Implantable Cardioverter Defibrillator (ICD)

Policy Number: 7.01.44
Origination: 10/1988
Last Review: 11/2018
Next Review: 11/2019

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for automatic implantable cardioverter defibrillator when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered
Adults
The use of the automatic implantable cardioverter defibrillator (ICD) may be considered medically necessary in adults who meet the following criteria:

Primary Prevention
- ischemic cardiomyopathy with New York Heart Association (NYHA) functional class II or class III symptoms, a history of myocardial infarction at least 40 days before ICD treatment, and left ventricular ejection fraction of 35% or less; or
- ischemic cardiomyopathy with NYHA functional class I symptoms, a history of myocardial infarction at least 40 days before ICD treatment, and left ventricular ejection fraction of 30% or less; or
- nonischemic dilated cardiomyopathy and left ventricular ejection fraction of 35% or less, after reversible causes have been excluded, and the response to optimal medical therapy has been adequately determined; or
- hypertrophic cardiomyopathy (HCM) with 1 or more major risk factors for sudden cardiac death (history of premature HCM-related sudden death in 1 or more first-degree relatives younger than 50 years; left ventricular hypertrophy greater than 30 mm; 1 or more runs of nonsustained ventricular tachycardia at heart rates of 120 beats per minute or greater on 24-hour Holter monitoring; prior unexplained syncope inconsistent with neurocardiogenic origin) and judged to be at high risk for sudden cardiac death by a physician experienced in the care of patients with HCM.
- diagnosis of any one of the following cardiac ion channelopathies and considered to be at high risk for sudden cardiac death (see “Considerations”):
  o congenital long QT syndrome; OR
Secondary Prevention
- Patients with a history of a life-threatening clinical event associated with sustained ventricular tachyarrhythmia, after reversible causes (eg, acute ischemia) have been excluded.

Pediatrics
The use of the ICD may be considered medically necessary in children who meet any of the following criteria:
- survivors of cardiac arrest, after reversible causes have been excluded;
- symptomatic, sustained ventricular tachycardia in association with congenital heart disease in patients who have undergone hemodynamic and electrophysiologic evaluation; or
- congenital heart disease with recurrent syncope of undetermined origin in the presence of either ventricular dysfunction or inducible ventricular arrhythmias.
- hypertrophic cardiomyopathy (HCM) with 1 or more major risk factors for sudden cardiac death (history of premature HCM-related sudden death in 1 or more first-degree relatives younger than 50 years; massive left ventricular hypertrophy based on age-specific norms; prior unexplained syncope inconsistent with neurocardiogenic origin) and judged to be at high risk for sudden cardiac death by a physician experienced in the care of patients with HCM.
- diagnosis of any one of the following cardiac ion channelopathies and considered to be at high risk for sudden cardiac death (see “Policy Guidelines”):
  - congenital long QT syndrome; OR
  - Brugada syndrome; OR
  - short QT syndrome; OR
  - catecholaminergic polymorphic ventricular tachycardia.

Subcutaneous ICD
The use of a subcutaneous ICD may be considered medically necessary for adults or children who have an indication for ICD implantation for primary or secondary prevention for any of the above reasons and meet all of the following criteria:
- Have a contraindication to a transvenous ICD due to one or more of the following: (1) lack of adequate vascular access; (2) compelling reason to preserve existing vascular access (ie, need for chronic dialysis; younger patient with anticipated long-term need for ICD therapy); or (3) history of need for explantation of a transvenous ICD due to a complication, with ongoing need for ICD therapy.
- Have no indication for antibradycardia pacing; AND

Note: Symptomatic heart failure is defined as the presence of dyspnea on exertion, angina, palpitations, or fatigue.
• Do not have ventricular arrhythmias that are known or anticipated to respond to antitachycardia pacing.

**When Policy Topic is not covered**
The use of the ICD is considered *investigational* in primary prevention patients who:

• have had an acute myocardial infarction (i.e., less than 40 days before ICD treatment)
• have New York Heart Association (NYHA) Class IV congestive heart failure (unless patient is eligible to receive a combination cardiac resynchronization therapy ICD device)
• have had cardiac revascularization procedure in past 3 months (coronary artery bypass graft [CABG] or percutaneous transluminal coronary angioplasty [PTCA]) or are candidates for a cardiac revascularization procedure
• have noncardiac disease that would be associated with life expectancy less than 1 year

The use of the ICD is considered *investigational* for all other indications in pediatric patients.

The use of a subcutaneous ICD is considered *investigational* for individuals who do not meet the criteria outlined above.

**Considerations**
This policy addressed the use of ICD devices as stand-alone interventions, not as combination devices to treat heart failure (ie, cardiac resynchronization devices) or in combination with pacemakers. Unless specified, the policy statements and policy Rationale are referring to transvenous ICDs.

Indications for pediatric ICD use are based on American College of Cardiology/American Heart Association/Heart Rhythm Society (ACC/AHA/HRS) guidelines published in 2008, which acknowledged the lack of primary research in this field on pediatric patients (see Rationale). These are derived from nonrandomized studies, extrapolation from adult clinical trials, and expert consensus.

**Criteria for ICD Implantation in Patients with Cardiac Ion Channelopathies**
Individuals with cardiac ion channelopathies may have a history of a life-threatening clinical event associated with ventricular arrhythmic events such as sustained ventricular tachyarrhythmia, after reversible causes, in which case they should be considered for ICD implantation for secondary prevention, even if they do not meet criteria for primary prevention.

Criteria for ICD implantation in patients with cardiac ion channelopathies are derived from results of clinical input, a 2013 consensus statement from the HRS, European Heart Rhythm Association (EHRA), and the Asia-Pacific Heart Rhythm Society on the diagnosis and management of patients with inherited primary
arrhythmia syndromes (Priori et al, 2013), 2013 guidelines from the ACC, AHA, HRS, the American Association of Thoracic Surgeons, and the Society of Thoracic Surgeons on device-based therapy of cardiac rhythm abnormalities (Tracy et al, 2013), and a report from the HRS/EHRA’s Second Consensus Conference on Brugada syndrome (Antzelevitch et al, 2005).

Indications for consideration for ICD implantation for each cardiac ion channelopathy are as follows:

- **Long QT syndrome:**
  o Patients with a diagnosis of LQTS who are survivors of cardiac arrest.
  o Patients with a diagnosis of LQTS who experience recurrent syncopal events while on beta-blocker therapy.

- **Brugada syndrome:**
  o Patients with a diagnosis of BrS who are survivors of cardiac arrest.
  o Patients with a diagnosis of BrS who have documented spontaneous sustained ventricular tachycardia (VT) with or without syncope.
  o Patients with a spontaneous diagnostic type 1 ECG who have a history of syncope, seizure, or nocturnal agonal respiration judged to be likely caused by ventricular arrhythmias (after noncardiac causes have been ruled out).
  o Patients with a diagnosis of BrS who develop ventricular fibrillation (VF) during programmed electrical stimulation.

- **Catecholaminergic polymorphic ventricular tachycardia:**
  o Patients with a diagnosis of CPVT who are survivors of cardiac arrest.
  o Patients with a diagnosis of CPVT who experience recurrent syncope or polymorphic/bidirectional VT despite optimal medical management, and/or left cardiac sympathetic denervation.

- **Short QT syndrome:**
  o Patients with a diagnosis of SQTS who are survivors of cardiac arrest.
  o Patients with a diagnosis of SQTS who are symptomatic and have documented spontaneous VT with or without syncope.
  o Patients with a diagnosis of SQTS or are asymptomatic or symptomatic and have a family history of sudden cardiac death.

**NOTE:** For congenital LQTS, patients may have one or more clinical or historical findings other than those outlined above that may, alone or in combination, put them at higher risk for sudden cardiac death. These may include patients with a family history of sudden cardiac death due to LQTS, infants with a diagnosis of LQTS with functional 2:1 atrioventricular block, patients with a diagnosis of LQTS in conjunction with a diagnosis of Jervell and Lange-Nielsen syndrome or Timothy syndrome, and patients a diagnosis of LQTS with profound QT prolongation (>550 msec). These factors should be evaluated on an individualized basis by a clinician with expertise in LQTS in considering the need for an ICD implantation.
Effective in 2015, the CPT coding for these devices was updated to include insertion of subcutaneous ICD devices (see Code Table)

## Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Individuals:  
- With a high risk of sudden cardiac death due to ischemic cardiomyopathy in adulthood | Interventions of interest are:  
- Transvenous implantable cardioverter defibrillator placement | Comparators of interest are:  
- Medical management without implantable cardioverter defibrillator placement | Relevant outcomes include:  
- Overall survival  
- Morbid events  
- Quality of life  
- Treatment-related mortality  
- Treatment-related morbidity |
| Individuals:  
- With a high risk of sudden cardiac death due to nonischemic cardiomyopathy in adulthood | Interventions of interest are:  
- Transvenous implantable cardioverter defibrillator placement | Comparators of interest are:  
- Medical management without implantable cardioverter defibrillator placement | Relevant outcomes include:  
- Overall survival  
- Morbid events  
- Quality of life  
- Treatment-related mortality  
- Treatment-related morbidity |
| Individuals:  
- With a high risk of sudden cardiac death due to hypertrophic cardiomyopathy in adulthood | Interventions of interest are:  
- Transvenous implantable cardioverter defibrillator placement | Comparators of interest are:  
- Medical management without implantable cardioverter defibrillator placement | Relevant outcomes include:  
- Overall survival  
- Morbid events  
- Quality of life  
- Treatment-related mortality  
- Treatment-related morbidity |
| Individuals:  
- With a high risk of sudden cardiac death due to an inherited cardiac ion channelopathy | Interventions of interest are:  
- Transvenous implantable cardioverter defibrillator placement | Comparators of interest are:  
- Medical management without implantable cardioverter defibrillator placement | Relevant outcomes include:  
- Overall survival  
- Morbid events  
- Quality of life  
- Treatment-related mortality  
- Treatment-related morbidity |
| Individuals:  
- With life-threatening ventricular tachyarrhythmia or fibrillation or who have been resuscitated from sudden cardiac arrest | Interventions of interest are:  
- Transvenous implantable cardioverter defibrillator placement | Comparators of interest are:  
- Medical management without implantable cardioverter defibrillator placement | Relevant outcomes include:  
- Overall survival  
- Morbid events  
- Quality of life  
- Treatment-related mortality  
- Treatment-related morbidity |
| Individuals:  
- Who need an implantable cardioverter defibrillator and | Interventions of interest are:  
- Subcutaneous implantable cardioverter | Comparators of interest are:  
- Medical management without | Relevant outcomes include:  
- Overall survival  
- Morbid events  
- Quality of life |
An implantable cardioverter defibrillator (ICD) is a device designed to monitor a patient’s heart rate, recognize ventricular fibrillation or ventricular tachycardia, and deliver an electric shock to terminate these arrhythmias to reduce the risk of sudden death. A subcutaneous implantable cardioverter defibrillator (S-ICD), which lacks transvenous leads, is intended to reduce lead-related complications.

