricular assist device at separate and distinct session from insertion
33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion
33999	Unlisted procedure, cardiac surgery
92970	Cardioassist-method of circulatory assist; internal
92971	; external
93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report

HCPCS CODES

Q0480	Driver for use with pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with pneumatic ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
Q0483	Monitor/display module for use with pneumatic ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with pneumatic ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
Q0488	Power pack base for use with pneumatic ventricular assist device, replacement only
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only
Q0490	Emergency power source for use with pneumatic ventricular assist device, replacement only
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only
Q0492	Emergency power supply cable for use with pneumatic ventricular assist device, replacement only

Cardiovascular Policies, Continued

Ventricular Assist Devices, continued

Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only
Q0494	Emergency hand pump for use with electric/pneumatic ventricular assist device, replacement only
Q0495	Battery power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0496	Battery for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0497	Battery clip for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0498	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0499	Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0500	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only
Q0503	Battery for pneumatic ventricular assist device, replacement only, each
Q0506	Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0507	Miscellaneous supply or accessory for use with an external ventricular assist device
Q0508	Miscellaneous supply or accessory for use with an implanted ventricular assist device

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Cardiovascular Policies, Continued

Ventricular Assist Devices, continued

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Cardiovascular Policies, Continued

Ventricular Assist Devices, continued

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VERTICAL AUTOPROFILING (VAP) CHOLESTEROL TEST

Policy # 298

Implementation Date: 2/15/06

Review Dates: 5/17/07, 4/24/08, 4/23/09, 2/18/10, 5/19/11, 6/21/12, 6/20/13, 4/17/14, 5/7/15, 4/14/16, 4/27/17, 7/20/18, 4/27/19, 4/15/20, 12/23/20, 7/5/21, 7/21/22

Revision Dates: 12/28/20

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS) and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Coronary heart disease (CHD) affects about 14 million men and women in the United States. Atherosclerosis is an important risk factor in the development of CHD. Routine cholesterol screening, which measures HDL, LDL (calculated), and triglycerides is a major component of CHD risk management. The Vertical Auto Profile (VAP) cholesterol test from Atherocare not only includes these standard tests, but also, measures atherogenic remnant lipids (VLDL and IDL), Lp(a), LDL pattern density, and HDL subtypes. This additional testing purports to improve CHD risk stratification by measuring these additional risk factors along with the traditional cholesterol panel. By measuring these lipid factors, the test also provides a screen for metabolic syndrome, a constellation of metabolic risk factors that increase risk for CHD.

The VAP test is the only commercially available test that measures possible cardiovascular risk factors Lp(a), LDL particle size, lipoprotein remnants, and HDL subfractions, at the same time. Alternatively, providers can order each test individually. Additionally, many other tests are available to assess cardiovascular risk. Tests covered by SelectHealth include fasting lipid profiles, PLAC testing, and hs-CRP. Other risk factors for CHD can be assessed through a variety of methods including the Framingham Risk Assessment tool.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

SelectHealth does NOT cover vertical autoprofiling (VAP) cholesterol testing for assessment of cardiovascular risk. This test is not medically necessary, as additional information obtained from VAP testing does not change treatment or clinical outcome.

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp> or [the manual website](#)

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Summary of Medical Information

The extant literature is somewhat equivocal on the prognostic value of the risk factors the VAP test adds to the traditional lipid panel:

Remnant lipoproteins: Fukushima et al.'s 2004 2-year follow-up study of 240 diabetes patients with or without CAD found remnant lipoproteins to be a strong independent risk factor for CAD. Inoue et al. reported similar findings in their 2004 study of 188 CAD patients and 68 controls. In contrast, Imke et al.'s study of 1,156 Japanese-American men over 7 years found that remnant lipoproteins levels did not improve the prediction of future CHD incidence beyond that already provided by total triglycerides.

