Medical Policy:
Automatic External Defibrillators
(Commercial)

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<tr>
<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
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<tr>
<td>MG.MM.DM.10dC6v3</td>
<td>04/10/2020</td>
<td>MPC (Medical Policy Committee)</td>
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IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Acronyms Key

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<td>Electrophysiologic study</td>
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<td>Left ventricular ejection fraction</td>
<td>LVEF</td>
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<td>Myocardial infarction</td>
<td>MI</td>
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<td>Sudden cardiac death</td>
<td>SCD</td>
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<td>Ventricular fibrillation</td>
<td>VF</td>
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<td>Ventricular tachycardia</td>
<td>VT</td>
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Guideline

Automatic external defibrillators are covered for members with the DME benefit who are at high risk for SCD due to one of the conditions described under Section I or II. It is expected that the ordering physician be experienced in the management of patients at risk for SCD.
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I. Wearable defibrillator; one of the criteria must be met:

1. Documented VF episode or a sustained VT (> 30 seconds). These dysrhythmias may be either spontaneous or induced during an EP study, but may not be due to a transient or reversible cause nor occur during the first 48 hours of an MI

2. Familial or inherited conditions with a high risk of life-threatening VT (i.e., long QT syndrome or hypertrophic cardiomyopathy)

3. Either documented prior MI or dilated cardiomyopathy and a measured LVEF ≤35%

4. Members that satisfy requirements for an ICD, but have a temporary contraindication or are awaiting heart transplantation

5. A previously implanted cardioverter defibrillator (ICD) now requires explanation (e.g. ICD system defect or infection caused by ICD)

II. Nonwearable defibrillator; both criteria 1 and 2 must be met:

1. The member has one of the following conditions:
   - A documented episode of cardiac arrest due to VF, not due to a transient or reversible cause
   - A sustained VT (> 30 seconds) either spontaneous or induced during an EP study, not associated with acute MI and not due to a transient or reversible cause
   - Familial or inherited conditions with a high risk of life-threatening VT (i.e., long QT syndrome or hypertrophic cardiomyopathy)
   - Coronary artery disease with a documented prior MI, measured LVEF ≤ 35% and inducible, sustained VT or VF during an EP study. To meet this criterion, both of the following must apply:
     - The MI must have occurred > 4 weeks prior to the external defibrillator prescription
     - The EP test must have been performed > 4 weeks after the qualifying MI
   - Documented prior MI and a measured LVEF ≤ 30%. Members must not have any of the following:
     - Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm
     - Coronary artery bypass graft or percutaneous transluminal coronary angioplasty within the past 3 months
     - Enzyme-positive MI within 40 days
     - Clinical symptoms or findings that would make them candidates for coronary revascularization
     - Irreversible brain damage from pre-existing cerebral disease
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- Any disease other than cardiac disease (i.e., cancer, uremia, liver failure) associated with a likelihood of survival < 1 year
- Ischemic dilated cardiomyopathy, documented MI, New York Heart Association (NYHA) Class II and III heart failure and measured LVEF ≤ 35%
- Nonischemic dilated cardiomyopathy for > 3 months, NYHA Class II and III heart failure and measured LVEF ≤ 35%
- One of the previous criteria in this section and NYHA Class IV heart failure.

OR

2. Implantation surgery is contraindicated.

OR

3. A previously implanted ICD now requires explanation (e.g. ICD system defect or infection caused by ICD).

Applicable Coding
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

| Applicable CPT and Diagnosis Codes |

References


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Specialty-matched clinical peer review.

**Revision history**

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<th>DATE</th>
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<td>10/05/2020</td>
<td>ConnectiCare, Inc. has adopted the clinical criteria of its parent corporation, EmblemHealth. Reformatted and reorganized policy, transferred content to new CCI template</td>
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