For individuals who have a high risk of sudden cardiac death (SCD) due to ischemic or to nonischemic cardiomyopathy (NICM) in adulthood who receive transvenous implantable cardioverter defibrillator (TV-ICD) placement for primary prevention, the evidence includes multiple well-designed and well-conducted randomized controlled trials (RCTs) as well as systematic reviews of these trials. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Multiple, well-done RCTs have shown a benefit in overall mortality for patients with ischemic cardiomyopathy and reduced ejection fraction. RCTs assessing early ICDs following recent myocardial infarction (MI) did not support a benefit for immediate versus delayed implantation for at least 40 days. For NICM, there is less clinical trial data, but pooled estimates of available evidence from RCTs enrolling patients with NICM and from subgroup analysis of RCTs with mixed populations has supported a survival benefit for this group. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a high risk of SCD due to hypertrophic cardiomyopathy (HCM) in adulthood who receive TV-ICD placement for primary prevention, the evidence includes several large registry studies. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. In these studies, the annual rate of appropriate ICD discharge ranged from 3.6% to 5.3%. Given the long-term high risk of SCD in patients with HCM, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence to support use of ICDs in patients with HCM. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a high risk of SCD due to an inherited cardiac ion channelopathy who receive TV-ICD placement for primary prevention, the
evidence includes small cohort studies of patients with these conditions treated with ICDs. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. The limited evidence for patients with long QT syndrome (LQTS), catecholaminergic polymorphic ventricular tachycardia (CPVT), and Brugada syndrome (BrS) has reported high rates of appropriate shocks. No studies were identified on the use of ICDs for patients with short QT syndrome (SQTS). Studies comparing outcomes between patients treated and untreated with ICDs are not available. However, given the relatively small patient populations and the high risk of cardiac arrhythmias, clinical trials are unlikely. Given the long-term high risk of SCD in patients with inherited cardiac ion channelopathy, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence to support use of TV-ICDs in patients with inherited cardiac ion channelopathy. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have had symptomatic life-threatening sustained ventricular tachycardia (VT) or ventricular fibrillation (VF) or who have been resuscitated from sudden cardiac arrest (secondary prevention) who receive TV-ICD placement, the evidence includes multiple well-designed and well-conducted RCTs as well as systematic reviews of these trials. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Systematic reviews of RCTs have demonstrated a 25% reduction in mortality for ICD compared to medical therapy. Analysis of data from a large administrative database has confirmed that this mortality benefit is generalizable to the clinical setting. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who need an ICD and have a contraindication to a TV-ICD but no indications for antibradycardia pacing and no antitachycardia pacing–responsive arrhythmias who receive S-ICD placement, the evidence includes nonrandomized studies and case series. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Nonrandomized controlled studies have reported success rates in terminating laboratory-induced VF that are similar to TV-ICD. Case series have reported high rates of detection and successful conversion of VF, and inappropriate shock rates in the range reported for TV-ICD. Given the need for ICD placement in this population at risk for SCD, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence to support use of S-ICDs in patients with contraindication to TV-ICD. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who need an ICD without contraindication to TV-ICD but no indications for antibradycardia pacing and no antitachycardia pacing–responsive arrhythmias who receive S-ICD placement, the evidence includes nonrandomized studies and case series. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Nonrandomized controlled studies have reported success rates in terminating laboratory-induced VF that are similar to TV-ICD. However, there is scant evidence on comparative
clinical outcomes of both types of ICD over longer periods. Case series have reported high rates of detection and successful conversion of VT, and inappropriate shock rates in the range reported for TV-ICD. This evidence does not support conclusions on whether there are small differences in efficacy between the 2 types of devices, which may be clinically important due to the nature to the disorder being treated. Also, adverse event rate is uncertain, with variable rates reported. At least 1 RCT is currently underway comparing S-ICD with TV-ICD. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input was obtained on the use of ICDs in pediatric populations and for primary prevention in patients with cardiac ion channelopathies, and for on the use of the S-ICD. For the use of ICDs in children with HCM or with a history of congenital heart disease, the evidence includes case series. These conditions have a low prevalence and heterogeneous patient populations, creating barriers to trials.

There was consensus that the use of ICDs in certain pediatric populations, consistent with specialty society guidelines, is medically necessary. Indications for the use of ICDs to prevent SCD in HCM in pediatric patients parallel those in adults. There was also consensus that the use of an ICD should be considered medically necessary for primary prevention of ventricular arrhythmias in adults and children with a diagnosis of QTS, BrS, SQTS, or CPVT. Criteria for determining patients at high risk of SCD for the cardiac ion channelopathies was derived from clinical input and specialty society guidelines. There was consensus that the use of an S-ICD should be considered medically necessary, particularly for patients with indications for an ICD but who have difficult vascular access (eg, children or patients undergoing chronic dialysis) or have had TV-ICD lead explantation due to complications.

**Background**
The risk of ventricular arrhythmia and sudden cardiac death (SCD) may be significantly increased in various cardiac conditions such as individuals with ischemic cardiomyopathy, particularly when associated with reduced left ventricular ejection fraction (LVEF) and prior myocardial infarction; nonischemic dilated cardiomyopathy with reduced LVEF; hypertrophic cardiomyopathy and additional risk factors; congenital heart disease, particularly with recurrent syncope; and cardiac ion channelopathies.

Implantable cardioverter defibrillators (ICDs) monitor a patient’s heart rate, recognize ventricular fibrillation (VF) or ventricular tachycardia (VT), and deliver an electric shock to terminate these arrhythmias to reduce the risk of SCD. Indications for ICD placement can be broadly subdivided into (1) secondary prevention, ie, use in patients who have experienced a potentially life-threatening episode of VT (near SCD); and (2) primary prevention, ie, use in patients who are considered at high risk for SCD but who have not yet experienced life-threatening VT or VF.
The standard ICD placement surgery involves placement of a generator in the subcutaneous tissue of the chest wall. Transvenous leads are attached to the generator and threaded intravenously into the endocardium. The leads sense and transmit information on cardiac rhythm to the generator, which analyzes the rhythm information and produces an electrical shock when a malignant arrhythmia is recognized.

A subcutaneous implantable cardioverter defibrillator (S-ICD) has been developed. It does not use transvenous leads and thus avoids the need for venous access and complications associated with the insertion of venous leads. Rather, the S-ICD uses a subcutaneous electrode implanted adjacent to the left sternum. The electrodes sense the cardiac rhythm and deliver countershocks through the subcutaneous tissue of the chest wall.

Several automatic ICDs have been approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process. FDA-labeled indications generally include patients who have experienced life-threatening VT associated with cardiac arrest or VT associated with hemodynamic compromise and resistance to pharmacologic treatment. In addition, devices typically have approval in the secondary prevention setting for patients with a previous myocardial infarction and reduced injection fraction.

**Regulatory Status**

**Transvenous Implantable Cardioverter Defibrillators**

A large number of implantable cardioverter defibrillators (ICDs) have been approved by the U.S. Food and Drug Administration (FDA) through the premarket approval (PMA) process (FDA product code: LWS). A 2014 review of FDA approvals of cardiac implantable devices reported that, between 1979 and 2012, FDA approved 19 ICDs (7 pulse generators, 3 leads, 9 combined systems) through new PMA applications. Many originally approved ICDs have received multiple supplemental applications. A selective summary of some currently available ICDs is provided in Table 1.

**Subcutaneous ICDs**

In September 2012, the Subcutaneous Implantable Defibrillator (S-ICD™) System was approved by FDA through the PMA process for the treatment of life-threatening ventricular tachyarhythmias in patients who do not have symptomatic bradycardia, incessant ventricular tachycardia, or spontaneous, frequently recurring ventricular tachycardia that is reliably terminated with antitachycardia pacing (see Table 1).

In March 2015, the Emblem™ S-ICD (Boston Scientific), which is smaller and longer-lasting than the original S-ICD, was approved by FDA through the PMA supplement process.
Table 1. Implantable Cardioverter Defibrillators With FDA Approval

<table>
<thead>
<tr>
<th>Device</th>
<th>Manufacturer</th>
<th>Original PMA Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transvenous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ellipse™/Fortify Assura™ Family (originally: Cadence Tiered Therapy Defibrillation System)</td>
<td>St. Jude Medical (St. Paul, MN)</td>
<td>Jul 1993</td>
</tr>
<tr>
<td>Dynagen™, Inogen™, Origen™, and Teligen® Family (originally: Ventak, Vitality, Cofient family)</td>
<td>Boston Scientific (Marlborough, MA)</td>
<td>Jan 1998</td>
</tr>
<tr>
<td>Evera™ Family (originally: Virtuosos/Entrust/Maximo/Intrisic/Marquis family)</td>
<td>Medtronic (Minneapolis, MN)</td>
<td>Dec 1998</td>
</tr>
<tr>
<td>Subcutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcutaneous Implantable Defibrillator System (S-ICD™)</td>
<td>Cameron Health (San Clemente, CA); acquired by Boston Scientific</td>
<td>Sep 2012</td>
</tr>
</tbody>
</table>

FDA: Food and Drug Administration; PMA: premarket application.

NOTE: ICDs may be combined with other pacing devices, such as pacemakers for atrial fibrillation, or biventricular pacemakers designed to treat heart failure. This evidence review addresses ICDs alone, when used solely to treat patients at risk for ventricular arrhythmias.

**Rationale**

This evidence review was created in March 1996 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through March 5, 2018.

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, two domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances,
nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

**Transvenous Implantable Cardioverter Defibrillators**

**Primary Prevention in Adults**

Transvenous implantable cardioverter defibrillators (TV-ICDs) have been evaluated for primary prevention in a number of populations considered at high risk of sudden cardiac death (SCD), including those with ischemic cardiomyopathy, nonischemic dilated cardiomyopathy (NIDCM), and hypertrophic cardiomyopathy (HCM). There is a large body of evidence, including a number of RCTs and systematic reviews of these trials, addressing the role of ICDs for primary prevention and identifying specific populations who may benefit.

**Ischemic Cardiomyopathy and NIDCM**

**Randomized Controlled Trials**

At least 13 RCTs of ICDs for primary prevention have been conducted. Five were in populations with ischemic cardiomyopathy with prior myocardial infarction (MI; usually ≥3 weeks post-MI):

- Multicenter Automatic Defibrillator Implantation Trial (MADIT);
- MADIT II;
- Coronary Artery Bypass Graft (CABG) Patch trial;
- Multicenter Unsustained Tachycardia Trial (MUSTT); and
- Sudden Cardiac Death in Heart Failure (SCD HeFT) trial.