Lp(a): Ariyo et al. studied 5,888 adults over 7.5 years (median) and concluded that Lp(a) level is an independent risk factor of future vascular events in men, but not in women. Danesh et al.'s meta-analysis of 27 studies supported the association between CHD and Lp(a) but called for additional research to determine the extent to which this relationship is causal. Moliterno et al.'s study of 140 African American subjects concluded that Lp(a) is not an independent risk factor for CAD in that population.

LDL particle size: Bemeis et al. studied LDL size in 38 type II diabetics and concluded that, among other lipid parameters, LDL particle size is the strongest predictor of CHD and atherosclerosis. Mykkanen et al., in contrast, studied 86 patients who were MI-free over 3.5 years and observed that LDL particle size was not an independent risk factor of CHD events once controlling for diabetes status. St-Pierre et al.'s study of 2,072 men over 13 years demonstrated that accumulation of small LDL particles was primarily responsible for the risk attributable to LDL size.

HDL subtypes: Lamarche et al.'s 1990 study of 1,169 men followed over 11 years found a statistical association between HDL2 and CHD but concluded that that in the clinical setting, measurement of HDL subtypes provides no additional information about CHD risk over traditional lipid risk markers. Sweetnam et al. followed 4,860 men between 3–5 years and observed an inverse association between HDL2 and HDL3 cholesterol and the incidence of CHD. They further noted that the predicting adding HDL subtype measurement to traditional HDL did not improve prediction of CHD risk.

Only 2 studies located for this literature review examined the impact of treating these risk factors on future atherosclerosis or CHD events. Campos et al. administered pravastatin or placebo to 837 MI survivors and matched controls with similarly elevated LDL and tracked outcomes over 5 years. In patients taking placebo, large LDL predicted coronary events, but this association was not present in patients taking pravastatin. However, the authors concluded that identifying LDL size 5, not to be very useful clinically since elevated LDL cholesterol and large LDL are both effectively treated in the same manner. Miller et al. prospectively followed 213 men enrolled in a cardiac risk reduction program that included lipid-altering therapies with counseling and training in the modification of diet, exercise, and other lifestyle factors. After four years, patients with higher dense LDL levels showed significant benefit from the program while subjects with higher buoyant (less dense) LDL had no benefit from the intervention.

ATP-III identifies lipoprotein remnants, Lp(a), LDL particle size, and HDL subtypes as “emerging risk factors”, suggesting that their association with CHD and the impact of modifying them on CHD risk is not well understood. Additional prospective trials are needed to more fully explain the relationship between these risk factors and atherosclerosis and future CHD events. Research is particularly needed to determine whether adding these emerging risk factors to traditional lipid panels adds any value to the prediction of CHD. The interaction between these emerging risk factors and other lipid and non-lipid risk factors in producing CHD risk must also be examined. Finally, research is needed to determine whether measuring these risk factors would have any unique impact on treatment decisions, whether treatments can be sufficiently tailored for specific lipid profiles, and whether patients with particular lipid parameters respond differently to lipid lowering therapies.

A June 2012 literature review identified the 2010 ACCF/AHA Guideline for Assessment of Cardiovascular Risk in Asymptomatic Adults and does not recommend lipid/lipoprotein subfraction. Similarly, the 2011

Cardiovascular Policies, Continued

Vertical Autoprofiling (VAP™) Cholesterol Test, continued

National Lipid Association Expert Panel did not recommend HDL and LDL subfraction measurements for clinical assessment. However, Apo-B or LDL particle measurement and Lp(a) are endorsed by NLA reasonable for many subjects at intermediate risk, those with a positive family history, and those with recurrent events, and selectively in those with coronary heart disease and CHD equivalents. These recommendations follow recent studies and metaanalyses that indicate that LDL particle number (measured by NML or as Apo-B) may be a better indicator of CHD risk than LDLc or non-HDLc.

