IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201203 JANUARY 24, 2012

The IHCP to reimburse implantable cardioverter defibrillators separately from outpatient implantation

Effective March 1, 2012, the Indiana Health Coverage Programs (IHCP) will reimburse the cost of implantable cardioverter defibrillator devices separately from reimbursement for the implantation procedure, when the implantation is performed in an outpatient surgical setting. This change in coverage and reimbursement policy is retroactive for dates of service on or after January 1, 2009. For dates of service on or after January 1, 2009, but before March 1, 2012, providers must submit a manufacturer cost invoice with their claims, as well as a copy of this bulletin, to receive separate reimbursement for the device.

Table 1 on the next page shows Healthcare Common Procedure Coding System (HCPCS) codes, and billing and reimbursement information for coverage effective March 1, 2012, for dates of service on or after January 1, 2009.

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Table 1 – HCPCS codes for implantable cardioverter defibrillator device

HCPCS Billing Code	Product/Service Description	Maximum Reimbursement Rate
C1721	Cardioverter-defibrillator, dual chamber (implantable)	Manually reimbursed
C1722	Cardioverter-defibrillator, single chamber (implantable)	Manually reimbursed
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	Manually reimbursed
C1779	Lead, pacemaker, transvenous VDD single pass	Manually reimbursed
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)	Manually reimbursed
C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	Manually reimbursed
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	Manually reimbursed
C1898	Lead, pacemaker, other than transvenous VDD single pass	Manually reimbursed
C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	Manually reimbursed
C1900	Lead, left ventricular coronary venous system	Manually reimbursed

The Fee Schedule on indianamedicaid.com will be updated to reflect this coverage and reimbursement information.

Reimbursement requirements

The IHCP provides reimbursement for implantable cardioverter defibrillators when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA). Implantable cardioverter defibrillator therapy is considered medically necessary for the treatment of ventricular tachyarrhythmias and for the prevention of sudden cardiac death (SCD) in individuals who are receiving optimal medical therapy.

Reimbursement requires compliance with all IHCP billing guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid managed care programs. Providers must bill using the appropriate procedure codes listed in Table 1, and must bill the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code to the highest level of specificity that supports medical necessity. Physicians should bill professional services on the *CMS-1500* claim form. For specific billing guidelines, please refer to *Chapter 8* of the *IHCP Provider Manual*.

The IHCP will reimburse for implantable cardioverter defibrillator devices when they are billed on *CMS-1500* claim forms or via 837P electronic transactions. The IHCP permits only certain implantable items to have separate reimbursement. Providers must bill using the procedure codes listed in Table 1.

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Prior authorization requirements

Prior authorization is required for all implantable cardioverter defibrillators, per *405 IAC 5-3-13*.

Covered indications

Implantable cardioverter defibrillators are indicated for members who are receiving ongoing optimal medical therapy, have a reasonable expectation of survival with good functional status for more than one year, and meet the following criteria:

- Survivors of cardiac arrest due to ventricular fibrillation or hemodynamically unstable, sustained ventricular tachycardia (VT) (after evaluation to define the cause of the event and to exclude any completely reversible causes). In addition:
  - Members must be able to give informed consent
  - Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography
  - Myocardial infarctions (MIs) must be documented and defined according to the criteria in Table 2
- Left ventricular (LV) dysfunction with prior myocardial infarction (MI) (ischemic cardiomyopathy) and one of the following:
  - Left ventricular ejection fraction (LVEF) less than or equal to 35%, due to prior MI; at least 40 days post-MI; and a New York Heart Association (NYHA) functional Class II or III classification (see Table 3)
  - LV dysfunction due to prior MI; at least 40 days post-myocardial infarction; an LVEF less than or equal to 30%; and an NYHA functional Class I classification (see Table 3)
  - Nonsustained VT due to prior MI; LVEF less than or equal to 40%; and inducible ventricular fibrillation or sustained VT at electrophysiological study
  - The following must also be met:
    - Members must be able to give informed consent
    - Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography
    - MIs must be documented and defined, according to the criteria in Table 2
- Nonischemic, dilated cardiomyopathy with an LVEF less than or equal to 35%; and an NYHA functional Class II or III classification (see Table 3)
- Sustained VT, either spontaneous or induced by an electrophysiology (EP) study; not associated with an acute MI; and not due to a transient or reversible cause
- Syncope of undetermined origin with one of the following:
  - Clinically relevant, hemodynamically significant sustained VT
  - Ventricular fibrillation induced at electrophysiological study
  - Unexplained syncope, significant LV dysfunction, and nonischemic dilated cardiomyopathy
- One or more of the following familial or inherited conditions with a high risk of life-threatening VT:
  - Hypertrophic cardiomyopathy with one or more of the following major risk factors for SCD:
    - Prior cardiac arrest
    - Spontaneous sustained VT
    - Spontaneous nonsustained VT
    - Family history of SCD
    - Syncope
    - LV thickness greater than or equal to 30 mm

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- ♦ Abnormal blood-pressure response to exercise

