

# Corporate Medical Policy

## Leadless Cardiac Pacemakers

<b>File Name:</b>	leadless_cardiac_pacemakers
<b>Origination:</b>	07/2019
<b>Last CAP Review:</b>	10/2020
<b>Next CAP Review:</b>	10/2021
<b>Last Review:</b>	10/2020

### Description of Procedure or Service

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Pacemakers are intended to be used as a substitute for the heart's intrinsic pacing system to correct cardiac rhythm disorders. By providing an appropriate heart rate and heart rate response, cardiac pacemakers can reestablish effective circulation and more normal hemodynamics that are compromised by a slow heart rate. Pacemakers vary in system complexity and can have multiple functions as a result of the ability to sense and/or stimulate both the atria and the ventricles.

#### **Conventional pacemakers**

Transvenous pacemakers or pacemakers with leads (referred to in this policy as conventional pacemakers) consist of two components: a pulse generator (ie, battery component) and electrodes (ie, leads). The pulse generator consists of a power supply and electronics that can provide periodic electrical pulses to stimulate the heart. The generator is commonly implanted in the infraclavicular region of the anterior chest wall and placed in a pre-pectoral position; in some cases, a subpectoral position is advantageous. The unit generates an electrical impulse, which is transmitted to the myocardium via the electrodes affixed to the myocardium to sense and pace the heart as needed.

Conventional pacemakers are also referred to as single-chamber or dual-chamber systems. In single-chamber systems, only 1 lead is placed, typically in the right ventricle. In dual-chamber pacemakers, two leads are placed, one in the right atrium and the other in the right ventricle. Single-chamber ventricular pacemakers are more common.

Annually, approximately 200,000 pacemakers are implanted in the United States and 1 million worldwide. Implantable pacemakers are considered life-sustaining, life-supporting class III devices for patients with a variety of bradyarrhythmias. Pacemaker systems have matured over the years with well-established, acceptable performance standards. As per the Food and Drug Administration (FDA), the early performance of conventional pacemaker systems from implantation through 60 to 90 days has usually demonstrated acceptable pacing capture thresholds and sensing. Intermediate performance (90 days through more than 5 years) has usually demonstrated the reliability of the pulse generator and lead technology. Chronic performance (5-10 years) includes a predictable decline in battery life and mechanical reliability but a vast majority of patients receive excellent pacing and sensing free of operative or mechanical reliability failures.

Even though the safety profile of conventional pacemakers is excellent, they are associated with complications particularly related to leads. Most safety data on the use of conventional pacemakers comes from registries from Europe, particularly from Denmark where all pacemaker implants are recorded in a national registry. It is important to recognize that valid comparison of complication rates is limited by differences in definitions of complications, which results in a wide variance of outcomes, as well as by the large variance in follow-up times, use of single-chamber or dual-chamber systems, and data reported over more than 2 decades. As such, the

# Leadless Cardiac Pacemakers

following data are contemporary and limited to single-chamber systems when reported separately.

In many cases when conventional pectoral approach is not possible, alternate approaches such as epicardial pacemaker implantation and trans-iliac approaches have been used. Cohen and colleagues (2001) reported outcomes from a retrospective analysis of 123 patients who underwent 207 epicardial lead implantations. Congenital heart disease was present in 103 (84%) of the patients. Epicardial leads were followed for 29 months (range 1 to 207 months). Lead failure was defined as the need for replacement or abandonment due to pacing or sensing problems, lead fracture, or phrenic/muscle stimulation. The 1-, 2-, and 5-year lead survival was 96%, 90%, and 74%, respectively. Epicardial lead survival in those placed by a subxiphoid approach was 100% at 1 year and at 10 years, by the sternotomy approach (93.9% at 1 year and 75.9% at 10 years) and lateral thoracotomy approach (94.1% at 1 year and 62.4% at 10 years).

Doll and colleagues (2008) reported results of an RCT comparing epicardial implantation vs conventional pacemaker implantation in 80 patients with indications for cardiac resynchronization therapy. The authors report that the conventional pacemaker group had significantly shorter ICU stay, less blood loss, and shorter ventilation times while the epicardial group had less exposure to radiation and less use of contrast medium. The left ventricular pacing threshold was similar in the two groups at discharge but longer in the epicardial group during follow-up. Adverse events were also similar in the two groups. The following events were experienced by one (3%) patient each in the epicardial group: pleural puncture, pneumothorax, wound infection, Acute Respiratory Distress Syndrome, and hospital mortality.

As a less invasive alternate to epicardial approach, the trans-iliac approach has also been utilized. Data using trans-iliac approach is limited. Multiple other studies with smaller sample size report a wide range of lead longevity.