Three trials were conducted in patients implanted with ICD in the first few weeks following MI (recent MI):

- Defibrillator in Acute Myocardial Infarction Trial (DINAMIT);
- Immediate Risk Stratification Improves Survival (IRIS) trial; and
- BEta-blocker STrategy plus ICD (BEST-ICD) trial.

Six trials were conducted in populations with NIDCM:

- Comparison of Medical Therapy, Pacing, and Defibrillation in Heart Failure (COMPANION) trial;
- Amiodarone Versus Implantable Cardioverter-Defibrillator (AMIOVIRT) trial;
- Defibrillators in Non-Ischemic Cardiomyopathy Treatment Evaluation (DEFINITE) trial;
- SCD HeFT trial;
- Cardiomyopathy Trial (CAT); and
- Danish Study to Assess the Efficacy of ICDs in Patients with Non-Ischemic Systolic Heart Failure on Mortality (DANISH).
The characteristics and mortality results for these 3 groups of trails are shown in Table 2.

Most trials for both ischemic and nonischemic cardiomyopathy have reported results consistent with a mortality benefit for ICD in patients with left ventricular systolic dysfunction or with heart failure and reduced ejection fraction, although not all trials were powered for the mortality outcome and some findings were not statistically significant. However, the DINAMIT, IRIS, and BEST-ICD trials did not support a mortality benefit for ICD in the early weeks following MI, and CABG Patch showed no benefit in patients having recently undergone coronary revascularization. Another notable exception is the 2016 DANISH trial, which enrolled primarily outpatients with nonischemic cardiomyopathy (NICM) in stable condition who were almost all receiving β-blocker or angiotensin-converting enzyme inhibitors, with the majority also receiving mineralocorticoid-receptor antagonists. While overall mortality did not differ significantly between the ICD and medical therapy groups in DANISH, SCD was significantly reduced in the ICD group (4% vs 8%; hazard ratio [HR], 0.50; 95% confidence interval [CI], 0.31 to 0.82).

Table 2. Characteristics and Results of RCTs of ICDs for Primary Prevention

<table>
<thead>
<tr>
<th>Trial</th>
<th>Participants</th>
<th>Treatment Groups</th>
<th>Mean Follow-Up</th>
<th>Mortality Results</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Group</td>
<td>n</td>
<td>Hazard Ratio</td>
</tr>
<tr>
<td><strong>ICM with prior MI</strong></td>
<td></td>
<td>ICD</td>
<td>95</td>
<td>0.46</td>
</tr>
<tr>
<td>MADIT (1996)</td>
<td>LVEF ≤35%</td>
<td>Standard therapy</td>
<td>101</td>
<td></td>
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<tr>
<td></td>
<td>Asymptomatic non-SVT</td>
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<tr>
<td></td>
<td>MI ≥3 wk prior</td>
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<tr>
<td></td>
<td>Inducible VT</td>
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<tr>
<td></td>
<td>NYHA class I-III</td>
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<td></td>
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<tr>
<td>MADIT II (2002)</td>
<td>LVEF ≤30%</td>
<td>ICD</td>
<td>742</td>
<td>0.69</td>
</tr>
<tr>
<td></td>
<td>No history of VT</td>
<td>Standard therapy</td>
<td>490</td>
<td></td>
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<tr>
<td></td>
<td>MI ≥1 mo prior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NYHA class I-III</td>
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<tr>
<td>CABG Patch (1997)</td>
<td>Scheduled for CABG</td>
<td>ICD during CABG</td>
<td>446</td>
<td>1.07</td>
</tr>
<tr>
<td></td>
<td>LVEF ≤35%</td>
<td>No ICD</td>
<td>454</td>
<td></td>
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<tr>
<td></td>
<td>No sustained VT or VF</td>
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<tr>
<td></td>
<td>Signal-averaged ECG abnormalities</td>
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<tr>
<td></td>
<td>82% had prior MI, time since MI not reported</td>
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</tbody>
</table>
### MUSTT (1999)\(^a\)
- LVEF ≤40%
- Asymptomatic non-SVT
- Inducible VT
- MI ≥4 d prior (median, ≈3 y prior)
- No sustained VT or VF
- EPS-guided therapy (AAD with or without ICD) (202 got ICD)
- Standard therapy

<table>
<thead>
<tr>
<th>5-y outcomes(^b):</th>
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<tbody>
<tr>
<td>EPS-guided vs standard therapy: 0.80</td>
</tr>
<tr>
<td>ICD vs AAD alone: 0.42</td>
</tr>
</tbody>
</table>

### SCD HeFT (2005)\(^c\)
- LVEF ≤35%
- NYHA class II-III
- No asymptomatic SVT
- 52% received ICM
- Treated with ACE inhibitors and β-blockers

<table>
<thead>
<tr>
<th>Ischemic patients:</th>
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</thead>
<tbody>
<tr>
<td>ICD 431</td>
</tr>
<tr>
<td>Amiodarone 426</td>
</tr>
<tr>
<td>Placebo 453</td>
</tr>
</tbody>
</table>

<table>
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<th>45 mo</th>
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<tbody>
<tr>
<td>ICD vs placebo</td>
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<tr>
<td>Ischemic: 0.79(a)</td>
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<tr>
<td>Overall: 0.77(a)</td>
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### ICM with recent MI

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<thead>
<tr>
<th>DINAMIT (2004)(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVEF ≤35%</td>
</tr>
<tr>
<td>NYHA class I-III</td>
</tr>
<tr>
<td>No asymptomatic SVT</td>
</tr>
<tr>
<td>MI in preceding 6-40 d (mean, 18 d)</td>
</tr>
<tr>
<td>Reduced HR variability or elevated resting HR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD</th>
</tr>
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<tbody>
<tr>
<td>Standard therapy</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>30 mo</th>
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<tbody>
<tr>
<td>1.08</td>
</tr>
<tr>
<td>0.76 to 1.55</td>
</tr>
</tbody>
</table>

### IRIS (2009)\(^e\)
- MI in preceding 5-31 d
- At least 1 of the following:
  - LVEF ≤40% and resting HR ≥90 or non-SVT

<table>
<thead>
<tr>
<th>ICD</th>
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<tbody>
<tr>
<td>Standard therapy</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>37 mo</th>
</tr>
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<tbody>
<tr>
<td>1.04</td>
</tr>
<tr>
<td>0.81 to 1.35</td>
</tr>
</tbody>
</table>

### BEST-ICD (2005)\(^f\)
- LVEF ≤35%
- NYHA class I-III
- No asymptomatic SVT
- MI in preceding 5-30 d
- At least 1 other risk factor

<table>
<thead>
<tr>
<th>EPS-guided therapy (24 got ICD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>540 d</th>
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<tbody>
<tr>
<td>59</td>
</tr>
<tr>
<td>1-year mortality(^d):</td>
</tr>
<tr>
<td>EPS-guided therapy: 14%</td>
</tr>
<tr>
<td>Convention al therapy: 18%</td>
</tr>
<tr>
<td>2-y mortality(^d):</td>
</tr>
<tr>
<td>EPS-guided therapy: 20%</td>
</tr>
<tr>
<td>Convention al therapy: 29.5%</td>
</tr>
</tbody>
</table>

### Nonischemic cardiomyopathy
<table>
<thead>
<tr>
<th>Study</th>
<th>LVEF ≤35%</th>
<th>NYHA Class</th>
<th>Treatment</th>
<th>Patients</th>
<th>Follow-up</th>
<th>Event Rates</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITE (2004)&lt;sup&gt;10&lt;/sup&gt;</td>
<td></td>
<td>II–IV</td>
<td>ICD and medical therapy alone</td>
<td>229</td>
<td>29 mo</td>
<td></td>
<td>0.65 (0.40 to 1.06)</td>
</tr>
<tr>
<td>SCD HeFT (2005)&lt;sup&gt;8&lt;/sup&gt;</td>
<td>LVEF ≤35%</td>
<td>II–III</td>
<td>Nonischemic patients: (45 mo)</td>
<td>398</td>
<td></td>
<td></td>
<td>ICD vs placebo: 0.50 to 1.07</td>
</tr>
<tr>
<td>COMPANION (2004)&lt;sup&gt;11&lt;/sup&gt;</td>
<td>LVEF ≤35%</td>
<td>II–IV</td>
<td>CRT-D</td>
<td>270</td>
<td>16 mo</td>
<td></td>
<td>CRT-D vs medical therapy: 0.29 to 0.88</td>
</tr>
<tr>
<td>AMIOVIRT (2003)&lt;sup&gt;12&lt;/sup&gt;</td>
<td>LVEF ≤35%</td>
<td>III–IV</td>
<td>ICD</td>
<td>51</td>
<td>2 y</td>
<td>1-y survival&lt;sup&gt;d&lt;/sup&gt;</td>
<td>ICD: 96% Amiodarone: 90%</td>
</tr>
<tr>
<td>CAT (2002)&lt;sup&gt;13&lt;/sup&gt;</td>
<td>LVEF ≤30%</td>
<td>II–III</td>
<td>ICD</td>
<td>50</td>
<td>23 mo</td>
<td>2-y survival&lt;sup&gt;d&lt;/sup&gt;</td>
<td>ICD: 4 deaths (8%) Amiodarone: 87%</td>
</tr>
<tr>
<td>DANISH (2016)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>LVEF ≤35%</td>
<td>II–IV</td>
<td>ICD and medical therapy alone</td>
<td>556</td>
<td>5.6 y&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td>0.87 (0.68 to 1.12)</td>
</tr>
</tbody>
</table>

AAD: antiarrhythmic drugs; ACE: angiotensin-converting enzyme; CABG: coronary artery bypass grafting; CI: confidence interval; CRT: cardiac resynchronization therapy; CRT-D: cardiac resynchronization therapy implantable cardioverter defibrillator; DCM: dilated cardiomyopathy; DSMB: Data Safety Monitoring Board; ECG: electrocardiogram; EPS: electrophysiologic study; HR: heart rate; ICD: implantable cardioverter defibrillator; ICM: ischemic cardiomyopathy; LVEF: left ventricular ejection fraction; MI: myocardial infarction; NYHA: New York Heart Association; RCT: randomized controlled trial; SVT: sustained ventricular tachycardia; VT: ventricular tachycardia.

<sup>a</sup> 97.5% CI.
<sup>b</sup> Relative risk.
<sup>c</sup> Hazard ratio not given, no significant differences.
<sup>d</sup> Median.
**Systematic Reviews**

Woods et al (2015) published an individual patient data network meta-analysis of primary prevention RCTs evaluating implantable cardiac devices, including studies of patients with heart failure and reduced ejection fraction and excluding studies of patients with recent MI or coronary revascularization. The COMPANION, DEFINITE, MADIT, MADIT II, SCD HeFT, AMIOVIRT, and CAT trials were included, representing 6134 patients for the direct ICD comparisons and 12,638 patients overall. The overall estimated effect of ICD on mortality compared with medical therapy was 0.71 (95% CI, 0.63 to 0.80).

