MEDICAL POLICY – 2.02.506
Wearable Cardioverter-Defibrillators as a Bridge to Implantable Cardioverter-Defibrillator Placement

BCBSA Ref. Policy: 2.02.15, 7.01.44
Effective Date: Jan. 1, 2023
Last Revised: Dec. 13, 2022
Replaces: 2.02.15
RELATED MEDICAL POLICIES: None

Introduction

Sudden cardiac arrest is when the heart stops beating. It can cause death within minutes if not treated. A cardiac defibrillator is a device that shocks the heart back into normal rhythm to prevent sudden cardiac arrest. A wearable cardiac defibrillator is one type of defibrillator. It’s strapped around the chest and worn underneath clothes. Electrodes (small patches applied to the skin) monitor the heart’s rhythm. Other electrodes deliver the current. The electrodes are attached to a small defibrillation unit, usually worn at the waist. When a life-threatening heart rhythm is detected, an alarm alerts the person and the defibrillator sends a shock to return the heart to a normal rhythm. These vests are useful when surgery to implant a permanent defibrillator is temporarily delayed due to a medical reason. This policy describes when a wearable cardioverter-defibrillator may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
### Policy Coverage Criteria

<table>
<thead>
<tr>
<th>Device</th>
<th>Medical Necessity</th>
</tr>
</thead>
</table>
| **Wearable cardioverter-defibrillator (WCD)** | The use of a wearable (external) cardioverter-defibrillator (WCD) to prevent sudden cardiac arrest or death (SCD) may be considered medically necessary as interim treatment as a bridge to permanent implantable (internal) cardioverter-defibrillator (ICD) surgery for a period not to exceed 90 days, when ALL of the following criteria are met:  
  - The criteria for an ICD placement are met in any ONE of the following (see Related Coverage Indications):  
    - The individual has an ejection fraction (LVEF) ≤ 35%; **and**  
      - Has ischemic cardiomyopathy due to a recent (< 40 days) myocardial infarction (MI); **or**  
      - Has newly diagnosed non-ischemic dilated cardiomyopathy and guideline-directed medical therapy initiated (e.g., ACE inhibitors, ARBs, beta blockers); **or**  
      - Revascularization was performed (e.g, CABG, percutaneous coronary angioplasty and/or stenting within the past 90 days)
  
  OR
  - The individual has familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy
  
  OR
  - The individual has a documented episode of ventricular fibrillation or a sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction

  **AND**
  - A temporary contraindication to receiving an ICD placement exists, such as a current systemic infection is being treated

  **OR**
Device | Medical Necessity
--- | ---

• An ICD was removed due to a concurrent infection or malfunction

**AND**

• The ICD placement or an ICD replacement surgery, if appropriate, will be scheduled once the temporary contraindication is treated or managed

Note: *ACE-Angiotensin-converting enzyme, ** ARB-Angiotensin-receptor blockers, ***CABG-Coronary artery bypass graft

Requests for re-authorization beyond the initial 90 days for another 30 days (additional one month rental) must be submitted with physician attestation of ≥90% daily compliance (demonstrated by the individual’s data reports downloaded from the manufacturer portal by the treating provider) along with an updated treatment plan documenting the ongoing medical necessity of the WCD from the treating provider.

### Investigational

**Wearable cardioverter-defibrillator**

Use of a wearable cardioverter-defibrillator for the prevention of sudden cardiac death (SCD) is considered investigational for the following indications when they are the sole indication for a WCD:

- High-risk individuals awaiting heart transplant
- Women with peripartum cardiomyopathy

Use of WCDs is considered investigational for all other indications.

### Related Coverage Indications

**Temporary Contraindications for ICD placement**

It is uncommon for individuals to have a temporary contraindication to implantable cardioverter defibrillator placement. The most common reason will be a systemic infection that requires treatment before the implantable cardioverter defibrillator can be implanted. The wearable
Related Coverage Indications

The implantable cardioverter defibrillator should only be used short-term while the temporary contraindication (e.g., systemic infection) is being clinically managed. Once treatment is completed, the permanent implantable cardioverter defibrillator should be implanted.

Indications for Implantable Cardioverter-Defibrillator (ICD) Implantation

Indications for ICD implantation can be broadly subdivided into two categories:

1. **Primary prevention**, in individuals who are considered at high risk for sudden cardiac death but who have not yet experienced life-threatening ventricular arrhythmia such as ventricular tachycardia (VT) or ventricular fibrillation (VF).

2. **Secondary prevention**, in individuals who have experienced a life-threatening episode of VT, after reversible causes have been excluded.

Primary Prevention indication\textsuperscript{33,34} for the use of the automatic ICD in adults includes:

- Ischemic cardiomyopathy with New York Heart Association (NYHA) functional Class II or Class III symptoms, a history of myocardial infarction at least 40 days before ICD treatment, and left ventricular ejection fraction of 35% or less

OR

- Ischemic cardiomyopathy with NYHA functional Class I symptoms, a history of myocardial infarction at least 40 days before ICD treatment, and left ventricular ejection fraction of 30% or less

OR

- Nonischemic dilated cardiomyopathy (NIDCM) and left ventricular ejection fraction of 35% or less, after reversible causes have been excluded, and the response to optimal medical therapy has been adequately determined