Harakeet and colleagues (2018) reported a retrospective analysis of 5 patients who underwent a transvenous iliac approach (median age 26.9 years). Pacing indications included AV block in three patients and sinus node dysfunction in two patients. After a median follow-up of 4.1 years (range 1.0-16.7 years), outcomes were reported for 4 patients. One patient underwent device revision for lead position-related groin discomfort; a second patient developed atrial lead failure following a Maze operation and underwent lead replacement by the iliac approach. One patient underwent heart transplantation six months after implant with only partial resolution of pacing-induced cardiomyopathy. Tsutsumi and colleagues (2010) reported a case series of 4 patients from Japan in whom conventional pectoral approach was precluded due to recurrent lead infections (n=1), superior vena cava obstruction following cardiac surgery (n=2) and a postoperative dermal scar (n=1). The mean follow-up was 24 months and authors concluded the iliac vein approach was satisfactory and less invasive alternative to epicardial lead implantation. However, the authors report that incidence of atrial lead dislodgement using this approach in the literature ranged from 7 to 21%. Experts who provided clinical input reported that trans-iliac or surgical epicardial approach require special expertise and long term performance is suboptimal.

## **Leadless Cardiac Pacemakers**

The potential advantages of leadless pacemakers fall into three categories: avoidance of risks associated with intravascular leads in conventional pacemakers, avoidance of risks associated with pocket creation for placement of conventional pacemakers, and an additional option for patients who require a single-chamber pacer.

Lead complications include lead failure, lead fracture, insulation defect, pneumothorax, infections requiring lead extractions and replacements that can result in a torn subclavian vein or the tricuspid valve. In addition, there are risks of venous thrombosis and occlusion of the subclavian system from the leads. Use of a leadless system eliminates such risks with the added advantage that a patient has vascular access preserved for other medical conditions (eg, dialysis, chemotherapy).

# Leadless Cardiac Pacemakers

Pocket complications include infections, erosions, and pain that can be eliminated with leadless pacemakers. Further, a leadless cardiac pacemaker may be more comfortable and appealing because, unlike conventional pacemakers, patients are unable to see or feel the device or have an implant scar on the chest wall.

Leadless pacemakers may also be a better option than surgical endocardial pacemakers for patients with no vascular access due to renal failure or congenital heart disease.

Leadless pacemakers are self-contained in a hermetically sealed capsule. The capsule houses a battery and electronics to operate the system. Similar to most pacing leads, the tip of the capsule includes a fixation mechanism and a monolithic controlled-release device. The controlled-release device elutes glucocorticosteroid to reduce acute inflammation at the implantation site. Leadless pacemakers have rate-responsive functionality, and current device longevity estimates are based on bench data. Estimates have suggested that these devices may last over 10 years, depending on the programmed parameters.

## Clinical Development

Three systems are currently being evaluated in clinical trials: (1) the Micra Transcatheter Pacing System (Medtronic), (2) the Nanostim leadless pacemaker (St. Jude Medical); and (3) the WiCS Wireless Cardiac Stimulation System (EBR Systems). The first two devices are free-standing capsule-sized devices that are delivered via femoral venous access using a steerable delivery sheath. However, the fixing mechanism differs between the two devices. In the Micra Transcatheter Pacing System, the fixation system consists of four self-expanding nitinol tines, which anchor into the myocardium; for the Nanostim device, there is a screw-in helix that penetrates about 1 mm into the myocardium, with nylon tines that provide secondary fixation. In both devices, the cathode is steroid eluting and delivers pacing current; the anode is located in a titanium case. The third device, WiCS system differs from the other devices; this system requires implanting a pulse generator subcutaneously near the heart, which then wirelessly transmits ultrasound energy to a receiver electrode implanted in the left ventricle. The receiver electrode converts the ultrasound energy and delivers electrical stimulation to the heart sufficient to pace the left ventricle synchronously with the right.

Of these three, only the Micra transcatheter pacing system is approved by the FDA and commercially available in the United States. Multiple clinical studies of Nanostim have been published but trials have been halted due to the migration of the docking button in the device. Evidence on Nanostim is not reviewed further because the device is not yet FDA approved.

The Micra is about 26mm in length and introduced using a 23 French catheter via the femoral vein to the right ventricle. It weighs about 2 grams and has an accelerometer-based rate response.

Nanostim is approximately 40mm in length and introduced using an 18 French catheter to the right ventricle. It also weights about 2 grams and uses a temperature-based rate response sensor.

## Regulatory Status

In April 2016, the Micra™ transcatheter pacing system (Medtronic) was approved by the FDA through the premarket approval process for use in patients who have experienced one or more of the following conditions:

- symptomatic paroxysmal or permanent high-grade arteriovenous block in the presence of atrial fibrillation
- paroxysmal or permanent high-grade arteriovenous block in the absence of atrial fibrillation, as an alternative to dual-chamber pacing, when atrial lead placement is considered difficult, high risk, or not deemed necessary for effective therapy
- symptomatic bradycardia-tachycardia syndrome or sinus node dysfunction (sinus bradycardia or sinus pauses), as an alternative to atrial or dual-chamber pacing, when

# Leadless Cardiac Pacemakers

atrial lead placement is considered difficult, high risk, or not deemed necessary for effective therapy.