Subsequent systematic reviews and meta-analyses of ICD trials in NICM incorporated the 2016 DANISH trial results. Two reviews published in 2017 included the CAT, AMIOVIRT, DEFINITE, SCD HeFT, COMPANION, and DANISH trials; other reviews included all but the COMPANION trial. All reviews have concluded that there was a statistically significant overall reduction in mortality for ICD vs medical therapy, ranging from 20% to 23%, even with the inclusion of the null DANISH results.

The risk for death varies by age, sex, and clinical characteristics such as LVEF and time since revascularization and comorbid conditions (eg, diabetes, kidney disease). Meta-analyses have examined whether there is a beneficial effect on mortality of ICD in these subgroups. Earley et al (2014) conducted a review of evidence for the Agency for Healthcare Research and Quality on use of ICD across important clinical subgroups. Reviewers included 10 studies that provided subgroup analyses. Subgroup data were available from at least 4 studies for sex, age (<65 years vs ≥65 years), and QRS interval (<120 ms vs ≥120 ms); they were combined to calculate a relative odds ratio (ROR) using random-effects meta-analyses. There was no statistically significant difference in the mortality benefit by sex (ROR=0.95; 95% CI, 0.75 to 1.27), age (ROR=0.93; 95% CI, 0.73 to 1.20), or QRS interval (ROR=1.13; 95% CI, 0.82 to 1.54). Other comparisons of subgroups were not meta-analyzed because too few studies compared them; however, no consistent differences between subgroups were found across studies for diabetes. The Woods individual patient data network meta-analysis (described previously) also examined ICD and medical therapy in various subgroups, and similarly concluded that ICD reduced mortality in patients with heart failure and reduced ejection for QRS interval less than 120 ms, 120 to 149 ms, and 150 ms or higher, age less than 60 and 60 and older, and for men. However, the effect on mortality in women was not statistically significant (HR=0.93; 95% CI, 0.73 to 1.18).

**Registry Studies**

Fontenla et al (2016) reported on results from the Spanish UMBRELLA Registry, a multicenter, observational, prospective nationwide registry of 1514 patients implanted with Medtronic ICDs equipped with remote monitoring (NTC01561144) who were enrolled between 2012 and 2013. Mean age was 64 years; 82% of the patients were men; and 65% received an ICD for primary prevention. Fifty-one percent of the patients had ischemic heart disease, 30% had NICM, 7% had HCM,
3% had Brugada syndrome (BrS), and 1.4% had long QT syndrome (LQTS). Mean follow-up was 26 months. The cumulative incidence of sustained ventricular arrhythmias was 15% (95% CI, 13% to 16%) at 1 year, 23% (95% CI, 21% to 25%) at 2 years, and 31% (95% CI, 28% to 34%) at 3 years. Thirteen percent of the episodes of sustained ventricular arrhythmias self-terminated and did not require shocks. One hundred seventy-five (12%) patients had 482 appropriate shocks, and 76 (5%) patients had 190 inappropriate shocks.

**High-Risk HCM**
Schinkel et al (2012) conducted a systematic review and meta-analysis of 27 observational studies (16 cohorts, 2190 patients) reporting outcomes after ICD therapy for HCM. Most patients (83%) received an ICD for primary prevention of SCD. Mean age was 42, 38% of patients were women, and patients had a mean of 1.8 risk factors for SCD. With a mean follow-up of 3.7 years, 14% of patients had an appropriate ICD intervention with an annualized rate of 3.3%. Twenty percent of patients had an inappropriate ICD intervention, for an annualized rate of 4.8%. The annualized cardiac mortality rate was 0.6%, the noncardiac mortality rate was 0.4%, and heart transplantation rate was 0.5%.

Magnusson et al (2015) reported on outcomes for 321 patients with HCM treated with an ICD and enrolled in a Swedish registry. Over a mean follow-up of 5.4 years, appropriate ICD discharges in response to ventricular tachycardia (VT) or ventricular fibrillation (VF) occurred in 77 (24%) patients, corresponding to an annual rate of appropriate discharges of 5.3%. At least 1 inappropriate shock occurred in 46 (14.3%) patients, corresponding to an annualized event rate of 3.0%. Ninety-two (28.7%) patients required at least 1 surgical intervention for an ICD-related complication, with a total of 150 ICD-related reinterventions. Most reinterventions (n=105 [70%]) were related to lead dysfunction.

**Inherited Cardiac Ion Channelopathy**
ICDs have been used for primary and secondary prevention in patients with a number of hereditary disorders (also called cardiac ion channelopathies) that predispose to ventricular arrhythmias and SCD, including LQTS, BrS, short QT syndrome, and catecholaminergic polymorphic ventricular tachycardia (CPVT). Some of these conditions are extremely rare. Use of ICDs has been described in small cohorts of patients with LQTS, BrS, and CPVT.

**Long QT Syndrome**
Horner et al (2010) reported on outcomes for 51 patients with genetically confirmed LQTS treated with an ICD from 2000 to 2010 who were included in a single-center retrospective analysis of 459 patients with genetically confirmed LQTS. Of patients treated with ICDs, 43 (84%) received the device as primary prevention. Twelve (24%) patients received appropriate VF or torsades de pointes–terminated ICD shocks. Factors associated with appropriate shocks included secondary prevention indications (p=0.008), QT corrected duration greater than 500 ms (p<0.001), non-LQT3 genotype (p=0.02), documented syncope (p=0.05), documented torsades de pointes (p=0.003), and a negative sudden family death history (p<0.001). Inappropriate shocks were delivered in 15
(29%) patients. Patients with the \textit{LQT3} genotype only received inappropriate shocks.

\textit{Brugada Syndrome}

Hernandez-Ojeda et al (2017) reported on results from a single-center registry of 104 patients with BrS who were treated with ICDs.\textsuperscript{25} Ten (9.6%) patients received an ICD for secondary prevention and in 94 (90.4%) patients received an ICD for primary prevention. During an average 9.3-year follow-up, 21 (20.2%) patients received a total of 81 appropriate shocks. In multivariate analysis, type 1 electrocardiogram with syncope and secondary prevention indication were significant predictors of appropriate therapy. Nine (8.7%) patients received 37 inappropriate shocks. Twenty-one (20.2%) patients had other ICD-related complications.

Conte et al (2015) described outcomes for a cohort of 176 patients with spontaneous or drug-induced Brugada type 1 electrocardiographic (ECG) findings who received an ICD at a single institution and were followed for at least 6 months.\textsuperscript{26} Before ICD implantation, 14.2\% of subjects had a history of aborted SCD due to sustained spontaneous ventricular arrhythmias, 59.7\% had at least 1 episode of syncope, and 25.1\% were asymptomatic. Over a mean follow-up of 83.8 months, 30 (17\%) patients had spontaneous sustained ventricular arrhythmias detected. Sustained ventricular arrhythmias were terminated by ICD shocks in 28 (15.9\%) patients and antitachycardia pacing in 2 (1.1\%) patients. However, 33 (18.7\%) patients experienced inappropriate shocks.

Dores et al (2015) reported on results of a Portuguese registry that included 55 patients with BrS, 36 of whom were treated with ICDs for primary or secondary prevention.\textsuperscript{27} Before ICD placement, 52.8\% of subjects were asymptomatic, 30.6\% had a history of syncope with suspected arrhythmic cause, and 16.7\% had a history of aborted SCD. Over a mean follow-up of 74 months, 7 patients experienced appropriate shocks, corresponding to an incidence rate of 19.4\% and an annual event rate of 2.8\%. In multivariable analysis, predictors of appropriate shocks were a history of aborted SCD (HR=7.87; 95\% CI, 1.27 to 49.6; p=0.027) and nonsustained VT during follow-up (HR=6.73; 95\% CI, 1.27 to 35.7; p=0.025).

\textit{Catecholaminergic Polymorphic Ventricular Tachycardia}

Roses-Noguer et al (2014) reported on results of a small retrospective study of 13 patients with CPVT who received an ICD.\textsuperscript{28} The indication for ICD therapy was syncope despite maximal \(\beta\)-blocker therapy in 6 (46\%) patients and aborted SCD in 7 (54\%) patients. Over a median follow-up of 4.0 years, 10 (77\%) patients received a median of 4 shocks. For 96 shocks, 87 ECGs were available for review; of those, 63 (72\%) were appropriate and 24 (28\%) inappropriate. Among appropriate shocks, 20 (32\%) restored sinus rhythm.

\textbf{Section Summary: Transvenous Implantable Cardioverter Defibrillators for Primary Prevention in Adults}
**Ischemic Cardiomyopathy and NIDCM**

A large body of RCTs has addressed the effectiveness of TV-ICD implantation for primary prevention in patients at high risk of SCD due to ischemic cardiomyopathy and NICM. Evidence from several RCTs has demonstrated improvements in outcomes with ICD treatment for patients with symptomatic heart failure due to ischemic or NICM with an LVEF of 35% or less. The notable exceptions are that data from several RCTs, including the BEST-ICD, DINAMIT and IRIS trials and subgroup analyses from earlier RCTs, have shown that outcomes with ICD therapy do not appear to improve for patients treated with an ICD within 40 days of recent MI and the CABG Patch trial did not find a benefit for patients undergoing coronary revascularization.

**Hypertrophic Cardiomyopathy**

Less evidence is available for the use of ICDs for primary prevention in patients with HCM. In a meta-analysis of cohort studies, the annual rates of appropriate ICD discharge were 3.3%, and the mortality rate was 1%. Given the long-term high risk of SCD in patients with HCM, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence for the use of SCDs in patients with HCM.

**Inherited Cardiac Ion Channelopathy**

The evidence related to the use of ICDs in patients with inherited cardiac ion channelopathy includes primarily single-center cohort studies or registries of patients with LQTS, BrS, and CPVT that have reported on appropriate shock rates. Patient populations typically include a mix of those requiring ICD placement for primary or secondary prevention. The limited available data for ICDs for LQTS and CPVT have indicated high rates of appropriate shocks. For BrS, more data are available and have suggested that rates of appropriate shocks are similarly high. Studies comparing outcomes between patients treated and untreated with ICDs are not available. However, given the relatively small patient populations and the high risk of cardiac arrhythmias, clinical trials are unlikely. Given the long-term high risk of SCD in patients with inherited cardiac ion channelopathy, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence for the use of SCDs in patients with inherited cardiac ion channelopathy.