Billing/Coding Information

**Not Covered: Investigational/Experimental/Unproven for this indication
(when used in this combination)**

CPT CODES

3011F	Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C) (CAD)
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)
80061	Lipid panel. This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
82465	Cholesterol, serum or whole blood, total
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)
83701	Lipoprotein, blood; high-resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e. electrophoresis, ultracentrifugation)
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83719	Lipoprotein, direct measurement; VLDL cholesterol
83721	Lipoprotein, direct measurement; LDL cholesterol
84478	Triglycerides

HCPCS CODES

No specific codes identified

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Vertical Autoprofiling (VAP™) Cholesterol Test, continued

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Disclaimer

Cardiovascular Policies, Continued

Vertical Autoprofiling (VAP™) Cholesterol Test, continued

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WEARABLE CARDIOVERTER-DEFIBRILLATOR

Policy # 406

Implementation Date: 8/1/08

Review Dates: 6/11/09, 9/15/11, 11/29/12, 2/20/14, 3/19/15, 2/16/17, 2/15/18, 2/5/19, 2/17/20, 12/23/20, 4/18/22

Revision Dates: 6/17/10, 2/29/16, 2/15/18, 3/2/22

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

The term "sudden cardiac death" (SCD) is used to describe cardiac arrest with cessation of cardiac function, whether resuscitation or spontaneous reversion occurs. This definition of SCD is misleading because not all affected individuals die, and the use of SCD in this sense has been challenged.

The implantable cardioverter defibrillator (ICD) is considered a cornerstone of modern cardiology practice for reducing the incidence of sudden cardiac death related to ventricular fibrillation (VF) or ventricular tachycardia (VT). However, several factors limit the prophylactic implantation of the ICD, mainly the inability of invasive and noninvasive laboratory investigations to predict sudden death accurately in a patient population bearing the risk of dying suddenly. As a result, a substantial portion of the at-risk population does not receive adequate preventive therapy and others with lower risk will have the ICD implanted. A potential solution to this problem could be the use of an external, wearable cardioverter defibrillator (vest) that has defibrillation features similar to those of the ICD (i.e., no operator required to defibrillate), providing protection to the patient until it is determined that the implantation of the ICD is warranted, or another strategy pursued (e.g., heart transplant). A device used as a "bridge" to ICD implantation must be capable of reliably terminating episodes of VF/VT, have a highly sensitive and specific algorithm for the detection of VT/VF, and be user-friendly, thereby, ensuring patient compliance.

The vest-like device consists of a chest garment with electrode belt, monitor/defibrillator, patient base station, and physician programming console. The belt is strapped under the heart directly onto the patient's skin to continuously sense electrical activity. If a life-threatening arrhythmia is detected and no response to device alarms is noted, the patient is presumed to be unconscious and the device delivers a shock to restore normal rhythm. Additional treatment may be delivered if the initial shock is not effective. The device weighs approximately 3 pounds. It is worn continuously, but it is not waterproof. For proper use, patients are trained to connect the device to an external modem and send data over the phone to the physician's computer for medical evaluation.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth covers wearable cardioverter-defibrillators when EITHER of the following criteria are met (A or B).

- A. Wearable cardioverter-defibrillators will be approved if recommended by Intermountain Healthcare Cardiovascular Clinical Program,

OR

Cardiovascular Policies, Continued

Wearable Cardioverter-Defibrillator, continued

- B. For all other clinicians, wearable cardioverter-defibrillators will be approved when at least one of the following criteria are met (1–4):

Criteria for coverage include:

1. The patient is at high risk for sudden cardiac death and meets criteria for implantable cardioverter defibrillator (ICD) placement, but is not currently a suitable candidate for ICD placement because of one of the following:
 - Awaiting heart transplantation
 - Awaiting ICD reimplantation following infection-related removal of ICD
 - Systemic infectious process or other temporary medical condition precludes implantation
 - ICD lead malfunction with anticipated lead revision