OR

- Hypertrophic cardiomyopathy (HCM) with one or more major risk factors for sudden cardiac death (history of premature HCM-related sudden death in one or more first-degree relatives younger than 50 years; left ventricular hypertrophy greater than 30 mm; one or more runs of non-sustained ventricular tachycardia at heart rates of 120 beats per minute or greater on 24-hour Holter monitoring; prior unexplained syncope inconsistent with neurocardiogenic origin) and judged to be at high risk for sudden cardiac death by a physician experienced in the care of individuals with HCM

OR

- Diagnosis of any one of the following cardiac ion channelopathies and considered to be at high risk for sudden cardiac death:
  - Brugada syndrome
**Related Coverage Indications**

- Catecholaminergic polymorphic ventricular tachycardia
- Congenital long QT syndrome
- Short QT syndrome

OR

- Diagnosis of cardiac sarcoid and considered to be at high risk for sudden cardiac death

**Secondary Prevention:**

- Individuals with a history of a life-threatening clinical event associated with ventricular arrhythmic events such as sustained ventricular tachyarrhythmia, after reversible causes (e.g., acute ischemia) have been excluded

**Indications where use of an ICD is considered investigational in primary prevention individuals:**

- Individual has had an acute myocardial infarction (i.e., less than 40 days before ICD treatment)
- Individual has NYHA Class IV congestive heart failure (unless individual is eligible to receive a combination cardiac resynchronization therapy ICD device)
- Individual has had a cardiac revascularization procedure in the past 3 months (coronary artery bypass graft [CABG] or percutaneous transluminal coronary angioplasty [PTCA]) or are candidates for a cardiac revascularization procedure
- Individual has noncardiac disease that would be associated with life expectancy less than 1 year

**Documentation Requirements**

The individual’s medical records submitted for review should document that medical necessity criteria are met. The record should include clinical documentation of:

- Diagnosis/condition
- History and physical examination documenting the severity of the condition
- Plans for placement of an implantable cardioverter-defibrillator (ICD)
- Temporary contraindication(s) to ICD placement

**Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
</tbody>
</table>
### Code | Description
--- | ---
93292* | Interrogation device evaluation (in person) with physician analysis, review and report, 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0606</td>
<td>Automatic external defibrillator, with integrated electrocardiogram analysis, garment type</td>
</tr>
<tr>
<td>K0607</td>
<td>Replacement battery for automated external defibrillator, garment type only, each</td>
</tr>
<tr>
<td>K0608</td>
<td>Replacement garment for use with automated external defibrillator, each</td>
</tr>
<tr>
<td>K0609</td>
<td>Replacement electrodes for use with automated external defibrillator, garment type only, each</td>
</tr>
</tbody>
</table>

*Code 93292 cannot be reported with code 93745.

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

### Related Information

N/A

### Evidence Review

### Description

A wearable cardioverter defibrillator (WCD) is a temporary, external device that is an alternative to an implantable cardioverter defibrillator (ICD). It is primarily intended for temporary conditions for which an implantable device is contraindicated, or for the period during which the need for a permanent implantable device is uncertain.
Background

Sudden Cardiac Arrest

Sudden cardiac arrest (SCA) is the most common cause of death in individuals with coronary artery disease.

Treatment

The implantable cardioverter defibrillator (ICD) has proven effective in reducing mortality for survivors of SCA and for individuals with documented malignant ventricular arrhythmias. More recently, use of ICDs has been broadened by studies reporting a reduction in mortality for individuals at risk for ventricular arrhythmias, such as individuals with prior myocardial infarction (MI) and reduced ejection fraction (EF).

ICDs consist of implantable leads, which are placed percutaneously in the heart, that are connected to a pulse generator placed beneath the skin of the chest or abdomen. Placement of the ICD is a minor surgical procedure. Potential adverse events of ICD placement are bleeding, infection, pneumothorax, and delivery of unnecessary counter shocks.

The wearable cardioverter defibrillator is an external device intended to perform the same tasks as an ICD, without requiring invasive procedures. It consists of a vest worn continuously underneath the individual’s clothing. Part of this vest is the “electrode belt” that contains the cardiac-monitoring electrodes and the therapy electrodes that deliver a counter shock. The vest is connected to a monitor with a battery pack and alarm module worn on the individual’s belt. The monitor contains the electronics that interpret the cardiac rhythm and determines when a counter shock is necessary. The alarm module alerts the individual to certain conditions by lights or voice messages, during which time a conscious individual can abort or delay the shock (see Appendix for graphic).

U.S. Food and Drug Administration (FDA) labeled indications for the WCD are adults at risk for SCA who either are not candidates for or refuse an implantable ICD. Some experts have suggested that the indications for a WCD should be broadened to include other populations at high risk for SCA. The potential indications include:

- Bridge to transplantation (i.e., the Use of a Wearable Defibrillator in Terminating Tachyarrhythmias in Patients at High Risk for Sudden Death [WEARIT] study population)
• Bridge to implantable device or clinical improvement (i.e., the Patients at High Risk for Sudden Death after a Myocardial Infarction or Bypass Surgery not receiving an ICD for up to four months [BIROAD] study population)
  o Post bypass with ejection fraction less than 30%
  o Post bypass with ventricular arrhythmias or syncope within 48 hours of surgery
  o Post myocardial infarction with ejection fraction less than 30%
  o Post myocardial infarction with ventricular arrhythmias within 48 hours
• Drug-related arrhythmias (during drug washout or after, during evaluation of long-term risk)
• Patients awaiting revascularization
• Patients too ill to undergo device implantation
• Patients who refuse device therapy.