**Secondary Prevention in Adults**

At least 5 trials comparing ICD plus medical therapy with medical therapy alone have been conducted in the secondary prevention setting: the Antiarrhythmics Versus Implantable Defibrillators (AVID) trial\(^29\) (N=1016), Cardiac Arrest Survival in Hamburg (CASH) trial\(^30\) (N=288), Canadian Implantable Defibrillator Study (CIDS)\(^31\) (N=659), Defibrillator Versus beta-Blockers for Unexplained Death in Thailand (DEBUT)\(^32\) trial (N=66; pilot, n=20; main study, n=46), and Wever et al (1995)\(^33\) (N=60). The trials are shown in Table 3. Mean length of follow-up varied from 18 to 57 months across trials. Lee et al (2003) combined the AVID, CASH, CIDS, and Wever et al (1995) trials in a meta-analysis of secondary prevention trials.\(^34\) The mortality analysis included 2023 participants and 518 events. In combined estimates, the ICD group had a significant reduction in both mortality
(HR = 0.75; 95% CI, 0.64 to 0.87) and SCD (HR = 0.50; 95% CI, 0.34 to 0.62) compared with the group receiving medical therapy alone. To support National Institute for Health and Care Excellence guidance on the use of ICDs, AVID, CASH, CIDS, and the pilot DEBUT participants were combined in a meta-analysis. The results were similar, indicating a reduction in mortality for ICDs compared with medical therapy alone (relative risk [RR], 0.75; 95% CI, 0.61 to 0.93). Two other meta-analyses that included AVID, CIDS, and CASH reached similar conclusions.

### Table 3. RCTs of ICDs for Secondary Prevention

<table>
<thead>
<tr>
<th>Trials</th>
<th>Participants</th>
<th>Treatment Groups</th>
<th>Mortality Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Group N</td>
<td>RR 95% CI</td>
</tr>
<tr>
<td>AVID (1997)</td>
<td>Patients resuscitated from near-fatal VT/VF, SVT with syncope, or SVT with LVEF ≤40% and symptoms</td>
<td>ICD 507</td>
<td>0.66 0.51 to 0.85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AAD 509</td>
<td></td>
</tr>
<tr>
<td>CASH (2000)</td>
<td>Patients resuscitated from cardiac arrest due to sustained ventricular arrhythmia</td>
<td>ICD 99</td>
<td>0.82 0.60 to 1.11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amiodarone 92</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metoprolol 97</td>
<td></td>
</tr>
<tr>
<td>CIDS (2000)</td>
<td>Patients with VF, out-of-hospital cardiac arrest requiring defibrillation, VT with syncope, VT with rate ≥150/min causing presyncope or angina in patient with LVEF ≤35% or syncope with inducible VT inducible</td>
<td>ICD 328</td>
<td>0.85 0.67 to 1.10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amiodarone 331</td>
<td></td>
</tr>
<tr>
<td>Weyer et al (1995)</td>
<td>Patients with previous MI and resuscitated cardiac arrest due to VT or VF and inducible VT</td>
<td>ICD 29</td>
<td>0.39 0.14 to 1.08</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AAD 31</td>
<td></td>
</tr>
<tr>
<td>DEBUT (2003)</td>
<td>Patients were either SUDS or probable SUDS survivors with ECG abnormalities showing a RBBB-like pattern with ST elevation in the right precordial leads and inducible VT/VF</td>
<td>Pilot RR not calculable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICD 10</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>β-blocker therapy 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Main trial 37</td>
<td>7 deaths in β-blockers vs 0 in ICD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICD 29</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>β-blocker therapy</td>
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</tbody>
</table>

AAD: antiarrhythmic drugs; CI: confidence interval; DSMB: data safety monitoring board; ECG: electrocardiogram; ICD: implantable cardioverter defibrillator; LVEF: left ventricular ejection fraction; MI: myocardial infarction; RBBB: right bundle-branch block; RCT: randomized controlled trial; RR: relative risk; SUDS: sudden unexplained death syndrome; SVT: sustained ventricular tachycardia; VF: ventricular fibrillation; VT: ventricular tachycardia.

An analysis by Chan and Hayward (2005) using the National Veterans Administration database previously confirmed that this mortality benefit is generalizable to the clinical setting. A cohort of 6996 patients in the National Veterans Administration database, from 1995 to 1999, who had new-onset ventricular arrhythmia and preexisting ischemic heart disease and congestive heart failure were included. Of those, 1442 patients had received an ICD. Mortality was determined through the National Death Index at 3 years from the hospital discharge date. The cohort was stratified by quintiles of a multivariable propensity...
score created using many demographic and clinical confounders. The propensity score-adjusted mortality reduction for ICD compared with no ICD was an RR of 0.72 (95% CI, 0.69 to 0.79) for all-cause mortality and an RR of 0.70 (95% CI, 0.63 to 0.78) for cardiovascular mortality.

Section Summary: Secondary Prevention in Adults
Systematic reviews of RCTs in patients who have experienced symptomatic life-threatening sustained VT or VF or have been successfully resuscitated from sudden cardiac arrest have shown a 25% reduction in mortality for ICD compared with medical therapy. Analysis of data from a large administrative database has confirmed that this mortality benefit is generalizable to the clinical setting.

TV-ICDs in Pediatric Populations
There is limited direct evidence on the efficacy of ICDs in the pediatric population. Most published studies have retrospectively analyzed small case series. Some representative series are reviewed next.

The largest published series, by Berul et al (2008), combined pediatric patients and patients with congenital heart disease from 4 clinical centers.\textsuperscript{39} Median age was 16 years, although some adults included were as old as 54 years. A total of 443 patients were included. The most common diagnoses were tetralogy of Fallot and HCM. ICD placement was performed for primary prevention in 52% of patients and secondary prevention in 48%. Over a 2-year follow-up, appropriate shocks occurred in 26% of patients and inappropriate shocks occurred in 21%.

Silka et al (1993) compiled a database of 125 pediatric patients treated with an ICD through a query of the manufacturers of commercially available devices.\textsuperscript{40} Indications for ICD placement were survivors of cardiac arrest (95 [76%] patients), drug-refractory VT (13 [10%] patients), and syncope with heart disease and inducible VT (13 [10%] patients). During a mean follow-up of 31 months, 73 (59%) patients received at least 1 appropriate shock and 25 (20%) received at least 1 inappropriate shock. Actuarial rates of SCD-free survival were 97% at 1 year, 95% at 2 years, and 90% at 5 years.

Alexander et al (2004) reported on 90 ICD procedures in 76 young patients (mean age, 16 years; range, 1-30 years).\textsuperscript{41} Indications for placement were 27 (36%) patients with cardiac arrest or sustained VT, 40 (53%) with syncope, 17 (22%) with palpitations, 40 (53%) with spontaneous ventricular arrhythmias, and 36 (47%) with inducible VT. Numerous patients had more than 1 indication for ICD in this study. Over a median follow-up of 2 years, 28% of patients received an appropriate shock and 25% received an inappropriate shock. Lewandowski et al (2010) reported on long-term follow-up for 63 patients, between the ages 6 and 21 years, who were treated with an ICD device.\textsuperscript{42} At 10-year follow-up, 13 (21%) patients had surgical infections. Fourteen (22%) patients experienced at least 1 appropriate shock and 17 (27%) had at least 1 inappropriate shock. Serious psychological sequelae developed in 27 (43%) patients.
Section Summary: TV-ICDs in Pediatric Populations

The available evidence for the use of ICDs in pediatric patients is limited and consists primarily of small case series that include mixed populations with mixed indications for device placement. Overall, these studies have reported both relatively high rates of appropriate and inappropriate shocks. Pediatric patients may be eligible for ICD placement if they have inherited cardiac ion channelopathy (see Inherited Cardiac Ion Channelopathy section).

Adverse Events Associated With TV-ICDs

Systematic Reviews: Mixed Adverse Events

Persson et al (2014) conducted a systematic review of adverse events following ICD placement. They included data from 35 cohort studies, reported in 53 articles. In-hospital serious adverse event rates ranged from 1.2% to 1.4%, most frequently pneumothorax (0.4%-0.5%) and cardiac arrest (0.3%). Posthospitalization complication rates varied: device-related complications occurred in 0.1% to 6.4%; lead-related complications in 0.1% to 3.9% of patients; infection in 0.2% to 3.7%; thrombosis in 0.2% to 2.9%; and inappropriate shock in 3% to 21%.

In another systematic review of adverse events following ICD placement, Ezzat et al (2015) compared event rates reported in clinical trials of ICDs with those reported in the U.S. National Cardiovascular Data Registry. Reviewers included 18 RCTs (total N=6796 patients). In the pooled analysis, the overall adverse event rate was 9.1% (95% CI, 6.4% to 12.6%). Rates of access-related complications, lead-related complications, generator-related complications, and infection were 2.1% (91% CI, 1.3% to 3.3%), 5.8% (95% CI, 3.3% to 9.8%), 2.7% (95% CI, 1.3% to 5.7%), and 1.5% (95% CI, 0.8% to 2.6%), respectively. Complication rates in the RCTs were higher than those in the U.S. registry, which reports only in-hospital complications (9.1% in the RCTs vs 3.08% in the U.S. registry, p<0.01). The overall complication rate was similar to that reported by Kirkfelt et al (2014), in a population-based cohort study including all Danish patients who underwent a cardiac implantable electronic device procedure from 2010 to 2011 (562 [9.5%] 5918 patients with at least 1 complication).

Van Rees et al (2011) reported on results of a systematic review of RCTs assessing implant-related complications of ICDs and cardiac resynchronization therapy (CRT) devices. Reviewers included 18 trials and 3 subgroup analyses. Twelve trials assessed ICDs, 4 of which used both thoracotomy and nonthoracotomy ICDs (n=951) and 8 of which used nonthoracotomy ICDs (n=3828). For nonthoracotomy ICD placement, the rates for in-hospital and 30-day mortality were 0.2% and 0.6%, respectively, and pneumothorax was reported in 0.9% of cases. For thoracotomy ICD placement, the average in-hospital mortality rate was 2.7%. For nonthoracotomy ICD placement, the overall lead dislodgement rate was 1.8%.

Olde Nordkamp et al (2016) reported on a systematic review and meta-analysis of studies reporting on ICD complications in individuals with inherited arrhythmia...
syndromes. Reviewers included 63 cohort studies with a total of 4916 patients (710 [10%] with arrhythmogenic right VT; 1037 [21%] with BrS; 28 [0.6%] with CPVT; 2466 [50%] with HCM; 162 [3.3%] with lamin A/C gene variants; 462 [9.4%] with LQTS; 51 [1.0%] with short QT syndrome). Overall, inappropriate shocks occurred in 20% of patients over a mean follow-up of 51 months, corresponding to an annual inappropriate shock rate of 4.7% (95% CI, 4.2% to 5.3%). Over a mean follow-up of 55 months, ICD-related complications occurred in 22%, most commonly lead malfunction (10.3% of patients). The pooled rate of ICD-related complications was 4.4% per year (95% CI, 3.6% to 5.2%).

