Policy: MP024

Section: Medical Benefit Policy

Subject: External Counterpulsation

I. Policy: External Counterpulsation

II. Purpose/Objective:
   To provide a policy of coverage regarding External Counterpulsation

III. Responsibility:
   A. Medical Directors
   B. Medical Management

IV. Required Definitions
   1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
   2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
   3. Devised – the date the policy was implemented.
   4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
   5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
External Counterpulsation (ECP), commonly referred to as Enhanced External Counterpulsation (EECP), is a noninvasive treatment that uses timed, sequential inflation of pressure cuffs on the legs to augment diastolic pressure, decrease left ventricular after load, and increase venous return. Coverage will be limited to its use in insured individuals with stable angina pectoris, because there has been sufficient evidence to demonstrate medical effectiveness in this clinical setting. Other uses will not be covered.

INDICATIONS:
- Disabling stable angina pectoris

Coverage is provided for members who have been diagnosed with disabling stable angina (Class III or above, [Canadian Cardiovascular Society Functional Classification (CCSC) or New York Heart Association (NYHA), see table 1]) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not candidates for surgical intervention, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Artery Bypass Graft (CABG) because of the following:
  1. The member’s condition is inoperable, or presents excessive risk of operative complications or post-operative failure.
  2. The member’s coronary anatomy does not lend itself to surgical intervention; or
  3. Co-morbid conditions introduce increased risk precluding surgical intervention.

<table>
<thead>
<tr>
<th>Classification</th>
<th>NYHA</th>
<th>CCSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Applicable</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td>I</td>
<td>Patients with no limitation of activities; they suffer no symptoms from ordinary activities</td>
<td>Angina with strenuous exercise</td>
</tr>
<tr>
<td>II</td>
<td>Patients with slight, mild limitation of activity; they are comfortable with rest or with mild exertion</td>
<td>Angina with mild exertion</td>
</tr>
<tr>
<td>III</td>
<td>Patients with marked limitation of activity; they are comfortable only at rest</td>
<td>Angina with mild exertion. Walking 1-2 level blocks at normal pace. Climbing 1 flight of stairs at normal pace</td>
</tr>
<tr>
<td>IV</td>
<td>Patients who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest</td>
<td>Angina at any level of physical exertion</td>
</tr>
</tbody>
</table>

Table 1. Angina Classification

American Heart Assn. Classes of Heart Failure. http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.V36T9E32bcs


PROCESS:
The member must be evaluated by a cardiologist prior to initiation of therapy.

The requesting provider should submit documentation indicating:
- functional level (Table 1)
- failure of other therapies including nitrates, beta blockers, or calcium channel blockers; and
- cardiac catheterization data documenting the degree of disease; and
- indications that the disease is not amenable to intravascular or open revascularization,
- ventricular function and
- absence of arterial insufficiency of the lower extremities or large symptomatic varicosities.

A full course of therapy usually consists of 35 one-hour treatments, which may be offered once or twice daily, usually 5 days per week.

EXCLUSIONS: The Plan does NOT provide coverage for ANY of the following because they are considered experimental, investigational or unproven (List may not be all-inclusive)
• Any diagnosis other than angina pectoris
• Hydraulic versions of this device
• Congestive heart failure in the absence of angina

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: External Counterpulsation
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

G0166  External counterpulsation, per treatment session
92971  Cardioassist-method of circulatory assist; external


LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


Geisinger Clinic Technology Assessment Committee, Dr. Thomas Modesto, Geisinger Medical Center Cardiology, 7/11/2001.


This policy will be revised as necessary and reviewed no less than annually.

Devised: 10/28/99

Revised: 08/29/01, 8/5/03 (add definition); 8/04; 8/05 (convert table); 8/06 (ref.), 8/08, 8/10 (exclusion lang.), 02/11 (removal of PA), 7/16 (revise criteria)

Reviewed: 08/02, 8/07, 9/09, 8/11, 8/12, 8/13, 8/14, 8/15, 7/17, 8/18, 8/19