

MEDICAL POLICY – 2.02.506

Wearable Cardioverter-Defibrillators as a Bridge to Implantable Cardioverter-Defibrillator Placement

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*Click here to view the current version of this policy.

RELATED MEDICAL POLICIES:

7.01.44 Implantable Cardioverter Defibrillator (ICD)

Select a hyperlink below to be directed to that section.

[POLICY CRITERIA](#) | [DOCUMENTATION REQUIREMENTS](#) | [CODING](#)
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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

Device	Medical Necessity
Wearable cardioverter-defibrillator	<p>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, for individuals who meet the criteria for an implantable cardioverter defibrillator (ICD) (see Related Policies); and have one of the following contraindications to ICD placement:</p> <ul style="list-style-type: none">• A systemic infection, at the current time; or• An ICD was removed due to a concurrent infection or malfunction, and the individual must undergo a waiting period before it can be replaced, or• The individual has an ejection fraction (LVEF) $\leq 35\%$; and has ischemic cardiomyopathy due to a recent (< 40 days) myocardial infarction (MI), or• The individual has an ejection fraction (LVEF) $\leq 35\%$; and has newly diagnosed non-ischemic dilated cardiomyopathy and guideline-directed medical therapy was initiated (e.g., ACE* inhibitors, ARBs**, beta blockers), or• The individual has an ejection fraction (LVEF) $\leq 35\%$; and revascularization was performed (e.g., CABG***, percutaneous coronary intervention) 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 and is being evaluated for effectiveness of medical therapy, 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,

Device	Medical Necessity
	<p>and not occur during the first 48 hours of an acute myocardial infarction, and are being evaluated for effectiveness of anti-arrhythmia medication,</p> <p>AND</p> <ul style="list-style-type: none"> The ICD placement or an ICD replacement surgery, if appropriate, will be scheduled once one of the temporary contraindications noted above is resolved. (See Note below) <p>Note: If the individual responds to the maximal medical treatment and their condition improves after 90 days, the ICD may no longer be necessary and the WCD should be discontinued. However, if there is no improvement in the individual's condition, permanent ICD placement should be implanted.</p> <p>*ACE-Angiotensin-converting enzyme, ** ARB-Angiotensin-receptor blockers, ***CABG-Coronary artery bypass graft</p> <p>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.</p>

Device	Investigational
Wearable cardioverter-defibrillator	<p>Use of a wearable cardioverter-defibrillator (WCD) for the prevention of sudden cardiac death (SCD) is considered investigational for the following indications when they are the sole indication for a WCD:</p> <ul style="list-style-type: none"> High-risk individuals awaiting heart transplant; Individuals with peripartum cardiomyopathy. <p>Use of WCDs is considered investigational for all other indications.</p>

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 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

See [Related Policies](#).

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

Code	Description
CPT	
93292	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system Note: Code 93292 cannot be reported with code 93745
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	
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type

Code	Description
K0607	Replacement battery for automated external defibrillator, garment type only, each
K0608	Replacement garment for use with automated external defibrillator, each
K0609	Replacement electrodes for use with automated external defibrillator, garment type only, each

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 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 WCD is an external device intended to perform the same tasks as an ICD, without 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).

The initial US Food and Drug Administration (FDA) labeled indication for WCD was adults at risk for (SCA) who either are not candidates for or refuse an implantable ICD.¹ Some experts have suggested that the indications for a WCD should be broadened to include other populations at high risk for SCA.² 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)
 - Post bypass with ejection fraction less than 30%
 - Post bypass with ventricular arrhythmias or syncope within 48 hours of surgery
 - Post myocardial infarction with ejection fraction less than 30%
 - 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.

Summary of Evidence

Overview of Wearable Cardioverter Defibrillator Versus Implantable Cardioverter Defibrillator

One randomized controlled trial (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 that the WCD detected 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 an 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 CABG 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 1](#).

Table 1 Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT05135403 ^a	ASSURE WCD Clinical Evaluation - Post Approval Study (ACE-PAS)	5179	Feb 2025
NCT06570902	Prospective WCD Post CABG Registry	910	May 2030
Unpublished			



NCT No.	Trial Name	Planned Enrollment	Completion Date
	EURObservational research programme: Peripartum Cardiomyopathy (PPCM) Registry ^b		ongoing

NCT: national clinical trial.

^a Denotes industry sponsored or co-sponsored study ^b Available at: [Available at: https://www.escardio.org/Research/registries/global-registries-and-surveys-programme/PeriPartum-CardioMyopathy-PPCM-Registry](https://www.escardio.org/Research/registries/global-registries-and-surveys-programme/PeriPartum-CardioMyopathy-PPCM-Registry).

Accessed May 13, 2025.

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

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

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.³¹ The guidelines note that "the individuals listed in this recommendation are represented in clinical series and registries that demonstrate the safety and effectiveness of the WCD. Individuals 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 2](#).

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 2. Guidelines for WCD Therapy

Recommendation	COR	LOE ^c
"In individuals 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." ^a	IIa	B-NR
"In individuals 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." ^b	IIb	B-NR



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%.³² 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.³³ 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 3](#).

Table 3. Guidelines for WCD Therapy

Recommendation	COR	LOE ^a
"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."	IIa	C
"Use of WCDs is reasonable as a bridge to more definitive therapy such as cardiac transplantation"	IIa	C
"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 patients starting guideline-directed medical therapy, or secondary cardiomyopathy (tachycardia mediated, thyroid mediated, etc.) in which the underlying cause is potentially treatable."	IIb	C
"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."	IIb	C
"WCDs should not be used when nonarrhythmic risk is expected to significantly exceed arrhythmic risk, particularly in patients who are not expected to survive >6 mo."	III	C

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

^a 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, the 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.

