New Century Health

Cardio Policy:

Synchronized Electrical Cardioversion

POLICY NUMBER UM CARDIO_1148	SUBJECT Synchronized Electrical Cardioversion		DEPT/PROGRAM UM Dept	PAGE 1 OF 3
DATES COMMITTEE REVIEWED 08/03/11, 12/12/12, 02/18/14, 08/12/15, 11/28/16, 12/21/16, 11/03/17, 03/13/19, 12/11/19, 05/13/20, 05/28/21, 08/11/21, 01/12/22, 01/11/23, 02/01/23	APPROVAL DATE February 1, 2023	EFFECTIVE DATE February 1, 2023	COMMITTEE APPROVAL DATES 08/03/11, 12/12/12, 02/18/14, 08/12/15, 11/28/16, 12/21/16, 11/03/17, 03/13/19, 12/11/19, 05/13/20, 05/28/21, 08/11/21, 01/12/22, 01/11/23, 02/01/23	
PRIMARY BUSINESS OWNER: UM		COMMITTEE/BOARD APPROVAL Utilization Management Committee		
URAC STANDARDS HUM v8: UM 1-2; UM 2-1	NCQA STANDARDS UM 2		ADDITIONAL AREAS OF IMPACT	
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS		APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid	

I. PURPOSE

Indications for determining medical necessity for Synchronized Electrical Cardioversion.

II. DEFINITIONS

Synchronized electrical cardioversion is a medical procedure by which an abnormally fast heart rate or cardiac arrhythmia is converted to a normal rhythm using a therapeutic dose of electric current to the heart, at a specific moment in the cardiac cycle.

Good Candidacy for Synchronized electrical cardioversion is defined as a patient who had failed guideline directed medical therapy or has mildly dilated Left Atrium and/or normal or mildly decreased LV function with absence of Pulmonary Hypertension.

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. Evidence of first episode or recurrent Atrial Flutter with failed on pharmacological therapy and patient is a suitable candidate for synchronized cardioversion. **(AUC Score 8)[1,2,3,4]**

B. Newly discovered or recurrent or persistent Atrial Fibrillation with or without pre-excitation, in a patient with rate control and/or antiarrhythmic drug treatment failure and is a suitable candidate for synchronized cardioversion. **(AUC Score 8)[1,2,3,4]**

C. Internal cardioversion is appropriate to perform for indications A and B in patients with Cardiovascular Implantable Electronic Device (CIED: AICD, CRT-D) to restore sinus rhythm. **(AUC Score 8)[1,2,3,4]**

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 synchronized electrical cardioversion for a patient with arrhythmias the following must be considered: Predicted or observed lack of adequate response to maximally tolerated GDMT in a patient that is adequately anticoagulated.[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. Progress notes that prompted request (including medication list)
   2. Recent EKG (less than 10 days)
   3. Most recent Holter/Event monitor/loop recorder/device interrogation strips report, if applicable.

B. Primary codes appropriate for this service: 92960, 92961

V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

1. Craig T. January, MD, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients with Atrial Fibrillation. Journal of the American College of Cardiology. Dec 2014. Volume 64, Issue 21, Pages e1-76.
2. Roy D, et al. Rhythm control versus rate control for atrial fibrillation and heart failure. Th New England Journal of Medicine. June 2008. Volume 358, Issue 25, Pages 2667-77.
3. Corley SD, et al. Relationships between sinus rhythm, treatment, and survival in the Atrial Fibrillation Follow-Up Investigation of Rhythm Management (AFFIRM) Study. March 2004. Volume 109, Issue 12, Pages 1509-13.
4. 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.
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: 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. 2019 Jul 9;74(1):104-132.
6. Douglas Packer, MD et.al. Ablation Versus Drug Therapy for Atrial Fibrillation in Heart Failure. Results From the CABANA Trial. Circulation. 2021; 143:1377–13904.
7. NCQA UM 2022 Standards and Elements.