**Systematic Review: Specific Complications**

**Lead Failure**
The failure of leads in specific ICD devices led the U.S. Food and Drug Administration to require St. Jude Medical to conduct 3-year postmarket surveillance studies to address concerns related to premature insulation failure and important questions related to follow-up of affected patients. An evaluation by Hauser et al (2010) found that 57 deaths and 48 serious cardiovascular injuries associated with device-assisted ICD or pacemaker lead extraction were reported to the Food and Drug Administration’s Manufacturers and User Defined Experience database.

Providencia et al (2015) reported on a meta-analysis of 17 observational studies evaluating the performance of 49,871 leads (5538 Durata, 10,605 Endotak Reliance, 16119 Sprint Quattro, 11,709 Sprint Fidelis, 5900 Riata). Overall, the incidence of lead failure was 0.93 per 100 lead-years (95% CI, 0.88 to 0.98). In an analysis of studies restricted to head-to-head comparisons of leads, there were no significant differences in the lead failure rates among nonrecalled leads (Endotak Reliance, Durata, Sprint Quattro).

Birnie et al (2012) reported on clinical predictors of failure for 3169 Sprint Fidelis leads implanted from 2003 to 2007 at 11 centers participating in the Canadian Heart Rhythm Society study. A total of 251 lead failures occurred, corresponding to a 5-year lead failure rate of 16.8%. Factors associated with higher failure rates included female sex (HR=1.51; 95% CI, 1.14 to 2.04; p=0.005), axillary vein access (HR=1.94; 95% CI, 1.23 to 3.04), and subclavian vein access (HR=1.63; 95% CI, 1.08 to 2.46). In a study from 3 centers reporting on predictors of Fidelis lead failures, compared with Quattro lead failures, Hauser et al (2011) reported a failure rate for the Fidelis lead of 2.81% per year (vs 0.42% per year for Quattro leads; p<0.001).

In an earlier study from 12 Canadian centers, Gould et al (2008) reported on outcomes from ICD replacements due to ICD advisories from 2004 to 2005, which included 451 replacements (of 2635 advisory ICD devices). Over 355 days of follow-up, 41 (9.1%) complications occurred, including 27 (5.9%) requiring surgical reintervention and 2 deaths.
In a large prospective multicenter study, Poole et al (2010) reported on complications rates associated with generator replacements and/or upgrade procedures of pacemaker or ICD devices, which included 1031 patients without a planned transvenous lead replacement (cohort 1) and 713 with a planned transvenous lead replacement (cohort 2). A total of 9.8% and 21.9% of cohort 1 and 19.2% and 25.7% of cohort 2 had a single chamber ICD and a dual chamber ICD, respectively, at baseline. Overall periprocedural complication rates for those with a planned transvenous lead replacement were a cardiac perforation in 0.7%, pneumothorax or hemothorax in 0.8%, cardiac arrest in 0.3%, and, most commonly, need to reoperate because of lead dislodgement or malfunction in 7.9%. Although rates were not specifically reported for ICD replacements, complication rates were higher for ICDs and CRT devices than pacemakers.

Ricci et al (2012) evaluated the incidence of lead failure in a cohort of 414 patients given an ICD with Sprint Fidelis leads. Patients were followed for a median of 35 months. Lead failures occurred in 9.7% (40/414) of patients, for an annual rate of 3.2% per patient-year. Most lead failures (87.5%) were due to lead fracture. Median time until recognition of lead failure, or until an adverse event, was 2.2 days. A total of 22 (5.3%) patients received an inappropriate shock due to lead failure.

Cheng et al (2010) examined the rate of lead dislodgements in patients enrolled in a national cardiovascular registry. Of 226,764 patients treated with an ICD between 2006 and 2008, lead dislodgement occurred in 2628 (1.2%). Factors associated with lead dislodgement were New York Heart Association class IV heart failure, AF or atrial flutter, a combined ICD and CRT device, and having the procedure performed by a nonelectrophysiologist. Lead dislodgement was associated with an increased risk for other cardiac adverse events and death.

In another single-center study, Faulknier et al (2010) reported on the time-dependent hazard of failure of Sprint Fidelis leads. Over an average follow-up of 2.3 years, 38 (8.9%) of 426 leads failed. There was a 3-year lead survival rate of 90.8% (95% CI, 87.4% to 94.3%), with a hazard of fracture increasing exponentially over time by a power of 2.13 (95% CI, 1.98 to 2.27; p<0.001).

**Infection Rates**

Several publications have reported on infection rates in patients receiving an ICD. Smit et al (2010) published a retrospective, descriptive analysis of the types and distribution of infections associated with ICDs over a 10-year period in Denmark. Of 91 total infections identified, 39 (42.8%) were localized pocket infections, 26 (28.6%) were endocarditis, 17 (18.7%) were ICD-associated bacteremic infections, and 9 (9.9%) were acute postsurgical infections. Nery et al (2010) reported on the rate of ICD-associated infections among consecutive patients treated with an ICD at a tertiary referral center. Twenty-four of 2417 patients had infections, for a rate of 1.0%. Twenty-two (91.7%) of the 24 patients with infections required device replacement. Factors associated with infection were device replacement (vs de novo implantation) and use of a complex device (eg, combined ICD plus CRT or dual-/triple-chamber devices). Sohail et al (2011)
performed a case-control study evaluating the risk factors for an ICD-related infection in 68 patients and 136 matched controls.\textsuperscript{60} On multivariate analysis, the presence of epicardial leads (odds ratio [OR], 9.7; \(p=0.03\)) and postoperative complications at the insertion site (OR=27.2, \(p<0.001\)) were significant risk factors for early infection. For late-onset infections, hospitalization for more than 3 days (OR=33.1, \(p<0.001\) for 2 days vs 1 day) and chronic obstructive pulmonary disease (OR=9.8, \(p=0.02\)) were significant risk factors.

Chua et al (2000) described the diagnosis and management of infections in a retrospective case series that included 123 patients, 36 of whom were treated for ICD infections.\textsuperscript{61} Most (n=117 [95%]) patients required removal of the device and all lead material. Of those who had all hardware removed, 1 patient experienced a relapse, while 3 of the 6 patients who did not undergo hardware removal experienced a relapse.

Borleffs et al (2010) also reported on complications after ICD replacement for pocket-related complications, including infection or hematoma, in a single-center study.\textsuperscript{62} Of 3161 ICDs included, 145 surgical reinterventions were required for 122 ICDs in 114 patients. Ninety-five (66\%) reinterventions were due to infection, and the remaining 50 (34\%) were due to other causes. Compared with first-implanted ICDs, the occurrence of surgical reintervention in replacements was 2.5 (95\% CI, 1.6 to 3.7) times higher for infection and 1.7 (95\% CI, 0.9 to 3.0) times higher for non-infection-related causes.

**Inappropriate Shocks**

Inappropriate shocks may occur with ICDs due to faulty sensing or sensing of atrial arrhythmias with rapid ventricular conduction; these shocks may lead to reduced QOL and risk of ventricular arrhythmias. In the MADIT II trial (described above), 1 or more inappropriate shocks occurred in 11.5\% of ICD subjects and were associated with a greater likelihood of mortality (HR=2.29; 95\% CI, 1.11 to 4.71; \(p=0.02\)).\textsuperscript{63}

Tan et al (2014) conducted a systematic review to identify outcomes and adverse events associated with ICDs with built-in therapy-reduction programming.\textsuperscript{64} Six randomized trials and 2 nonrandomized cohort studies (total \(N=7687\) patients) were included (3598 with conventional ICDs, 4089 therapy-reduction programming). A total of 267 (4.9\%) patients received inappropriate ICD shocks, 99 (3.4\%) in the therapy-reduction group and 168 (6.9\%) in the conventional programming group (RR=0.50; 95\% CI, 0.37 to 0.61; \(p<0.001\)). Therapy-reduction programming was associated with a significantly lower risk of death than conventional programming (RR=0.30; 95\% CI, 0.16 to 0.41; \(p<0.001\)).

Sterns et al (2016) reported on results of an RCT comparing a strategy using a prolonged VF detection time to reduce inappropriate shocks with a standard strategy among secondary prevention patients.\textsuperscript{65} This trial reported on a prespecified subgroup analysis of the PainFree SST trial, which compared standard with prolonged detection in patients receiving an ICD for secondary prevention. Patients treated for secondary prevention indications were randomized to a
prolonged VF detection period (n=352) or a standard detection period (n=353). At 1 year, arrhythmic syncope-free rates were 96.9% in the intervention group, and 97.7% in the control group (rate difference, -1.1%; 90% lower confidence limit, -3.5%; above the prespecified noninferiority margin of -5%; p=0.003 for noninferiority).

Auricchio et al (2015) assessed data from the PainFree SST trial, specifically newer ICD programming strategies for reducing inappropriate shocks. A total of 2790 patients with an indication for ICD placement were given a device programmed with a SmartShock Technology designed to differentiate between ventricular arrhythmias and other rhythms. The inappropriate shock incidence for dual-/triple-chamber ICDs was 1.5% at 1 year (95% CI, 1.0% to 2.1%), 2.8% at 2 years (95% CI, 2.1% to 3.8%), and 3.9% at 3 years (95% CI, 2.8% to 5.4%).

**Other Complications**

Lee et al (2010) evaluated rates of early complications among patients enrolled in a prospective, multicenter population-based registry of all newly implanted ICDs in Ontario, from 2007 through 2009. Of 3340 patients receiving an ICD, major complications (lead dislodgement requiring intervention, myocardial perforation, tamponade, pneumothorax, infection, skin erosion, hematoma requiring intervention) within 45 days of implantation occurred in 4.1% of new implants. Major complications were more common in women, in patients who received a combined ICD-CRT device, and in patients with a left ventricular end-systolic size of larger than 45 mm. Direct implant-related complications were associated with a major increase in early death (HR=24.9; p<0.01).

Furniss et al (2015) prospectively evaluated changes in high-sensitivity troponin T levels and ECG results that occur during ICD placement alone, ICD placement with testing, and ICD testing alone. The 13 subjects undergoing ICD placement alone had a median increase in high-sensitivity troponin T level of 95% (p=0.005) while the 13 undergoing implantation and testing had a median increase of 161% (p=0.005). Those undergoing testing alone demonstrated no significant change in high-sensitivity troponin T levels.

**Subcutaneous implantable cardioverter defibrillators**

The subcutaneous ICD (S-ICD) is intended for patients who have standard indications for an ICD, but who do not require pacing for bradycardia or antitachycardia overdrive pacing for VT. The S-ICD has been proposed to benefit patients with limited vascular access (including patients undergoing renal dialysis or children) or those who have had complications requiring TV-ICDs explantation. No RCTs were identified comparing the performance of an S-ICD with that of TV-ICDs. The first multicenter, randomized trial (PRAETORIAN; NCT01296022) to directly compare S-ICDs with TV-ICDs is underway.

**S-ICD Efficacy**

Several observational studies have compared S-ICD to TV-ICD.
**Observational Studies**
The observational studies are briefly described in Table 4. All studies were performed in the United States and/or Europe.

