TRANSCATHETER CLOSURE OF SEPTAL DEFECTS

Effective Date: June 27, 2016
Date Of Origin: April 11, 2007
Status: Current

Summary of Changes

Clarifications:
- Pg. 1, Section I, A, language added to clarify coverage applies for patients less than 18 years old.
- Pg. 2, Section II, Medical Necessity Review updated to reflect PA is required for Transcatheter Closure of Septal Defects when patient is >17 years old
- Pg. 2, Section I, C, 5, Obstructive Sleep Apnea added to list of indications that are not covered.

Deletions:

Additions:

I. POLICY/Criteria

A. Transcatheter closure of septal defects using FDA approved devices is covered for any of the following when patient is less than 18 years old:
   1. Secundum atrial septal defects (ASDs)
   2. Patent ductus arteriosis (PDA)
   3. Fenestration following a Fontan procedure

B. Transcatheter closure of patent foramen ovale (PFO) is covered for associated cryptogenic stroke, transient ischemic attack, or arterial embolism due to presumed paradoxical embolism through the PFO, when conventional drug therapy (one or more antithrombotics) has failed and the procedure is prior authorized by Priority Health. Both of the following apply to coverage for transcatheter closure of PFO:
   1. PFO closure devices (e.g. Amplatzer PFO Occluder, CardioSEAL Septal Occlusion System) are available only as IDEs (Investigational Device Exemption) in a clinical trial. Devices classified as IDEs are not a covered benefit.
   2. Routine care in a clinical trial is a covered benefit for PFO closure, even though the device itself is not covered.

C. Transcatheter closure of septal defects is not covered for all other indications including, but not limited to:
   1. Ventricular septal defects
   2. When any of the following conditions are present:
      - Multiple defects that cannot be adequately covered by the device
      - Associated congenital cardiac anomalies that require cardiac surgery
- Ostium primum atrial septal defects
- Sinus venosus atrial septal defects
- Partial anomalous pulmonary venous drainage
- Pulmonary hypertension
- Congestive heart failure
- Sepsis
- Coagulation disorders in patients who are unable to take antiplatelet or anticoagulant therapy

3. Migraine prophylaxis
4. Transmyocardial (perventricular) transcatheter closure of VSDs
5. Obstructive Sleep Apnea

II. MEDICAL NECESSITY REVIEW

☒ Required for Transcatheter Closure of Septal Defects when patient is >17 years old
☒ Required for Transcatheter Closure of Patent Foramen Ovale (PFO)
☐ Not Required
☐ Not Applicable

III. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

☒ HMO/EPO: This policy applies to insured HMO/EPO plans.
☒ POS: This policy applies to insured POS plans.
☒ PPO: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
☒ ASO: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
☐ INDIVIDUAL: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
☒ MEDICAID/HEALTHY MICHIGAN PLAN: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
☒ MEDICAID/HEALTHY MICHIGAN PLAN: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.
IV. DESCRIPTION

Background

Transcatheter septal occlusion devices are implantable devices that are used to repair septal wall defects. Atrial or ventricular defects in the septal wall of the heart can have a number of adverse consequences, including abnormal ventricular volume load, ventricular pressure load, mixing of un-oxygenated and oxygenated blood and inadequate systemic cardiac output. These abnormalities can lead to cardiac enlargement, pulmonary hypertension, rhythm disturbance, and stroke. Conventional open-heart surgical repair of septal defects carries some risk, especially in patients in whom heart or pulmonary function may be compromised. In addition, there is considerable morbidity associated with open-heart surgery. Moreover, some types of ventricular septal defects (VSDs) are difficult to repair surgically due to their location or orientation. Consequently, there has been considerable interest in the development of a transcatheter method of repairing septal lesions. Access to the defect is achieved through the venous system via the internal jugular vein or femoral vein in the groin.

V. CODING INFORMATION

ICD-10 Codes that may apply:
Q21.1  Atrial septal defect
Q21.2  Atrioventricular septal defect
Q25.0  Patent ductus arteriosus
I23.1  Atrial septal defect as current complication following acute myocardial infarction
I51.0  Cardiac septal defect, acquired

CPT Codes:
93580  Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant
93582  Percutaneous transcatheter closure of patent ductus arteriosus

Revenue Codes:
0272 Sterile Supply,
0278 Other Implants

HCPCS Codes:
C1817  Septal defect implant system, intracardiac
C2628  Catheter, occlusion
Not Covered
93581 Percutaneous transcatheter closure of a congenital ventricular septal defect with implant
93799 Unlisted cardiovascular service or procedure (for transcatheter ventricular septal defect procedure – explanatory notes must accompany claim)

VI. REFERENCES

7. Wisconsin Physicians Service (WPS), Medical Devices, Local Coverage Decision (LCD), PHY 067, Original effective date: 09/01/1996, Revision date: 01/01/2005.
8. Wisconsin Physicians Service (WPS), Transesophageal Echocardiography, Local Coverage Decision (LCD) CV-007, Original effective date: 02/15/1996, Revision date: 10/01/2005.

AMA CPT Copyright Statement: All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association. This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member’s plan in effect as of the date services are rendered. Priority Health’s medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health’s medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan’s ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name “Priority Health” and the term “plan” mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.