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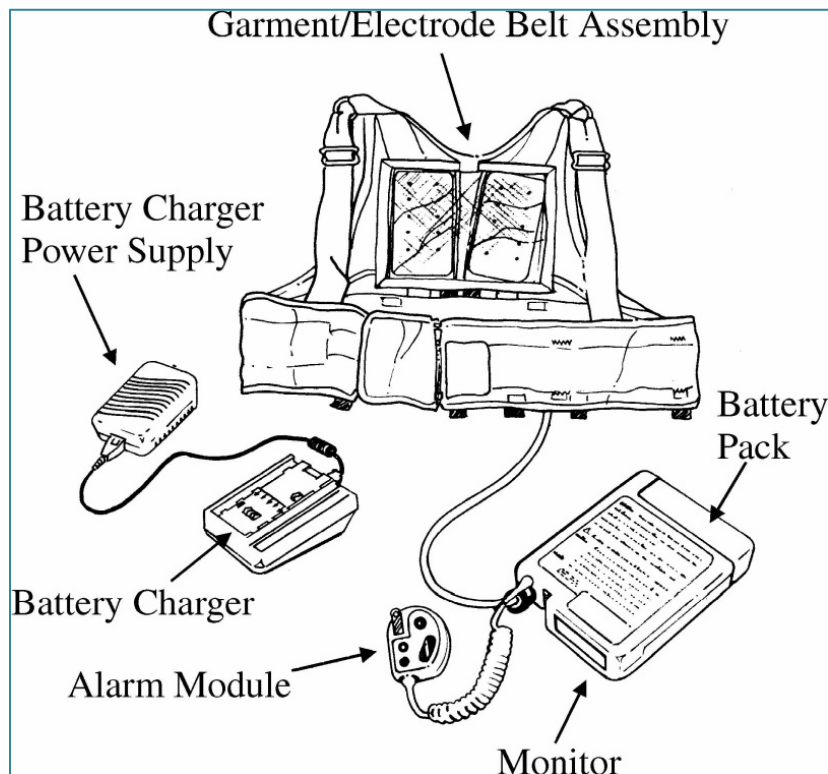


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Appendix



Figure 1.



Selected components of the wearable cardioverter-defibrillator¹

History

Date	Comments
11/13/12	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.
12/09/13	Replace policy. Policy updated with literature review. References 6, 7, 13, 15 added. No change to policy statement.
03/25/14	Replace policy. Policy statement unchanged. References 5, 6 added. ICD-9 and ICD-10 diagnosis codes removed; these are not utilized in adjudication.

Date	Comments
05/12/14	Interim review. Added primary prevention criteria found in 7.01.44 to the Policy Guidelines section.
12/01/14	Update Related Policies. Remove 2.02.10 as it was archived.
03/31/15	Annual Review. Policy statements unchanged. References 8,17,23,26,27,28 added.
06/09/15	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.
12/15/15	Update Related Policies. Remove 7.01.44 as it is archived.
04/01/16	Update Related Policies Removed 2.02.505 as it was archived.
08/01/16	Annual Review, approved July 12, 2016. Policy updated with literature review through March 22, 2016; references added. Policy statements unchanged.
10/07/16	Minor formatting update. Updated hyperlink in reference number 1.
07/01/17	Annual Review, approved June 22, 2017. Updated 2016 ACC -AHA guidelines. Policy moved into new format.
08/01/18	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.
04/01/19	Minor update, added Documentation Requirements section.
08/01/19	Annual Review, approved July 25, 2019. Policy updated with literature review through March 2019; reference 31 added. Policy statements unchanged.
04/01/20	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.
07/02/20	Delete policy.
11/01/20	Policy reinstated effective February 5, 2021, approved October 13, 2020. Annual review. Policy updated with literature review through March, 2020; reference added. Policy statements unchanged.
08/01/21	Annual Review, approved July 9, 2021. Policy updated with literature review through April 10, 2021; reference added. Policy statements unchanged.
06/01/22	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.



Date	Comments
08/01/22	Annual Review, approved July 11, 2022. Policy updated with literature review through March 16, 2022; reference added. Policy statements unchanged.
01/01/23	Interim Review, approved December 13, 2022. Added additional criteria for ICD placement: The individual has 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. 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.
08/01/23	Annual Review, approved July 10, 2023. Policy updated with literature review through March 14, 2023; no references added. Minor editorial refinements to policy statement; intent unchanged.
01/01/24	Interim Review, approved December 26, 2023. Policy criteria reorganized and clarifying language added for greater clarity, policy intent unchanged.
08/01/24	Annual Review, approved July 8, 2024. Policy updated with literature review through March 27, 2024; references added. Policy statements reformatted for greater clarity with minor edits; policy statements unchanged.
07/01/25	Annual Review, approved June 10, 2025. Policy updated with literature review through March 18, 2025; no references added. Policy statements unchanged except for minor edits for greater clarity. Policy intent unchanged. The following policy changes are effective October 3, 2025, following 90-day provider notification. Related Indications section updated and content relative to implantable cardioverter defibrillators appears in policy 7.01.44 Implantable Cardioverter Defibrillators.

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). ©2025 Premera All Rights Reserved.



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