

**Policy terminated because policy is outdated and no longer necessary.  
This is standard of care, codes covered, and do not require PA or review.**

## **Table of Contents**

1.0	Definition of the Procedure.....	1
2.0	Eligible Recipients.....	1
2.1	General Provisions.....	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age.....	1
3.0	When the Procedure Is Covered.....	2
3.1	Ventricular Tachycardia and Ventricular Fibrillation.....	3
3.2	Prophylactic Implantation.....	3
3.3	Dual Chamber ICD.....	3
3.4	Biventricular Pacing.....	3
4.0	When the Procedure Is Not Covered.....	3
4.1	History of or Active Substance Abuse.....	4
4.2	Psychosocial History.....	4
4.3	Medical Compliance.....	4
5.0	Requirements for and Limitations on Coverage.....	4
6.0	Providers Eligible to Bill for the Procedure.....	4
7.0	Additional Requirements.....	4
8.0	Policy Implementation/Revision Information.....	5
	Attachment A: Claims-Related Information.....	6
A.	Claim Type.....	6
B.	Diagnosis Codes that Support Medical Necessity.....	6
C.	Procedure Codes.....	6
D.	Reimbursement.....	6

## **1.0 Definition of the Procedure**

Implantable cardioverter defibrillator (ICD) is an electronic device designed to monitor a patient's heart rate, recognize ventricular fibrillation (VF) or ventricular tachycardia (VT), and deliver a shock to terminate these life-threatening arrhythmias for patients who are at risk. The device is connected to leads positioned inside the heart or on its surface. These leads are used to deliver electrical shocks, sense the cardiac rhythm, and pace the heart, as needed. The various leads are tunneled to a pulse generator, which is implanted in a pouch beneath the skin of the chest or abdomen (epicardial). These generators are typically a little larger than a wallet and have electronics that automatically monitor and treat heart rhythms recognized as abnormal. Newer devices are smaller and have simpler lead systems. They can be installed through blood vessels (transvenous), eliminating the need for open chest surgery.

When an implantable cardioverter defibrillator detects ventricular tachycardia or fibrillation, it shocks the heart to restore the normal rhythm. New devices also provide overdrive pacing to electrically convert a sustained ventricular tachycardia, and "backup" pacing if bradycardia occurs. They also offer a host of other sophisticated functions, such as storage of detected arrhythmic events and the ability to do "noninvasive" electrophysiologic testing. Implantable cardioverter defibrillators have been very useful in preventing sudden death in patients with known, sustained ventricular tachycardia or fibrillation.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid eligible individuals with a need for this specialized treatment confirmed by a licensed physician are eligible as long as they meet individual eligibility requirements. Medicaid recipients may have service restrictions due to their eligibility category, which would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

**Basic Medicaid Billing Guide:** <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### 3.0 When the Procedure Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

Each recipient's condition is evaluated on an individual basis. There may be other conditions that are indications for coverage. The N.C. Medicaid program covers implantable cardioverter defibrillator related to the following disease processes.

### 3.1 Ventricular Tachycardia and Ventricular Fibrillation

- a. Documented episode of life threatening ventricular tachyarrhythmia, or cardiac arrest not associated with myocardial infarction
- b. Documented cardiac arrest due to ventricular fibrillation and not due to a transient or reversible cause
- c. CAD, decreased LVEF (EF < 40%) after a previous myocardial infarction, and inducible sustained tachyarrhythmia by programmed electrical stimulation

### 3.2 Prophylactic Implantation

Prophylactic implantation for patients who meet the following criteria:

- a. Previous myocardial infarction, at least 30 days prior
- b. EF of 30% or less
- c. CAD
- d. Patients who have not had coronary revascularization within the previous three months
- e. Absence of any co-morbid conditions that would hinder the benefit of the ICD implant, such as but not limited to:
  1. Terminal cancer
  2. Continual VT not controlled by medication
  3. Psychosocial instability, i.e. non-compliance with medical regime
  4. Other conditions that limit the life expectancy to one year or less

### 3.3 Dual Chamber ICD

Dual chamber ICD for patients who meet the following criteria:

- a. Criteria for traditional ICD as listed in **Sections 3.1 and 3.2**
- b. Two documented episodes of atrial fibrillation, or atrial tachycardia in the year prior, with EKG documentation
- c. Patients with chronic atrial fibrillation are **excluded**

### 3.4 Biventricular Pacing

Refer to Clinical Coverage Policy #11D for coverage criteria on biventricular pacing.

## 4.0 When the Procedure Is Not Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

Implantable cardioverter defibrillators are not covered when the medical necessity criteria listed in Section 3.0 are not met. Each recipient's condition is evaluated on an individual basis. There may be other conditions that are indications for non-coverage.

The N.C. Medicaid program does not cover traditional implantable cardioverter defibrillator for ventricular tachycardia and ventricular fibrillation or dual chamber ICD for ventricular arrhythmias and atrial fibrillation for any other conditions than those listed in Section 3.0 including acute myocardial infarction.

#### **4.1 History of or Active Substance Abuse**

Must have documentation of substance abuse program completion plus six months of negative sequential random drug screens.

**Note:** To satisfy the requirement for sequential testing as designated in this policy, the Division of Medical Assistance (DMA) must receive a series of test (alcohol and drug) results spanning a minimum six-month period, allowing no fewer than a three-week interval and no more than six-week interval between each test during the given time period. A complete clinical packet for prior approval must include at least one documented test performed within one month of the date of request to be considered.

#### **4.2 Psychosocial History**

Psychosocial history that would limit ability to comply with medical care pre and post transplant.

#### **4.3 Medical Compliance**

Current patient and/or caretaker non-compliance that would make compliance with a disciplined medical regime improbable.

### **5.0 Requirements for and Limitations on Coverage**

All applicable N.C. Medicaid policies and procedures must be followed in addition to the ones listed in this policy.

All procedures must be prior approved by DMA.

### **6.0 Providers Eligible to Bill for the Procedure**

Physicians enrolled in the N.C. Medicaid program who perform this procedure may bill for this service.

### **7.0 Additional Requirements**

FDA approved procedures, products, and devices for implantation must be utilized.

Implants, products, and devices must be used in accordance with all FDA requirements current at the time of surgery.

A statement signed by the surgeon certifying all FDA requirements for the implants, products, and devices must be retained in the recipient's medical record and made available for review upon request.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** January 1, 1994

**Revision Information:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
7/1/05	Entire Policy	Policy was updated to include coverage criteria effective with approved date of State Plan amendment 4/1/05.
9/1/05	Section 2.2	The special provision related to EPSDT was revised.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2.2	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
5/1/07	Sections 2 through 4	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
5/1/07	Attachment A	Added the UB-04 as an accepted claims form.
4/30/12	Throughout	Policy Termination

### Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

**A. Claim Type**

Physicians bill professional services on the CMS-1500 claim form.

Hospitals bill for services on the UB-92 or UB-04 claim form.

**B. Diagnosis Codes that Support Medical Necessity**

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

**C. Procedure Codes**

Codes that are covered include

33215	33216	33217	33225	33226	33240
33241	33243	33244	33245	33246	33249
93641					

**D. Reimbursement**

Providers must bill their usual and customary charges.