Immediate Post Myocardial Infarction Period

Olgin et al (2018) randomly allocated 1524 individuals with acute MI and an ejection fraction ≤35% to WCD and 778 to receive only guideline-based therapy (tai N=2302).13 Individuals in the treatment group wore the device a median of 18.0 hours per day (interquartile range, 3.8 to 22.7). Within 90 days, 1.6% of participants in the WCD group and 2.4% of those in the control group had died of arrhythmia (relative risk [RR], 0.67; 95% CI, 0.37 to 1.21; p=0.18). In the WCD group, death from any cause was seen in 3.1% of participants; in the control group, the death rate was 4.9% (RR, 0.64; 95% CI, 0.43 to 0.98; uncorrected p=0.04). In the WCD group, of the 48 individuals who died, 12 were wearing the WCD at time of death. Twenty participants in the WCD (1.3%) group received appropriate shock, and 9 (0.6%) an inappropriate shock. The results of this trial show that for individuals with these specific conditions, the WCD did not improve the rate of arrhythmic death compared with usual care.

Epstein et al (2013) reported on the results of postmarket registry data from 8453 post-MI individuals who received WCDs for risk of SCA while awaiting ICD placement.14 The WCD was worn a median of 57 days (mean, 69 days), with a median daily use of 21.8 hours. Study characteristics and results are summarized in Table1 and Table2, respectively. While 1.4% of this registry population was successfully treated with WCDs, interpretation of registry data is limited. It is not possible to determine whether outcomes were improved without a control group, and
the registry contained limited patient and medical information making interpretation of results difficult.

Clark et al (2019) reported on the results of a retrospective cohort analysis of Medicare claims data of 16,935 individuals who were post-MI and received WCDs. The analysis utilized a 5% sample of Medicare's Standard Analytical Files (2010–2012) and included individuals with an inpatient admission for acute MI. One-year adjusted mortality rates were compared between individuals who received a WCD within 15 days of discharge and those who did not receive a WCD (Tables 1 and 2). The 30-day mortality rate in the WCD group was not reported due to Medicare restrictions on reporting that represents <11 beneficiaries, but was stated to be lower than that in the no WCD group (10.4%; p=0.18). While these results favored WCD, interpretation of these findings is limited; for example, the authors noted the potential for confounding by indication and performance bias, and the WCD group was significantly younger and had more frequent congestive heart failure, unstable angina and other acute ischemic heart disease.

Uyei and Braithwaite (2014) reported on the results of a systematic review conducted to evaluate the effectiveness of WCD use in several clinical situations, including individuals soon after post-MI (≤40 days) with a LVEF of 35% or less. Four studies (Chung et al [2010], Epstein et al [2013], 2 conference abstracts) assessed the effectiveness of WCD use in post-MI patients. Outcomes reported were heterogeneous. For two studies that reported VF- and VT-related mortality, on average, 0.52% (2/384) of the study population died of VF or VT over a mean of 58.3 days of WCD use. For two studies that reported on VT and VF incidence, on average, 2.8% (11/384) of WCD users experienced a VT and/or VF event over a mean of 58.3 days of WCD use (range, 3-146 days). Among those who experienced a VT or VF event, on average, 82% (9/11) had successful termination of 1 or more arrhythmic events. Reviewers concluded that the quality of evidence was low to very low quality and confidence in the reported estimates was weak.

In summary one RCT of WCD in the early post-acute MI period found no benefit to WCD over guideline-directed therapy. Two RCTs of ICD use in this period concluded that mortality rates did not improve compared with usual care. In both trials, SCD was reduced in the ICD group, but non-SCD events increased, resulting in no difference in overall mortality. Analysis of data from a retrospective post market registry reported a success rate of 82% but interpretation of registry data was limited in the absence of a control group. Similarly, a retrospective cohort of Medicare data found that WCD use was associated with lower 1-year mortality than no WCD use, but potential biases were noted. Because a permanent ICD does not appear to be beneficial in the early post-MI period, a WCD would also not be beneficial for these patient populations. Use of WCD in the immediate post-MI period as a bridge to permanent ICD placement was reviewed in a TEC Assessment (2010). For these individuals, indications for a permanent ICD cannot be reliably assessed immediately post-MI because it is not possible to determine the final EF until at
least 30 days after the event. Because the first 30 days after an acute MI represent a high-risk period for lethal ventricular arrhythmias, there is a potential to reduce mortality using other treatments. Despite the rationale for this potential indication, the TEC Assessment concluded that the available evidence does not support the contention that any cardioverter defibrillator improves mortality in individuals in the immediate post-MI period. Two RCTs (Defibrillator in Acute Myocardial Infarction Trial [DINAMIT], Immediate Risk Stratification Improves Survival [IRIS]) and a post hoc analysis of an RCT, the Prophylactic Implantation of a Defibrillator in Patients with Myocardial Infarction and Reduced Ejection Fraction (MADIT-II) led to this conclusion. In the DINAMIT (674 patients) and IRIS (898 patients) trials, which randomized patients with LVEF of 35% or less to early ICD implantation 6 to 40 days after acute MI or medical therapy alone, there was no significant improvement in overall mortality.17,18 The hazard ratios (HR) for OS in the DINAMIT and IRIS trials were 1.08 (95% CI, 0.76 to 1.55; p=.66) and 1.04 (95% CI, 0.81 to 1.35; p=.78), respectively. Despite a reduction in arrhythmic deaths among individuals with an ICD, there was a higher risk of nonarrhythmic deaths during this early period, resulting in similar overall mortality rates in the 2 trials. Secondary analysis of data from the MADIT-II trial showed that the survival benefit associated with ICDs appeared to be greater for remote MI and remained substantial for up to 15 or more years after MI. Within the first 18 months post-MI, there was no benefit found for ICD placement (HR, 0.97; 95% CI, 0.51 to 1.81; p=.92). In contrast, there was a significant mortality benefit when the length of time since MI was greater than 18 months (HR, 0.55; 95% CI, 0.39 to 0.78; p=.001).