OR

2. As a bridge to ICD risk stratification and possible implantation for patients:
 - Had ventricular tachycardia (VT) or ventricular fibrillation (VF) within 48 hours of a myocardial infarction (MI), **or**
 - The first 40 days after myocardial infarction (MI) in patients with an ejection fraction (EF) < 35%, **or**
 - Within 3 months of CABG or PCI with ejection fraction (EF) < 35%, **or**
 - With non-ischemic cardiomyopathy and EF of < 35%

OR

3. Newly diagnosed non-ischemic/idiopathic dilated cardiomyopathy (EF ≤ 35) with ICD implantation deferred to titrate therapy with at least one of the following risk markers as listed below:
 - Left or right bundle branch block
 - Marked impairment of left ventricular function (EF < 20)
 - Left ventricular end-diastolic dimension < 7.0 cm
 - Consistent right ventricular dysfunction
 - Non-sustained ventricular arrhythmias
 - No obvious reversible causes (e.g., ETOH on thyroid induced cardiomyopathy)

OR

4. Recent myocardial infarction (< 40 days) with severe left ventricular dysfunction (EF < 35) and additional markers of early mortality risk with at least one additional marker of risk:
 - Left or right bundle branch block
 - History of chronic ischemic heart failure (EF ≤ 40) with severe left ventricular dysfunction

Cardiovascular Policies, Continued

Wearable Cardioverter-Defibrillator, continued

- Sustained ventricular tachycardia induced during electrophysiology study
- Frequent premature ventricular ectopy and/or non-sustained ventricular tachycardia during telemetry monitoring
- T wave alternans
- Late potentials on signal average ECOG

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or the [manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

The U.S. Food and Drug Administration (FDA) approved the Lifecor Wearable Cardioverter Defibrillator 2000 system via 510(k) approval in December 2001, based on clinical data submitted to the FDA by the manufacturer, which has subsequently been published in the peer-reviewed literature, and referred to as the BIROAD and WEARIT studies. The trials consisted of prospective, non-randomized studies, which compared the outcomes of the WCD with historical controls of patients suffering sudden cardiac arrest who called 911 emergency services. While this study demonstrated that the WCD could detect arrhythmias and appropriately deliver a counter shock, its long-term efficacy will depend on patient compliance, and from a practical perspective, the WCD cannot be continuously worn. For example, the BIROAD and WEARIT studies included 289 patients; there were 12 deaths reported, and 50% occurred in patients either not wearing the device or wearing it inappropriately. Additionally, 68 of the 289 patients discontinued wearing the device due to comfort issues or adverse reactions. Therefore, an implantable cardiac defibrillator (ICD) is considered the gold standard, and, as such, a WCD would be considered an alternative to an ICD only in the small subset of patients who have co-morbidities or other contraindications for an ICD. Patients with an infected ICD requiring removal may benefit from a WCD worn during the limited interim period until an ICD can be re-implanted. Additionally, a small subset of patients awaiting heart transplantation may be considered at high risk for arrhythmia but are not candidates for an ICD due to co-morbidities. A WCD may be considered an alternative to an ICD in these patients while they are on the heart transplant waiting list.

There has been interest in offering WCDs to patients in the immediate post myocardial infarction (MI) period, when patients are considered at high risk of arrhythmia. However, the DINAMIT trial demonstrated that an ICD is not indicated during this period, thus, the WCD cannot be considered an alternative to an ICD in this setting. The DINAMIT trial randomized 674 patients to receive either an ICD or no ICD within 40 days of a myocardial infarction. All patients had reduced ejection fractions (ejection fraction $\leq 35\%$) and impaired cardiac autonomic function. There was no difference in overall mortality between the two groups. While the nonrandomized BIROAD study investigated patients treated with a WCD in the immediate post MI period, the results of the large randomized DINAMIT study provide a higher level of evidence, which may be extrapolated to WCD.