– For the prevention of SCD in members with arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C) with one or more risk factors for SCD:
  - ♦ Induction of VT during electrophysiological testing
  - ♦ Detection of nonsustained VT on noninvasive testing
  - ♦ Male gender
  - ♦ Severe right-ventricular dilation
  - ♦ Extensive right-ventricular involvement
  - ♦ Young age at presentation (less than five years)
  - ♦ LV involvement
  - ♦ Prior cardiac arrest
  - ♦ Unexplained syncope
  - ♦ Deleterious genetic mutations associated with ARVD/C
– The reduction of SCD in members with long QT syndrome who are experiencing syncope or VT while receiving beta blockers
– Brugada syndrome and one of the following:
  - ♦ Previous syncope
  - ♦ Documented VT that has not resulted in cardiac arrest
  - ♦ Catecholaminergic polymorphic VT with syncope or documented, sustained VT while receiving beta blockers
  - ♦ Nonhospitalized members awaiting heart transplants
  - ♦ Cardiac sarcoidosis
  - ♦ Giant cell myocarditis
  - ♦ Chagas disease

Implantable cardioverter defibrillators for pediatric members and members with congenital heart disease

Implantable cardioverter defibrillators are indicated for pediatric members and members with congenital heart disease who meet the following criteria:

- ■ Survival of cardiac arrest (after evaluation to define the cause of the event and to exclude any reversible causes)
- ■ Symptomatic, sustained VT in association with congenital heart disease in members who have undergone hemodynamic and electrophysiological evaluation. Catheter ablation or surgical repair may offer possible alternatives in carefully selected patients
- ■ Congenital heart disease with recurrent syncope of undetermined origin in the presence of ventricular dysfunction or inducible ventricular arrhythmias at electrophysiological study
- ■ Recurrent syncope associated with complex, congenital heart disease and advanced, systemic, ventricular dysfunction when thorough invasive and noninvasive investigations have failed to define a cause

Noncovered indications

Implantable cardioverter defibrillators are not covered when members meet the following criteria:

- ■ Irreversible brain damage, or disease or dysfunction that precludes the ability to give informed consent
- ■ Significant psychiatric illnesses that may be aggravated by device implantation or that may preclude systematic follow-up

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- Any disease, other than cardiac disease (for example, cancer, uremia, liver failure, advanced cerebrovascular disease), associated with less than one year's survival
- Ventricular tachyarrhythmias due to a completely reversible disorder in the absence of structural heart disease (for example, electrolyte imbalance, drugs, or trauma)
- Asymptomatic VT or symptomatic VT/ventricular fibrillation (VF):
  - Associated with acute MI within two days
  - Due to a remediable cause
  - Controlled by appropriate drug therapy
  - Manageable through the use of other therapies (for example, ablation procedures, surgery)
- Incessant VT or VF
- Syncope of undetermined cause without inducible ventricular tachyarrhythmias and without structural heart disease
- Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm
- Coronary artery bypass graft (CABG) or percutaneous transluminal coronary angiography within the past three months
- Acute MI within the past 40 days
- Clinical symptoms or findings that make the member a candidate for coronary revascularization
- NYHA Class IV symptoms and drug-refractory congestive heart failure but no possibility of cardiac transplantation or implantation of a cardiac resynchronization therapy (CRT) device that incorporates both pacing and defibrillation capabilities
- Ventricular fibrillation or VT that is amenable to surgical or catheter ablation (for example, atrial arrhythmias associated with Wolff-Parkinson-White syndrome, right ventricular or LV outflow tract VT, idiopathic VT, or fascicular VT in the absence of structural heart disease)
- Recipient of an implantable cardioverter defibrillator that has not received market approval from the Food and Drug Administration (FDA)

*Table 2 – Diagnosis criteria for an MI**

Diagnosis criteria for acute, evolving, or recent MI – Either of the following criteria satisfies the diagnosis for an acute, evolving, or recent MI

- Typical rise and gradual fall (Troponin) or more rapid rise and fall (CK-MB) of biochemical markers of myocardial necrosis with at least one of the following:
  - Ischemic symptoms
  - Development of pathologic Q waves on the electrocardiogram (ECG)
  - ECG changes indicative of ischemia (ST segment elevation or depression)
  - Coronary artery intervention (for example, coronary angioplasty)
- Pathologic findings of an acute MI

Diagnosis criteria for established MI – Either of the following criteria satisfies the diagnosis for an established MI

- Development of new pathologic Q waves on serial ECGs
  - Member may or may not remember previous symptoms
  - Biochemical markers of myocardial necrosis may have normalized, depending on the length of time that has passed since the infarct developed
- Pathologic findings of a healed or healing MI

* *As defined by the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction (MI)*

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Table 3 – New York Heart Association (NYHA) Functional Classification

NYHA Class	Symptoms
I	No symptoms and no limitation in ordinary physical activity, e.g., shortness of breath when walking, climbing stairs, etc.
II	Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity
III	Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g., walking short distances (20–100 m). Comfortable only at rest
IV	Severe limitations. Experiences symptoms even while **at rest**. Mostly bedbound patients

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