In January 2020, the Micra AV Transcatheter Pacing System Model MC1AVR1 and Application Software Model SW044, were approved as a premarket approval supplement (S061) to the Micra system described above. The Micra AV includes an enhanced algorithm to provide AV synchronous pacing.

**\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

## Policy

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**BCBSNC will provide coverage for leadless cardiac pacemakers when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.**

## Benefits Application

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This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

## When Leadless Cardiac Pacemakers are covered

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The Micra transcatheter pacing system may be considered medical necessary in patients when both conditions below are met:

1. The patient 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. The patient has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following;
  - History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection, **or**
  - 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**
  - Presence of a bioprosthetic tricuspid valve

## When Leadless Cardiac Pacemakers are not covered

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The Micra transcatheter pacing system is considered investigational in all other situations in which the above criteria are not met.

## Policy Guidelines

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For individuals with a guidelines-based indication for a ventricular pacing system who are medically eligible for a conventional pacing system who receive a Micra transcatheter pacing system, the evidence includes a pivotal prospective cohort study and a post-approval prospective cohort study. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Results at 6 months and 1 year for the pivotal study reported high procedural success (>99%) and device effectiveness (pacing capture threshold met in 98% patients). Most of the system- or procedural-related complications occurred within 30 days. At 1 year, the incidence of major complication did not increase substantially from 6 months (3.5% at 6 months vs 4% at 1 year). Results of the post-approval study were consistent with the pivotal study and showed a lower incidence of major complications up to 30 days post-implantation as

# Leadless Cardiac Pacemakers

well as 1 year (1.5% and 2.7%, respectively). In both studies, the point estimates of major complications were lower than the pooled estimates from 6 studies of conventional pacemakers used as a historical comparator. While Micra device eliminates lead- and surgical pocket-related complications, its use can result in potentially more serious complications related to implantation and release of the device (traumatic cardiac injury) and less serious complications related to the femoral access site (groin hematomas, access site bleeding). Considerable uncertainties and unknowns remain in terms of durability of device and device end-of-life issues. Early and limited experience has suggested that retrieval of these devices is unlikely because, in due course, the devices will be encapsulated. There are limited data on device-device interactions (both electrical and mechanical), which may occur when there is a deactivated Micra device alongside another leadless pacemaker or when a leadless pacemaker and transvenous device are both present. While the current evidence is encouraging, overall benefit with the broad use of Micra transcatheter pacing system compared with conventional pacemakers has not been shown. The evidence is insufficient to determine the effects of technology on health outcomes.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a Micra transcatheter pacing system, the evidence includes subgroup analysis of a pivotal prospective cohort study and a post-approval prospective cohort study. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Information on the outcomes in the subgroup of patients from the post-approval study showed that the Micra device was successfully implanted in 98% of cases and safety outcomes were similar to the original cohort. Even though the evidence is limited and long-term effectiveness and safety are unknown, the short-term benefits outweigh the risks because the complex trade-off of adverse events for these devices needs to be assessed in the context of the life-saving potential of pacing systems for patients, ineligible for conventional pacing systems. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

## **Billing/Coding/Physician Documentation Information**

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcsnc.com](http://www.bcsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: 33274, 33275*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## **Scientific Background and Reference Sources**

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BCBSA Medical Policy Reference Manual [Electronic Version]. 2.02.32, 7/2019

Medical Director review 7/2019

Specialty Matched Consultant Advisory Panel review 10/2019

Medical Director review 10/2019

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.02.32, 8.2020

Specialty Matched Consultant Advisory Panel review 10/2020

# Leadless Cardiac Pacemakers

Medical Director review 10/2020

## **Policy Implementation/Update Information**

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- 8/13/2019 New policy developed. Leadless cardiac pacemakers, specifically, the Micra transcatheter pacing system may be considered medically necessary in patients when the medical criteria are met. Added the following codes, *0387T, 0388T, 0389T, 0390T, 0391T* to “Billing/Coding” section. References added. Medical Director review 7/2019. (jd)
- 10/29/19 Specialty Matched Consultant Advisory Panel review 10/2019. Medical Director review 10/2019. (jd)
- 2/25/20 Billing/Coding section updated: removed CPT codes 0387T-0391T and added 33274 and 33275. (jd)
- 11/10/20 References updated. Specialty Matched Consultant Advisory Panel review 10/2020. Medical Director review 10/2020. (jd)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.