Table 1: Key Nonrandomized Trial Characteristics in Immediate Post-MI Period

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>Country</th>
<th>Dates</th>
<th>Participants</th>
<th>Treatment</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epstein et al (2013)(^a)</td>
<td>Retrospective registry (postmarket study)</td>
<td>U.S.</td>
<td>2005-2011</td>
<td>High-risk post-MI patients during the 40-d and 3-mo waiting periods</td>
<td>WCD</td>
<td>3 mo</td>
</tr>
<tr>
<td>Clark et al (2019)(^b)</td>
<td>Retrospective cohort</td>
<td>United States</td>
<td>2010-2012</td>
<td>Medicare patients hospitalized for MI</td>
<td>WCD</td>
<td>1 y</td>
</tr>
</tbody>
</table>

MI: myocardial infarction; WCD: wearable cardioverter defibrillator.
Table 2: Key Nonrandomized Trial Results in Immediate Post MI Period

<table>
<thead>
<tr>
<th>Study</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epstein et al (2013)¹⁴</td>
<td>N=8453</td>
</tr>
<tr>
<td>Wearable cardioverter defibrillator</td>
<td>• Number of patients receiving shock: n=133</td>
</tr>
<tr>
<td></td>
<td>• Shock events: n=146</td>
</tr>
<tr>
<td></td>
<td>• Appropriate shocks: n=309ᵃ</td>
</tr>
<tr>
<td></td>
<td>• Shocks successful in terminating VT or VF: n=252 (82% success)</td>
</tr>
<tr>
<td></td>
<td>• Shocks leading to asystole: n=9</td>
</tr>
<tr>
<td></td>
<td>• Unsuccessful shocks: n=41 (10% failure)</td>
</tr>
<tr>
<td></td>
<td>• Inappropriate shocks: n=99 patients received 114 inappropriate shocks</td>
</tr>
<tr>
<td>Clark et al (2019)¹⁵</td>
<td>N=16,935</td>
</tr>
<tr>
<td>WCD, n/N (%) (n=89)</td>
<td>1-y mortality: NR (11.5%)</td>
</tr>
<tr>
<td>No WCD, n/N (%) (n=16,846)</td>
<td>1-y mortality: NR (19.8%)</td>
</tr>
<tr>
<td>HR (95% CI)</td>
<td>1-y mortality 0.46 (NR)</td>
</tr>
</tbody>
</table>

CI: confidence interval; HR: hazard ratio; NR: not reported; VF: ventricular fibrillation; VT: ventricular tachycardia; WCD: wearable cardioverter defibrillator.

ᵃ Shocks deemed appropriate if they occurred during sustained (>30 seconds) VT or VF and inappropriate if not.

Individuals with Newly Diagnosed Nonischemic Cardiomyopathy

In individuals with newly diagnosed nonischemic cardiomyopathy, final EF is uncertain because some individuals show an improvement in EF over time. The Defibrillators in Nonischemic Cardiomyopathy Treatment Evaluation (DEFINITE) RCT compared ICD implantation plus standard medical therapy with standard medical therapy alone for primary prevention of SCD in individuals who had nonischemic cardiomyopathy, nonsustained VT, and a LVEF of 35% or less. Results of this trial did not show a significant reduction in mortality with ICD regardless of duration since diagnosis (HR, 0.65; 95% CI, 0.40 to 1.06; p=0.08). Kadish et al (2006) conducted a post hoc analysis of the same trial that evaluated use of an ICD in individuals with nonischemic dilated cardiomyopathy and examined the benefit of ICD use by time since diagnosis (<3 months and >9 months).²⁴ This trial excluded individuals with a clinical picture consistent with a reversible cause of cardiomyopathy and thus may differ from the population considered for a WCD. The difference in survival was of borderline significance for the ICD group compared with controls, both for the recently diagnosed subgroup (HR, 0.38; 95% CI, 0.14 to 1.00; p=0.05) and the remotely diagnosed subgroup (HR, 0.43; 95% CI, 0.22 to 0.99; p=0.046).
Study characteristics and results are summarized in Tables 3 and 4, respectively. In the WEARIT-II Registry study (discussed previously), 46% (n=927) of individuals were prescribed WCD for nonischemic cardiomyopathy. After three months of follow-up, the rate of sustained VTs was 1% among those with nonischemic cardiomyopathy. However, outcomes data (appropriate and inappropriate shocks) were not reported separately for individuals with nonischemic cardiomyopathy.

Another potential indication for the WCD is alcoholic cardiomyopathy where cardiomyopathy is reversible but temporary protection against arrhythmias is needed. Salehi et al (2016) reported on the results of analysis of a subset of individuals identified from manufacturer registry. Mean EF was 19.9% on presentation. Patients wore the WCD for a median of 51 days and a median of 18.0 hours a day. At the end of WCD use, 33% of patients had improved EF and did not require ICD placement; 24% received an ICD. Four deaths occurred during this period, with one death in a patient wearing WCD (due to ventricular asystole).

