New Century Health

# Cardio Policy:

# Cardiac Electrophysiology Study without Arrhythmia Induction

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| **POLICY NUMBER**<br>UM CARDIO_1101 | **SUBJECT**<br>Cardiac Electrophysiology Study without Arrhythmia Induction | | **DEPT/PROGRAM**<br>UM Dept | **PAGE 1 OF 4** |
| **DATES COMMITTEE REVIEWED**<br>04/06/11, 08/22/13, 06/28/14, 08/12/15, 11/28/16, 12/21/16, 10/31/17, 02/21/19, 03/13/19, 12/11/19, 05/13/20, 05/28/21, 08/11/21, 07/13/22, 02/01/23 | **APPROVAL DATE**<br>February 1, 2023 | **EFFECTIVE DATE**<br>February 1, 2023 | **COMMITTEE APPROVAL DATES**<br>04/06/11, 08/22/13, 06/28/14, 08/12/15, 11/28/16, 12/21/16, 10/31/17, 02/21/19, 03/13/19, 12/11/19, 05/13/20, 05/28/21, 08/11/21, 07/13/22, 02/01/23 | |
| **PRIMARY BUSINESS OWNER:** UM | | **COMMITTEE/BOARD APPROVAL**<br>Utilization Management Committee | | |
| **URAC STANDARDS**<br>HUM v8: UM 1-2; UM 2-1 | **NCQA STANDARDS**<br>UM 2 | | **ADDITIONAL AREAS OF IMPACT** | |
| **CMS REQUIREMENTS** | **STATE/FEDERAL REQUIREMENTS** | | **APPLICABLE LINES OF BUSINESS**<br>Commercial, Exchange, Medicaid | |

## I. PURPOSE

Indications for determining medical necessity for Cardiac Electrophysiology Study without Arrhythmia Induction.

## II. DEFINITIONS

An electrophysiological study (EP study) is an invasive procedure that evaluated abnormal heart rhythm disturbances. During an EP study, small, thin wire electrodes are inserted through a vein in the groin (or neck, in some cases). The wire electrodes are threaded into the heart, using a special type of X-ray, called fluoroscopy. Once in the heart, electrical signals are measured. Electrical signals are sent through the catheter to stimulate the heart tissue to try to initiate the abnormal heart rhythm disturbances for evaluation.

An appropriate diagnostic or therapeutic procedure is one in which the expected clinical benefit exceeds the risks or negative consequences of the procedure by a sufficiently wide margin such that the procedure is generally considered acceptable or reasonable care. The ultimate objective of AUC is to improve patient care and health outcomes in a cost – effective manner but is not intended to ignore ambiguity and nuance intrinsic to clinical decision making.

Appropriate Care- Median Score 7-9

May be Appropriate Care- Median Score 4-6

Rarely Appropriate Care- Median Score 1-3

Guideline directed medical therapy (GDMT) are outlined by joint American College of Cardiology (ACC)/American Heart Association (AHA) in cardiovascular clinical practice guidelines as Class I recommendation. These are maximally tolerated medications for a cardiovascular condition, when prescribed, have shown to improve healthcare outcomes such as survival along with significant reduction in major adverse cardiovascular events and hospitalization. For all recommended drug treatment regimens, the prescriber should confirm the dosage with product insert material and carefully evaluate for contraindications and interactions[1,2,3,4,5,6].

## III. POLICY

**Patients should be on maximally tolerated GDMT. Indications for approving a request for medical necessity are:**

A. EPS is being performed for a patient with symptomatic syncope or near syncope suspected of having sinus node dysfunction but a causal relation between an arrhythmia and the symptoms cannot be established by other means. **(AUC Score 8)[1,2,3,4,5]**

B. EPS is being performed for a patient with symptomatic syncope or near syncope suspected or diagnosed His Purkinje second or third-degree AV block. **(AUC Score 8)[1,2,3,4,5]**

C. Patients with second or third-degree AV block treated with a pacemaker who remain symptomatic (with syncope or near syncope) in whom ventricular tachyarrhythmia is suspected as a cause of symptoms. **(AUC Score 8)[1,2,3,4,5]**