**Noncomparative Studies**
The EFFORTLESS S-ICD Registry is a multicenter European registry reporting outcomes for patients treated with S-ICD. Several publications from EFFORTLESS, the pivotal trial submitted to the Food and Drug Administration for the investigational device exemption, and other noncomparative studies are described in Table 5.

### Table 4. Summary of Observational Comparative Studies of S-ICD and TV-ICD

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>N</th>
<th>Follow-Up</th>
<th>Results</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mithani et al (2018)</td>
<td>Matching based on dialysis status, sex, age</td>
<td>182 (91 matched pairs)</td>
<td>180 d</td>
<td>• Inappropriate shocks</td>
<td>TV-ICD: 2.2% S-ICD: 1.1% DC: 2.2%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Infection requiring explant</td>
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<td></td>
<td></td>
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<td></td>
<td>• Death from all causes</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Total with adverse event or death</td>
<td>TV-ICD: 7.7% S-ICD: 5.5% DC: 1.7%</td>
</tr>
<tr>
<td>Honarbakhsh et al (2017)</td>
<td>Propensity matched case-control</td>
<td>138 (69 matched pairs)</td>
<td>32 mo a</td>
<td>• Total device-related complications</td>
<td>TV-ICD: 29% S-ICD: 14.3% DC: 9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Infections</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inappropriate shocks</td>
<td>TV-ICD: 5.8% S-ICD: 9% DC: 4.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Failure to cardiovert VA</td>
<td>TV-ICD: 8.7% S-ICD: 4%</td>
</tr>
<tr>
<td>Kobe et al (2017)</td>
<td>Sex- and age-matched case-control</td>
<td>120 (60 pairs); 84 pairs analyzed</td>
<td>942 d vs 622 d</td>
<td>• Posttraumatic stress disorder</td>
<td>TV-ICD: 14.3% S-ICD: 14.3%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Major depression</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• SF-12 physical well-being score</td>
<td>TV-ICD: 43% S-ICD: 44%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• SF-12 mental well-being score</td>
<td></td>
</tr>
<tr>
<td>Pedersen et al (2016)</td>
<td>Retrospective analysis of propensity-matched cohort</td>
<td>334 (167 matched pairs)</td>
<td>6 mo</td>
<td>• SF-12 physical well-being score</td>
<td>TV-ICD: 43% S-ICD: 44%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• SF-12 mental well-being score</td>
<td></td>
</tr>
<tr>
<td>Brouwer et al (2016)</td>
<td>Retrospective analysis of propensity-matched cohort</td>
<td>280 (140 matched pairs)</td>
<td>5 y</td>
<td>• Overall complications</td>
<td>TV-ICD: 18% S-ICD: 14%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Lead complications</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Non-lead complications</td>
<td>TV-ICD: 11.5% S-ICD: 0.8%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Infections</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Appropriate ICD intervention (HR=2.4; 95% CI, NR; p=0.01)</td>
<td>TV-ICD: 31% S-ICD: 17%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inappropriate ICD intervention (HR=1.3; 95% CI, NR; p=0.42)</td>
<td>TV-ICD: 30% S-ICD: 21%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Survival</td>
<td>TV-ICD: 95% S-ICD: 96%</td>
</tr>
<tr>
<td>Friedman et al (2016)</td>
<td>Retrospective analysis of propensity-matched cohort</td>
<td>5760 (1920 matched, groups)</td>
<td>NR</td>
<td>• Any in-hospital complication</td>
<td>TV-ICD: 0.6% S-ICD: 0.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Deaths</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Infections</td>
<td>TV-ICD: 0% S-ICD: 0.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Lead dislodgements</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Pneumothorax</td>
<td>TV-ICD: 0.2% S-ICD: 0%</td>
</tr>
</tbody>
</table>

*Implantable Cardioverter Defibrillator (ICD) 7.01.44*
- Pericardial effusion 1 0
- Successful termination of induced VF 91% 90%
- Appropriate shocks 3 5
- Inappropriate shocks

CI: confidence interval; DC: dual chamber; HR: hazard ratio; ICD: implantable cardioverter defibrillator; NCDR: National Cardiovascular Data Registry; NR: not reported; SF-12: 12-Item Short-Form Health Survey; S-ICD: subcutaneous implantable cardioverter defibrillator; TV-ICD: transvenous implantable cardioverter defibrillator; VA: ventricular arrhythmia; VF: ventricular fibrillation.
a Mean.
b Median.

### Table 5. Summary of Observational Studies of S-ICD

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Countries</th>
<th>N</th>
<th>Mean FU</th>
<th>Results</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFFORTLESS S-ICD Registry</td>
<td></td>
<td></td>
<td></td>
<td>- Inappropriate shocks by 360 d</td>
<td>8.1%</td>
</tr>
<tr>
<td>EFFORTLESS and IDE studies</td>
<td></td>
<td></td>
<td></td>
<td>- Infections requiring device removal or revision</td>
<td>1.7%</td>
</tr>
<tr>
<td>Bardy et al (2010); Theuns et al (2015)</td>
<td>Europe, New Zealand</td>
<td>55</td>
<td>5.8 y</td>
<td>- Annual mortality rate</td>
<td>3.2%</td>
</tr>
<tr>
<td>Olde-Nordkamp et al (2012)</td>
<td>Netherlands</td>
<td>118</td>
<td>18 mo</td>
<td>- Incidence of therapy for VT or VF:</td>
<td>5.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>o 1 year</td>
<td>7.9%</td>
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<td></td>
<td></td>
<td>o 2 years</td>
<td>10.5%</td>
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<td></td>
<td></td>
<td>o 3 years</td>
<td>13.1%</td>
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<td></td>
<td></td>
<td></td>
<td>- Incidence of inappropriate shock at 3 y</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Devices replaced</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Devices explanted</td>
<td>(47%)</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>- Replaced with TV-ICD</td>
<td>5 (9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Shocks recorded in 16 (29%) patients</td>
<td>4 (7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- All device-related complications</td>
<td>14%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Infections</td>
<td>5.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Dislodgements of device/leads</td>
<td>3.3%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Skin erosion</td>
<td>1.7%</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>- Battery failure</td>
<td>1.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Replaced with TV-ICD</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Appropriate shocks experienced in 8 patients</td>
<td>(0.8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Total inappropriate shocks delivered to 15 (13%) patients</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Deaths (cancer, progressive heart failure)</td>
<td>2</td>
</tr>
</tbody>
</table>

ESRD: end-stage renal disease; FU: follow-up; S-ICD: subcutaneous implantable cardioverter defibrillator; TV-ICD: transvenous implantable cardioverter defibrillator; VF: ventricular fibrillation; VT: ventricular tachycardia.
a Median.
**Inappropriate Shocks**
Although Kobe et al (2017) reported no differences between inappropriate shock rates in patients treated TV-ICD or S-ICD, noncomparative studies have reported relatively high rates of inappropriate shocks with S-ICD.\textsuperscript{71} Inappropriate shocks from S-ICDs often result from T-wave oversensing. Because the sensing algorithm and the discrimination algorithm for arrhythmia detection are fixed in the S-ICD, management to reduce inappropriate shocks for an S-ICD differs from that for a TV-ICD. Kooiman et al (2014) reported on inappropriate shock rates among 69 patients treated at a single center with an S-ICD between 2009 and 2012 who were not enrolled in 1 of 2 other concurrent trials.\textsuperscript{86} Over a total follow-up of 1316 months (median per patient, 21 months), the annual incidence of inappropriate shocks was 10.8%. In 8 patients, inappropriate shocks were related to T-wave oversensing. After patients underwent adjustment of the sensing vector, no further inappropriate shocks occurred in 87.5% of patients with T-wave oversensing.

**Section Summary: Subcutaneous Implantable Cardioverter Defibrillators**

**Contraindications to TV-ICD**
Nonrandomized studies have suggested that S-ICDs are as effective as TV-ICDs at terminating laboratory-induced ventricular arrhythmias. Data from 2 large patient registries have suggested that S-ICDs are effective at terminating ventricular arrhythmias when they occur. Given the need for cardioverter defibrillation for SCD risk in this population, with the assumption that appropriate shocks are life-saving, these rates suggest S-ICDs, in patients with contraindication to TV-ICD, are likely improvements over medical management alone.

**No Contraindications to TV-ICD**
No RCTs directly comparing TV-ICDs with S-ICDs were identified, and therefore evidence is not sufficient to show that outcomes for S-ICDs are noninferior to those for TV-ICD for patients who could otherwise receive TV-ICD.

**Summary of Evidence**

**Transvenous ICDs**
For individuals who have a high risk of SCD due to ischemic or to nonischemic cardiomyopathy in adulthood who receive TV-ICD placement for primary prevention, the evidence includes multiple well-designed and well-conducted RCTs as well as systematic reviews of these trials. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Multiple, well-done RCTs have shown a benefit in overall mortality for patients with ischemic cardiomyopathy and reduced ejection fraction. RCTs assessing early ICD use following recent myocardial infarction did not support a benefit for immediate vs delayed implantation for at least 40 days. For nonischemic cardiomyopathy, there is less clinical trial data, but pooled estimates of available evidence from RCTs enrolling patients with nonischemic cardiomyopathy and from subgroup analyses of RCTs with mixed populations have supported a survival benefit for this group. The evidence is sufficient to determine
that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a high risk of SCD due to HCM in adulthood who receive TV-ICD placement for primary prevention, the evidence includes several large registry studies. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. In these studies, the annual rate of appropriate ICD discharge ranged from 3.6% to 5.3%. Given the long-term high risk of SCD in patients with HCM, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence to support the use of ICDs in patients with HCM. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a high risk of SCD due to an inherited cardiac ion channelopathy who receive TV-ICD placement for primary prevention, the evidence includes small cohort studies of patients with these conditions treated with ICDs. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. The limited evidence for patients with long QT syndrome, catecholaminergic polymorphic ventricular tachycardia, and Brugada syndrome has reported high rates of appropriate shocks. No studies were identified on the use of ICDs for patients with short QT syndrome. Studies comparing outcomes between patients treated and untreated with ICDs are not available. However, given the relatively small patient populations with these channelopathies and the high risk of cardiac arrhythmias, clinical trials are unlikely. Given the long-term high risk of SCD in patients with inherited cardiac ion channelopathy, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence to support the use of TV-ICDs in patients with inherited cardiac ion channelopathy. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have had symptomatic life-threatening sustained VT or VF or who have been resuscitated from sudden cardiac arrest (secondary prevention) who receive TV-ICD placement, the evidence includes multiple well-designed and well-conducted RCTs as well as systematic reviews of these trials. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Systematic reviews of RCTs have demonstrated a 25% reduction in mortality for ICD compared with medical therapy. Analysis of data from a large administrative database has confirmed that this mortality benefit is generalizable to the clinical setting. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Subcutaneous ICDs**