Wässnig et al (2016) reported on the results of a national German registry of 6043 individuals with multiple etiologies including dilated cardiomyopathy, myocarditis, and ischemic and nonischemic cardiomyopathies who were prescribed WCD. Overall seven (1%) of 735 individuals with nonischemic cardiomyopathy were appropriately shocked for sustained VT or VF.

Duncker et al (2017) reported on the results of the Avoiding Untimely Implantable Cardioverter/Defibrillator Implantation by Intensified Heart Failure Therapy Optimization Supported by the Wearable Cardioverter/Defibrillator (PROLONG) study of 156 individuals of whom 111 with nonischemic cardiomyopathy with a newly diagnosed LVEF of 35% or less were prescribed WCD and analyzed separately from the full cohort.

The Uyei and Braithwaite (2014) systematic review also identified four studies (Saltzberg et al [2012], Chung et al [2010], and 2 conference abstracts) that assessed WCD use in newly diagnosed nonischemic cardiomyopathy. In the 3 studies that reported VT and VF incidences, on average, 0.57% (5/871) subjects experienced VT and/or VF over a mean duration of 52.6 days. Among those who experienced a VT or VF event, on average, 80% had successful event termination.

In summary, for individuals with newly diagnosed nonischemic cardiomyopathy, the evidence includes an RCT for ICD and multiple retrospective analyses of registry data for WCD. The RCT found that prophylactic ICD placement in nonischemic cardiomyopathy did not improve mortality compared with usual clinical care. The retrospective analysis did not provide sufficient evidence to determine whether a WCD improves outcomes compared with usual care. Thus, given the lack of evidence that a permanent ICD improves outcomes, a WCD is not expected to improve outcomes under the conditions studied in this trial.
Table 3: Key Nonrandomized Trial Characteristics for Newly Diagnosed Nonischemic Cardiomyopathy

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>Country</th>
<th>Dates</th>
<th>Participants</th>
<th>Treatment</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kutyifa et al (2015)(^{10}); WEARIT-II Registry</td>
<td>Prospective registry</td>
<td>U.S., Germany</td>
<td>2011-2014</td>
<td>Patients with nonischemic cardiomyopathy</td>
<td>WCD</td>
<td>90 d</td>
</tr>
<tr>
<td>Salehi et al (2016)(^{25})</td>
<td>Retrospective registry</td>
<td>U.S.</td>
<td>2005-2012</td>
<td>Patients with nonischemic cardiomyopathy who self-reported a history of excess alcohol use</td>
<td>WCD</td>
<td>100 d</td>
</tr>
<tr>
<td>Duncker et al (2017)(^{26,27}); PROLONG</td>
<td>Retrospective cohort</td>
<td>Germany</td>
<td>2012-2016</td>
<td>Newly diagnosed LVEF ≤35%</td>
<td>WCD</td>
<td>11 mo</td>
</tr>
<tr>
<td>Wässnig et al (2016)(^{22})</td>
<td>Retrospective cohort</td>
<td>Germany, multiple sites</td>
<td>2010-2013</td>
<td>Patients with multiple etiology</td>
<td>WCD</td>
<td>NR</td>
</tr>
</tbody>
</table>

LVEF: left ventricular ejection fraction; NR: not reported; PROLONG: Avoiding Untimely Implantable Cardioverter/Defibrillator Implantation by Intensified Heart Failure Therapy Optimization Supported by the Wearable Cardioverter/Defibrillator; WCD: wearable cardioverter defibrillator; WEARIT-II: Use of the Wearable Cardioverter Defibrillator in High-Risk Cardiac Patients.

Table 4: Key Nonrandomized Trial Results for Newly Diagnosed Nonischemic Cardiomyopathy

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Appropriate Shock(^{a})</th>
<th>Inappropriate Shock(^{a})</th>
<th>Nonadherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kutyifa et al (2015)(^{10}); WEARIT-II Registry</td>
<td>927</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>WCD</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Salehi et al (2016)(^{25})</td>
<td>7/127 (6%)</td>
<td>13/127 (10.2%)</td>
<td></td>
</tr>
<tr>
<td>Duncker et al (2017)(^{26,27}); PROLONG</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Study; Trial

<table>
<thead>
<tr>
<th></th>
<th>Appropriate Shock&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Inappropriate Shock&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Nonadherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCD</td>
<td>8/117 (7%)</td>
<td>None</td>
<td>Of 156 (entire cohort), 48 terminated WCD treatment before 3-mo follow-up. Of the 48, 24 (50%) discontinued due to noncompliance</td>
</tr>
<tr>
<td>Wässnig et al (2016)&lt;sup&gt;23&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WCD</td>
<td>7/735 (1%)</td>
<td>Stratified data not reported</td>
<td>Stratified data not reported</td>
</tr>
</tbody>
</table>

Summary of Evidence

**Overview of Wearable Cardioverter Defibrillator Versus Implantable Cardioverter Defibrillator**

One RCT has compared WCD with usual guideline-based care and found no significant benefit to WCD over usual care. No studies have directly compared the performance of a WCD with a permanent ICD. One small study in an electrophysiology lab demonstrated that the WCD can correctly identify and terminate most induced ventricular arrhythmias. Similarly, a study of the ASSURE WCD in individuals with cardiomyopathy found the WCD to detect all events recorded by an ICD with few false-positive shock alarms in a 30-day period. A cohort study of WCD use estimated that the percentage of successful resuscitations was approximately 70%. Multiple studies have demonstrated suboptimal adherence. Device failures were largely attributed to incorrect device use and/or nonadherence. A more recent registry study has reported a high compliance rate, although these results may be biased by self-selection. Collectively, this evidence indicates that the WCD can successfully detect and terminate arrhythmias in at least some individuals but that overall performance in clinical practice might be inferior to a permanent ICD.