A 2009 technology assessment published by the California Technology Assessment Forum (CTAF), concluded that the use of a wearable cardioverter defibrillator (WCD) for patients at risk for sudden

Cardiovascular Policies, Continued

Wearable Cardioverter-Defibrillator, continued

cardiac arrest and who are not candidates for or refuse an ICD does not meet the CTAF criteria. The assessment included uncontrolled case series by Auricchio (1998, n = 15), and Reek (2003, n = 12) that evaluated the ability of the device to detect and terminate tachyarrhythmias induced in the controlled setting of the electrophysiology laboratory. The author concluded that the limited scientific evidence, consisting of one pivotal trial with a precursor device and a small number of events, does not permit conclusions regarding the effectiveness of the WCD regarding health outcomes. A multicenter cohort study evaluating the impact of the WCD on mortality and quality of life in patients who meet criteria for, but are unable or unwilling to have an ICD, is needed before definitive conclusions can be made regarding safety and effectiveness. For patients who do not meet criteria for an ICD, but who are considered to be at increased risk of SCD (e.g., post-acute MI with reduced EF), a randomized controlled trial with mortality data is recommended before the safety and efficacy of the device can be evaluated for use in clinical practice.

Billing/Coding Information

Covered: *For the conditions outlined above*

CPT CODES

- 93292** Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system
- 93745** Initial set-up and programming by a physician of wearable cardioverter-defibrillator, includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events

HCPCS CODES

- K0606** Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
- K0607** Replacement battery for automated external defibrillator, garment type only, each
- K0608** Replacement garment for use with automated external defibrillator, each
- K0609** Replacement electrodes for use with automated external defibrillator, garment type only, each

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Cardiovascular Policies, Continued

Wearable Cardioverter-Defibrillator, continued

determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

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WIRELESS CARDIAC MONITORING (E.G., CARDIOMEMS)

Policy # 642

Implementation Date: 9/28/20

Review Dates: 1/20/22

Revision Dates:

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare/CMS), and SelectHealth Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Heart failure (HF) is a chronic condition that develops over time due to circumstances that overwork and damage the heart. The primary causes include coronary heart disease, high blood pressure, and diabetes. HF is characterized by the inability of the heart to pump blood efficiently. HF is estimated to affect approximately 5.7 million people in the United States. Currently, there is no cure for HF. It can affect both children and adults, although, it most commonly occurs in adults 65 years of age or older.

The CardioMEMS (CM) System (Abbott) is a wireless implantable hemodynamic monitor (IHM), for use at home in patients with HF. The CM-IHM system includes an implantable pulmonary artery pressure (PAP) sensor, a transvenous catheter delivery system, a patient home-monitoring electronic system, and a secure Internet-accessible database that allows clinicians to access patient data. The CM-IHM system provides measurement of the systolic, diastolic, and mean PAP, intending to allow for adjustment of HF medical therapy based on pressure trends and specified pressure goals. Once implanted, the patient will take a wireless reading from their PAP sensor once a day from home. Pressure data from this daily reading is then transmitted to a secure website for the physician and clinical team to review and make any necessary adjustments to HF treatment.

Commercial Plan Policy/CHIP (Children's Health Insurance Program)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

SelectHealth **covers the CardioMEMS wireless cardiac monitor for heart failure patients, if either A or B are documented:**

- A. Recommended by Intermountain Healthcare Cardiovascular Clinical Program, **OR**
- B. All the following criteria are met:
 1. Left-sided heart failure diagnosis (preserved or reduced ejection fraction) for at least 3 months
 2. History of ≥ 1 heart failure hospitalizations/events in the past year
 3. HFrEF (heart failure with reduced ejection fraction) patients must be on optimal heart failure medications (GDMT [guideline-directed medical therapy] at best-tolerated doses)
 4. NYHA (New York Heart Association) class III heart failure symptoms

Cardiovascular Policies, Continued

Wireless Cardiac Monitoring (e.g., Cardiomems), continued

5. The patient is an outpatient, and actively being monitored by a cardiologist specializing in heart failure with the capability of daily monitoring of the CardioMEMS data
6. The patient agrees to the patient training and home measurement schedule

Absolute Contraindications to CardioMEMS:

- a. Non-adherence with medication use, and/or laboratory follow-up recommendations
- b. The patient has refused CRT (cardiac resynchronization therapy)
- c. Inability to take dual antiplatelet therapy or anticoagulation for one-month post-implantation
- d. Patient cannot tolerate a right heart catheterization
- e. Mechanical tricuspid or pulmonic valve
- f. BMI > 35 with chest circumference (at axillary level) > 165cm

Relative Contraindications to CardioMEMS:

- g. Patients with an active but treatable infection
- h. Patients with a history of recurrent (> 1) pulmonary embolism or deep vein thrombosis
- i. Patients with a GFR < 25 ml/min who are non-responsive to diuretic therapy.
- j. Patients with ESRD on dialysis
- k. Patients with congenital heart disease
- l. Patients with known coagulation disorders
- m. Patients with a hypersensitivity or allergy to aspirin, and/or clopidogrel
- n. CRT implantation in the past 3 months (as these patients may clinically improve post-CRT)
- o. Recent pacemaker, ICD, or CRT implantation (risk of lead dislodgement and would need to discuss timing with electrophysiology)
- p. Tricuspid valve clip (would need to be discussed with structural heart team)

SelectHealth Advantage (Medicare/CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the SelectHealth Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

SelectHealth Community Care (Medicaid)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the SelectHealth Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website <http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

Summary of Medical Information

Cardiovascular Policies, Continued

Wireless Cardiac Monitoring (e.g., CardiomeMs), continued

CardioMEMS pulmonary artery monitoring device has been approved by the US Food and Drug Administration to monitor pulmonary artery pressure and heart rate in patients with NYHA class III HF who have been hospitalized during the previous year. Further study is needed to determine the efficacy and safety of this device. The 2016 ESC HF (European Society of Cardiology Heart Failure) guidelines included only a very weak recommendation stating that this device may be considered in symptomatic patients with HF with previous HF hospitalization.

The CardioMEMS Heart Sensor Allows Monitoring of Pressure to Improve Outcomes In NYHA Class III Heart Failure Patients (CHAMPION) randomized single-blind trial of 550 patients found that transmission of pulmonary artery pressure data from the device reduced HF-related hospitalizations at six months (31 versus 44 percent, HR 0.70, 95% CI 0.60–0.84). There was a 1.5 percent rate of device- or system-related complications. An exploratory subgroup analysis found that device-guided management reduced HF-related hospitalization in patients with preserved LVEF (left ventricular ejection fraction) (LVEF \geq 40 percent or LVEF \geq 50 percent), as well as in patients with LVEF < 40 percent. Another exploratory analysis found that device-guided management reduced respiratory hospitalization rates as well as HF hospitalization rates in the entire cohort, as well as in a subgroup of 187 patients with chronic obstructive pulmonary disease.

A later analysis reported sustained reduction in HF-related hospitalization in the device-guided management group compared with the control at 18-month average follow-up (46 versus 68 percent, HR 0.67, 95% CI 0.55 to 0.80). During a subsequent open access period (mean duration 13 months), pulmonary artery pressure information was made available to guide therapy in the former control group; the rate of admission was reduced compared with that in the control group during the randomized access period (36 versus 68 percent; HR 0.52, 95% CI 0.40 to 0.69). The rate of device- or system-related complications was 1 percent and the rate of procedure-related adverse events was 1 percent.

However, the efficacy of the CardioMEMS device is uncertain given concerns raised about potential bias introduced in the conduct of the CHAMPION trial (including interaction between the trial sponsor and clinical investigators on certain treatment group subjects) and the analysis of data.

Billing/Coding Information

CPT CODES

- 33289** Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed
- 93264** Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care

HCPCS CODES

- C2624** Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components

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2. Hayes Brief. (2019). CardioMEMS Implantable Hemodynamic Monitor (Abbott) for Managing Patients with Heart Failure.

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Cardiovascular Policies, Continued

Wireless Cardiac Monitoring (e.g., Cardiomems), continued

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