D. EPS being performed for a patient with symptomatic syncope and or near syncope with chronic bundle branch block (RBBB with Left anterior or posterior hemi block) where ventricular arrhythmia is suspected. **(AUC Score 7)[1,2,3,4,5]**

E. EPS is being performed for a patient with narrow QRS tachycardia poorly responsive to drug therapy or with associated drug side effects. **(AUC Score 8)[1,2,3,4,5]**

F. EPS is being performed for a patient with wide QRS complex tachycardia (sustained and/or symptomatic). **(AUC Score 8)[1,2,3,4,5]**

G. EPS is being performed in a patient with W-P-W who participates in high risk occupation/activities, has a family history of premature sudden death or is undergoing cardiac surgery for other reasons. **(AUC Score 7)[1,2,3,4,5]**

H. EPS is being performed in a patient with suspected antidromic tachycardia. **(AUC Score 7)[1,2,3,4,5]**

I. EPS is being performed in a patient with prolonged QT interval syndrome and evidence of sustained ventricular tachycardia or sudden death. **(AUC Score 8)[1,2,3,4,5]**

J. EPS is being performed in a patient with unexplained syncope with known, suspected or without structural heart disease. **(AUC Score 8)[1,2,3,4,5]**

K. EPS is being performed in a patient surviving a cardiac arrest. **(AUC Score 8)[1,2,3,4,5]**

**Limitations**

A. Requests for services that are part of a surveillance protocol for patients who are involved in a clinical trial are considered out of scope (OOS) for New Century Health and cannot be reviewed.

B. Before proceeding with comprehensive EPS study for a patient with established atrial or ventricular arrhythmia the following must be considered: Predicted or observed lack of adequate response to maximally tolerated GDMT[1,2,3,4,5,6]

## IV. PROCEDURE

A. To review a request for medical necessity, the following items must be submitted for review:
   1. Cardiologist or EP Progress Note that prompted request
   2. Recent EKG (within 10 days)
   3. Other previous monitoring tests pertinent to referral (Holter, Event Monitoring, Device Analysis)

B. Primary codes appropriate for this service: 93619 (EPS without induction)

## V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

## VI. ATTACHMENTS

A. None

## VII. REFERENCES


1. Sana M. Al-Khatib, et al. 2017 AHA/ACC/HRS Guideline for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death - A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. Circulation. 2018; 138: e272–e391
2. S. Adam Strickberger, MD, etc. AHA/ACCF Scientific Statement on the Evaluation of Syncope. From the American Heart Association Councils on Clinical Cardiology, Cardiovascular Nursing, Cardiovascular Disease in the Young, and Stroke, and the Quality of Care and Outcomes Research Interdisciplinary Working Group; and the American College of Cardiology Foundation In Collaboration With the Heart Rhythm Society. Circulation 2006 Volume 113 Number 2, Pages 316-327.
3. Robert C. Hendel MD, FACC, FAHA, et al. Appropriate use of cardiovascular technology: 2013 ACCF appropriate use criteria methodology update: a report of the American College of Cardiology Foundation appropriate use criteria task force. Journal of the American College of Cardiology. March 2013, Volume 61, Issue 12, Pages 1305-1317.
4. Cronin EM, et al. 2019 HRS/EHRA/APHRS/LAHRS expert consensus statement on catheter ablation of ventricular arrhythmias. Europace. 2019 Aug 1;21(8):1143-1144. doi: 10.1093/europace/euz132. Erratum in: Europace. 2019 Aug 1;21(8):1144. Erratum in: J Arrhythm. 2020 Jan 12;36(1):214. Erratum in: Europace. 2020 Mar 1;22(3):505.
5. January CT, et al. 2019 AHA/ACC/HRS Focused Update of the 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation. JACC VOL. 74, NO. 1, 2019. JULY 9, 2019:104-32.
6. DuPage RL, et al. 2015 ACC/AHA/HRS Guideline for the Management of Adult Patients With Supraventricular Tachycardia: A Report of the American College of Cardiology/American Heart

Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol. 2016 Apr 5;67(13):e27-e115.

7. NCQA UM 2022 Standards and Elements.