**Temporary Contraindications**

For individuals who have a temporary contraindication to an ICD who receive a WCD, the evidence includes prospective cohort studies and a technology assessment that assessed ICD
devices, given the absence of evidence on WCD devices. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. A small number of individuals meet established criteria for an ICD but have a transient contraindication for an implantable device, most commonly an infectious process. The available data have established that the WCD device can detect lethal arrhythmias and can successfully deliver a countershock in most cases. In individuals scheduled for ICD placement, the WCD will improve outcomes as an interim treatment. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

**Immediate Post Myocardial Infarction**

For individuals who are in the immediate post MI period who receive a WCD, the evidence includes a RCT comparing WCD with guideline-based therapy, two cohort studies, and a systematic review. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. The RCT reported no benefit of WCD over guideline-based therapy. The cohort study of 8453 individuals showed that 252 shocks successfully terminated VF or VT (82% success rate), but without a control group, interpretation is difficult. Similarly, a retrospective cohort of Medicare data found that WCD use was associated with lower 1-year mortality than no WCD use, but potential biases were noted. Evidence from the systematic review was deemed of low to very low quality, and the reviewers had weak confidence in the reported estimates. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

**Post–Coronary Artery Bypass Graft Surgery at High Risk for Lethal Arrhythmias**

For individuals who are post coronary artery bypass graft (CABG) surgery and are at high risk for lethal arrhythmias, the evidence includes an RCT for ICD and a registry study. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. For high-risk post coronary artery bypass graft patients, an RCT reported no difference in OS associated with early ICD placement. The registry study found survival benefits with WCD but had limited interpretation of data. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.
Awaiting Heart Transplantation at High Risk for Lethal Arrhythmias

For individuals who are awaiting heart transplantation and are at high risk for lethal arrhythmias, the evidence includes analyses of subsets of individuals from the manufacturer registry, a subset from a prospective cohort study, and a case series. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. These studies do not provide sufficient evidence to determine whether a WCD is of benefit compared with usual care. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Newly Diagnosed Nonischemic Cardiomyopathy

For individuals who have newly diagnosed nonischemic cardiomyopathy, the evidence includes an RCT for ICD and several retrospective analyses of WCD registry data. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. The RCT found that prophylactic ICD placement for nonischemic cardiomyopathy did not improve mortality compared with usual care. Evidence from the retrospective analysis was not sufficient to determine whether WCD improves outcomes compared with usual care. Given the lack of evidence that ICD improves outcomes, WCD is not expected to improve outcomes under the conditions studied in these trials. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Peripartum Cardiomyopathy

For individuals who have peripartum cardiomyopathy, the evidence includes a retrospective registry data analysis and a small cohort study. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. The registry study revealed that no shocks were delivered during use over an average of 124 days. The cohort study identified four episodes of appropriate electric shock over 133 days. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 5.
Table 5: Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT05201495</td>
<td>A Clinical Evaluation of the Jewel P-WCD in Subjects at High Risk for Sudden Cardiac Arrest</td>
<td>290</td>
<td>Jun 2023</td>
</tr>
<tr>
<td>NCT02816047</td>
<td>Indications for and Experience With the Wearable Cardioverter Defibrillator (WCD)–Austrian WCD Registry</td>
<td>450</td>
<td>Dec 2021</td>
</tr>
<tr>
<td></td>
<td>EURObservational research programme: Peripartum Cardiomyopathy (PPCM) Registry&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NCT: national clinical trial.
<sup>a</sup> Available at: https://www.escardio.org/Research/Registries-&-surveys/Observational-research-programme/PeriPartumCardioMyopathy-PPCM-Registry Accessed June 10, 2022.

Clinical Input from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2014 Input

In response to requests, further input was received from two physician specialty societies and seven academic medical centers while this policy was under review in 2014. Input related to the role of WCDs in preventing SCD among high-risk patients awaiting a heart transplant. Overall, input on the use of WCDs in this patient population was mixed. Some reviewers indicated that it may have a role among certain individuals awaiting heart transplant, but there was no consensus on specific patient indications for use.
2013 Input

In response to requests, input was received from three physician specialty societies and eight academic medical centers while this policy was under review in 2013. Overall, the input was mixed. Most, but not all, providing comments suggested that the WCD may have a role in select high-risk patients following acute MI or in newly diagnosed cardiomyopathy. However, reviewers acknowledged the lack of evidence for benefit and that available evidence was not consistent in defining high-risk subgroups that may benefit.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Heart Association et al

In 2018, the American Heart Association (AHA), the American College of Cardiology and the Heart Rhythm Society published a guideline on the management of individuals with ventricular arrhythmias and prevention of SCD. The guidelines note that “the patients listed in this recommendation are represented in clinical series and registries that demonstrate the safety and effectiveness of the WCD. Patients with recent MI, newly diagnosed NICM, recent revascularization, myocarditis, and secondary cardiomyopathy are at increased risk of VT/SCA. However, the wearable cardioverter-defibrillator is of unproven benefit in these settings, in part because the clinical situation may improve with therapy and time.” The specific recommendations are summarized in Table 6. Level of evidence class IIa is moderate recommendation, and class IIb is a weak recommendation, and class III is a moderate recommendation for no benefit or a strong recommendation for harm.
Table 6. Guidelines for WCD Therapy

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;In patients with an ICD and a history of SCA or sustained VA in whom removal of the ICD is required (as with infection, the WCD is reasonable for the prevention of SCD).&quot;a</td>
<td>IIa</td>
<td>B-NR</td>
</tr>
<tr>
<td>&quot;In patients at an increased risk of SCD but who are not ineligible for an ICD, such as awaiting cardiac transplant, having an LVEF of 35% or less and are within 40 days from an MI, or have newly diagnosed, NICM, revascularization within the past 90 days, myocarditis or secondary cardiomyopathy or a systemic infection, the WCD may be reasonable.&quot;</td>
<td>IIb</td>
<td>B-NR</td>
</tr>
</tbody>
</table>

B-NR: Level B - nonrandomized; COR: class of recommendation; ICD: implantable cardioverter defibrillator; LOE: level of evidence; LVEF: left ventricular ejection fraction; MI: myocardial infarction; NICM: non-ischemic cardiomyopathy; SCA: sudden cardiac arrest; SCD: sudden cardiac death; VT: ventricular tachycardia; WCD: wearable cardioverter defibrillator.

a Removal of an ICD for a period of time, most commonly due to infection, exposes the patient to risk of untreated VT/SCD unless monitoring and access to emergency external defibrillation is maintained. In 1 series of 354 patients who received the WCD, the indication was infection in 10%.31 For patients with a history of SCA or sustained ventricular arrhythmia, the WCD may allow the patient to be discharged from the hospital with protection from VT/SCD until the clinical situation allows reimplantation of an ICD.

b The patients listed in this recommendation are represented in clinical series and registries that demonstrate the safety and effectiveness of the WCD. Patients with recent MI, newly diagnosed nonischemic cardiomyopathy, recent revascularization, myocarditis, and secondary cardiomyopathy are at increased risk of VT or SCD. However, the WCD is of unproven benefit in these settings, in part because the clinical situation may improve with therapy and time. In patients awaiting transplant, even with anticipated survival <1 year without transplant, and depending on clinical factors such as use of intravenous inotropes and ambient ventricular arrhythmia, a WCD may be an alternative to an ICD.

c B-NR: data derived from ≥1 nonrandomized trials or meta-analysis of such studies.

In 2016, the American Heart Association published a scientific advisory on the WCD.32 The AHA stated that "because there is a paucity of prospective data supporting the use of the WCD, particularly in the absence of any published, randomized, clinical trials, the recommendations provided in this advisory are not intended to be prescriptive or to suggest an evidence-based approach to the management of individuals with FDA-approved indications for use." The specific recommendations are summarized in Table 7.

Table 7. Guidelines for WCD Therapy

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Use of WCDs is reasonable when there is a clear indication for an implanted/permanent device accompanied by a transient contraindication or interruption in ICD care such as infection.&quot;</td>
<td>IIa</td>
<td>C</td>
</tr>
<tr>
<td>&quot;Use of WCDs is reasonable as a bridge to more definitive therapy such as cardiac transplantation&quot;</td>
<td>IIa</td>
<td>C</td>
</tr>
<tr>
<td>&quot;Use of WCDs may be reasonable when there is concern about a heightened risk of SCD that may resolve over time or with treatment of left ventricular dysfunction/ for example, in ischemic heart disease with recent revascularization, newly diagnosed nonischemic dilated cardiomyopathy in&quot;</td>
<td>IIb</td>
<td>C</td>
</tr>
</tbody>
</table>
**Recommendation**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>patients starting guideline-directed medical therapy, or secondary cardiomyopathy (tachycardia mediated, thyroid mediated, etc.) in which the underlying cause is potentially treatable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“WCDs may be appropriate as bridging therapy in situations associated with increased risk of death in which ICDs have been shown to reduce SCD but not overall survival such as within 40 D of MI.”</td>
<td>IIb</td>
<td>C</td>
</tr>
<tr>
<td>“WCDs should not be used when nonarrhythmic risk is expected to significantly exceed arrhythmic risk, particularly in patients who are not expected to survive &gt;6 mo.”</td>
<td>III</td>
<td>C</td>
</tr>
</tbody>
</table>

COR: class of recommendation; ICD: implantable cardioverter defibrillator; LOE: level of evidence; MI: myocardial infarction; SCD: sudden cardiac death; WCD: wearable cardioverter defibrillator.

* Level C evidence is based on limited data or expert opinion.

**Medicare National Coverage**

There is no national coverage determination.

**Regulatory Status**

In 2001, the Lifecor WCD® 2000 system was approved by the FDA through the premarket approval process for “adult patients who are at risk for cardiac arrest and are either not candidates for or refuse an implantable defibrillator.” The vest was renamed the LifeVest®.

In 2015, FDA approved the LifeVest® “for certain children who are at risk for sudden cardiac arrest but are not candidates for an implantable defibrillator due to certain medical conditions or lack of parental consent.”

In 2021, the FDA approved the ASSURE® WCD for adult patients at risk for SCA who are not candidates for (or refuse) an ICD.

FDA product code: MVK.

**References**


**Appendix**
**Figure 1.**

![Selected components of the wearable cardioverter-defibrillator](image)

Selected components of the wearable cardioverter-defibrillator

### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/13/12</td>
<td>New Policy. Premera policy created to include in the policy statement, information about when coverage for the WCD will stop, and to maintain the allowance of newly diagnosed nonischemic cardiomyopathy (as explained in the Policy Guidelines) as an indication for the temporary use of the WCD. The Policy Guidelines statement on nonischemic cardiomyopathy was changed to investigational in the October 2012 version of BCBSA policy 2.02.15. Therefore, Policy 2.02.15 is deleted.</td>
</tr>
<tr>
<td>12/09/13</td>
<td>Replace policy. Policy updated with literature review. References 6, 7, 13, 15 added. No change to policy statement.</td>
</tr>
<tr>
<td>03/25/14</td>
<td>Replace policy. Policy statement unchanged. References 5, 6 added. ICD-9 and ICD-10 diagnosis codes removed; these are not utilized in adjudication.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>05/12/14</td>
<td>Interim review. Added primary prevention criteria found in 7.01.44 to the Policy Guidelines section.</td>
</tr>
<tr>
<td>12/01/14</td>
<td>Update Related Policies. Remove 2.02.10 as it was archived.</td>
</tr>
<tr>
<td>03/31/15</td>
<td>Annual Review. Policy statements unchanged. References 8,17,23,26,27,28 added.</td>
</tr>
<tr>
<td>06/09/15</td>
<td>Interim review. Policy statement and policy guidelines rewritten for clarification. Reference 28 the Noridian LCD on WCD for jurisdiction D added; others renumbered. Policy statements revised as noted, intent is unchanged.</td>
</tr>
<tr>
<td>12/15/15</td>
<td>Update Related Policies. Remove 7.01.44 as it is archived.</td>
</tr>
<tr>
<td>04/01/16</td>
<td>Update Related Policies Removed 2.02.505 as it was archived.</td>
</tr>
<tr>
<td>08/01/16</td>
<td>Annual Review, approved July 12, 2016. Policy updated with literature review through March 22, 2016; references added. Policy statements unchanged.</td>
</tr>
<tr>
<td>10/07/16</td>
<td>Minor formatting update. Updated hyperlink in reference number 1.</td>
</tr>
<tr>
<td>08/01/18</td>
<td>Annual Review, approved July 10, 2018. Policy updated with literature review through March 2018; reference 28 added; Policy statements edited for clarity. Added “patients post coronary artery bypass graft (CABG) surgery, high-risk patients awaiting heart transplant, patients with newly diagnosed nonischemic cardiomyopathy and women with peripartum cardiomyopathy” as indications that are considered investigational.</td>
</tr>
<tr>
<td>04/01/19</td>
<td>Minor update, added Documentation Requirements section.</td>
</tr>
<tr>
<td>04/01/20</td>
<td>Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.</td>
</tr>
<tr>
<td>07/02/20</td>
<td>Delete policy.</td>
</tr>
<tr>
<td>06/01/22</td>
<td>Interim Review, approved May 10, 2022. Added “for a period not to exceed 90 days” to medically necessary statement for use of a WCD as interim treatment as a bridge to permanent implantable (internal) cardioverter-defibrillator (ICD) surgery for greater clarity. This becomes effective for dates of service on or after September 2, 2022. Policy intent unchanged.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>01/01/23</td>
<td>Interim Review, approved December 13, 2022. Added additional criteria for ICD placement: The individual has LVEF &lt; 35% and has ischemic cardiomyopathy due to a recent (&lt; 40 days) myocardial infarction (MI); or has newly diagnosed non-ischemic dilated cardiomyopathy and guideline-directed medical therapy initiated (e.g., ACE inhibitors, ARBs, beta blockers); or revascularization was performed (e.g., CABG, percutaneous coronary angioplasty and/or stenting within the past 90 days, or the individual has familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy, or the individual has a documented episode of ventricular fibrillation or a sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an electrophysiologic (EP) study but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction. Added documentation requirements for reauthorization of WCD beyond initial 90 days for another 30 days (one month rental). Changed the wording from “patient” to “individual” throughout the policy for standardization.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2023 Premera All Rights Reserved.

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Alaska residents: Contact the Alaska Division of Insurance via email at insurance@alaska.gov, or by phone at 907-269-7900 or 1-800-INSURAK (in-state, outside Anchorage).

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).


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_rooms: �ำอย่าง ท่านบัตรสมาชิกเรา, ทางบริการลูกค้าจะมีข้อมูลที่ท่านส่งมา, โดยท่านจะ, จัดสมมติไปยังท่าน. ในที่ 800-722-1471 (TTY: 711).

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خیمه: پهښه یې په لیکه کولی، په پوهنځی کرکه وینه سره، لره سره د پاینډو نه راکه کوم چې په کتابی پېښور پیوسته یې، د یې غوره 800-722-1471 (TTY: 711) کې وکړئ. 

خیمه: په پوښتنه کې زه د خپلې نوم چې په پوهنځی کوره وینه سره، د زه لرونکي مرپښه غوړي چې زه یې غوره 800-722-1471 (TTY: 711) کې وکړئ. 


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नोट: उपयोगकर्ता को स्वतंत्रता के लिए अपनी स्वतंत्रता उद्देश्योक्ति को देखें। तंत्र 800-722-1471 (TTY: 711).


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802493 (07-01-2021)

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