For individuals who need an ICD and have a contraindication to a TV-ICD but no indications for antibradycardia pacing and no antitachycardia pacing-responsive arrhythmias who receive S-ICD placement, the evidence includes nonrandomized studies and case series. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Nonrandomized
controlled studies have reported success rates in terminating laboratory-induced VF that are similar to TV-ICD. Case series have reported high rates of detection and successful conversion of VF, and inappropriate shock rates in the range reported for TV-ICD. Given the need for ICD placement in this population at risk for SCD, with the assumption that appropriate shocks are life-saving, these rates are considered adequate evidence to support the use of S-ICDs in patients with contraindication to TV-ICD. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have need for an ICD and have no contraindication to TV-ICD but no indications for anti-bradycardia pacing and no antitachycardia pacing–responsive arrhythmias who receive S-ICD placement, the evidence includes nonrandomized studies and case series. Relevant outcomes are overall survival, morbid events, quality of life, and treatment-related mortality and morbidity. Nonrandomized controlled studies have reported success rates in terminating laboratory-induced VF that are similar to TV-ICD. However, there is scant evidence on comparative clinical outcomes of both types of ICD over longer periods. Case series have reported high rates of detection and successful conversion of ventricular tachycardia, and inappropriate shock rates in the range reported for TV-ICD. This evidence does not support conclusions on whether there are small differences in efficacy between the 2 types of devices, which may be clinically important due to the nature to the disorder being treated. Also, adverse event rates are uncertain, with variable rates reported. At least 1 RCT is currently underway comparing S-ICD with TV-ICD. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Supplemental Information**

**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.

**2015 Input**

In response to requests, input was received from 1 physician specialty society (4 responses) and 5 academic medical centers, for a total of 9 responses, while this policy was under review in 2015. Input focused on the use of implantable cardioverter defibrillators (ICDs) as primary prevention for cardiac ion channelopathies and use of the subcutaneous implantable cardioverter defibrillator. Reviewers generally indicated that an ICD should be considered medically necessary for primary prevention of ventricular arrhythmias in adults and children with a diagnosis of long QT syndrome, Brugada syndrome, short QT syndrome, and catecholaminergic polymorphic ventricular tachycardia. Reviewers generally indicated that the subcutaneous implantable cardioverter defibrillator should be considered medically necessary particularly for patients with indications
for an ICD but who have difficult vascular access or have had transvenous ICD lead explantation due to complications.

2011 Input
In response to requests, input was received from 6 academic medical centers while this policy was under review in 2011. For most policy indications, including pediatric, there was general agreement from those providing input. On the question of timing of ICD placement, input was mixed, with some commenting about the potential role of early implantation in select patients. Reviewers indicated that a waiting period of 9 months for patients with nonischemic cardiomyopathy was not supported by the available evidence or consistent with the prevailing practice patterns in academic medical centers. Input emphasized the difficulty of prescribing strict timeframes given the uncertainty of establishing the onset of cardiomyopathy and the inability to risk-stratify patients based on time since onset of cardiomyopathy.

Practice Guidelines and Position Statements

American Heart Association et al

Heart Failure
The American Heart Association (AHA), American College of Cardiology (ACC), and Heart Rhythm Society (HRS) (2017) published joint guidelines on the management of heart failure, which updated their 2012 guidelines. These guidelines made the following recommendations on the use of implantable cardioverter defibrillator (ICD) devices (see Tables 6-11). The recommendations for the use of an ICD apply only if meaningful survival is expected to be greater than 1 year.

Table 6. Guidelines on Device-Based Therapy of Cardiac Rhythm Abnormalities

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In patients with ischemic heart disease, who either survive SCA due to VT/VF or experience hemodynamically unstable VT (LOE: B-R) or stable VT (LOE: B-NR) not due to reversible causes....”</td>
<td>I</td>
<td>B-R</td>
</tr>
<tr>
<td>“A transvenous ICD provides intermediate value in the secondary prevention of SCD particularly when the patient’s risk of death due to a VA is deemed high and the risk of nonarrhythmic death (either cardiac or noncardiac) is deemed low based on the patient’s burden of comorbidities and functional status.”</td>
<td></td>
<td>B-R</td>
</tr>
<tr>
<td>“In patients with ischemic heart disease and unexplained syncope who have inducible sustained monomorphic VT on electrophysiological study....”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients resuscitated from SCA due to coronary artery spasm in whom medical therapy is ineffective or not tolerated....”</td>
<td>IIa</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients resuscitated from SCA due to coronary artery spasm, an ICD in addition to medical therapy may be reasonable....”</td>
<td>IIb</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with arrhythmogenic right ventricular cardiomyopathy and an additional marker of increased risk of SCD (resuscitated SCA, sustained VT, significant ventricular dysfunction with RVEF or LVEF ≤35%)....”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with arrhythmogenic right ventricular cardiomyopathy and syncope presumed due to VA....”</td>
<td>IIa</td>
<td>B-NR</td>
</tr>
</tbody>
</table>

COR: class of recommendation; ICD: implantable cardioverter defibrillator; LOE: level of evidence; LVEF: left ventricular ejection fraction; RVEF: right ventricular ejection fraction; SCA: sudden
cardiac arrest; SCD: sudden cardiac death; VA: ventricular arrhythmia; VF: ventricular fibrillation; VT: ventricular tachycardia.

### Table 7. Guidelines on Use of ICDs as a Primary Prevention of Ischemic Heart Disease

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In patients with LVEF of 35% or less that is due to ischemic heart disease who are at least 40 days’ post-MI and at least 90 days postrevascularization, and with NYHA class II or III HF despite GDMT....”</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>“In patients with LVEF of 30% or less that is due to ischemic heart disease who are at least 40 days’ post-MI and at least 90 days postrevascularization, and with NYHA class I HF despite GDMT....”</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>“A transvenous ICD provides high value in the primary prevention of SCD particularly when the patient’s risk of death due to a VA is deemed high and the risk of nonarrhythmic death (either cardiac or noncardiac) is deemed low based on the patient’s burden of comorbidities and functional status....”</td>
<td>B-R</td>
<td></td>
</tr>
<tr>
<td>“In patients with NSVT due to prior MI, LVEF of 40% or less and inducible sustained VT or VF at electrophysiological study....”</td>
<td>I</td>
<td>B-R</td>
</tr>
<tr>
<td>“In nonhospitalized patients with NYHA class IV symptoms who are candidates for cardiac transplantation or an LVAD....”</td>
<td>IIa</td>
<td>B-NR</td>
</tr>
<tr>
<td>“An ICD is not indicated for NYHA class IV patients with medication-refractory HF who are not also candidates for cardiac transplantation, an LVAD, or a CRT defibrillator that incorporates both pacing and defibrillation capabilities.”</td>
<td>IIIa</td>
<td>C-EO</td>
</tr>
</tbody>
</table>

CRT: cardiac resynchronization therapy; COR: class of recommendation; ICD: implantable cardioverter defibrillator; GDMT: guideline-directed management and therapy; HF: heart failure; LOE: level of evidence; LVAD: left ventricular assist device; LVEF: left ventricular ejection fraction; MI: myocardial infarction; NSVT: nonsustained ventricular tachycardia; NYHA: New York Heart Association; SCA: sudden cardiac arrest; SCD: sudden cardiac death; VA: ventricular arrhythmia; VF: ventricular fibrillation; VT: ventricular tachycardia.

### Table 8. Guidelines on Use of ICDs for Nonischemic Cardiomyopathy

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In patients with NICM who either survive SCA due to VT/VF or experience hemodynamically unstable VT (LOE: B-R) (1-4) or stable VT (LOE: B-NR) (5) not due to reversible causes....”</td>
<td>I</td>
<td>B-R</td>
</tr>
<tr>
<td>“In patients with NICM who experience syncope presumed to be due to VA and who do not meet indications for a primary prevention ICD, an ICD or an electrophysiological study for risk stratification for SCD can be beneficial....”</td>
<td>IIa</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with NICM, HF with NYHA class II-III symptoms and an LVEF of 35% or less, despite GDMT....”</td>
<td>IIa</td>
<td>B-R</td>
</tr>
<tr>
<td>“In patients with NICM, HF with NYHA class I symptoms and an LVEF of 35% or less, despite GDMT....”</td>
<td>IIb</td>
<td>B-R</td>
</tr>
<tr>
<td>“In patients with medication-refractory NYHA class IV HF who are not also candidates for cardiac transplantation, an LVAD, or a CRT defibrillator that incorporates both pacing and defibrillation capabilities, an ICD should not be implanted.”</td>
<td>IIIa</td>
<td>C-EO</td>
</tr>
</tbody>
</table>

COR: class of recommendation; CRT: cardio resynchronization therapy; GDMT: guideline-directed management and therapy; HF: heart failure; ICD: implantable cardioverter defibrillator; LOE: level of evidence; LVAD: left ventricular assist device; LVEF: left ventricular ejection fraction; NICM: nonischemic cardiomyopathy; NYHA: New York Heart Association; SCA: sudden cardiac arrest; SCD: sudden cardiac death; VA: ventricular arrhythmia; VF: ventricular fibrillation; VT: ventricular tachycardia.

a No benefit.
Table 9. Guidelines on Use of ICDs for HCM

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In patients with HCM who have survived an SCA due to VT or VF, or have spontaneous sustained VT causing syncope or hemodynamic compromise.”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with HCM and 1 or more of the following risk factors....”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Maximum LV wall thickness ≥30 mm (LOE: B-NR).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. SCD in 1 or more first-degree relatives presumably caused by HCM (LOE: C-LD).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. 1 or more episodes of unexplained syncope within the preceding 6 months (LOE: C-LD)”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“In patients with HCM who have spontaneous NSVT (LOE: C-LD) or an abnormal blood pressure response with exercise (LOE: B-NR), who also have additional SCD risk modifiers or high risk features...”</td>
<td>IIA</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with HCM who have NSVT (LOE: B-NR) or an abnormal blood pressure response with exercise (LOE: B-NR) but do not have any other SCD risk modifiers, an ICD may be considered, but its benefit is uncertain.”</td>
<td>IIB</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with an identified HCM genotype in the absence of SCD risk factors, an ICD should not be implanted”</td>
<td>IIIa</td>
<td>B-NR</td>
</tr>
</tbody>
</table>

COR: class of recommendation; HCM: hypertrophic cardiomyopathy; ICD: implantable cardioverter defibrillator; LOE: level of evidence; LV: left ventricular; NSVT: nonsustained ventricular tachycardia; SCA: sudden cardiac arrest; SCD: sudden cardiac death; VF: ventricular fibrillation; VT: ventricular tachycardia.

Table 10. Guidelines on Use of ICDs for Other Conditions

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In patients with HFrEF who are awaiting heart transplant and who otherwise would not qualify for an ICD (e.g., NYHA class IV and/or use of inotropes) with a plan to discharge home, an ICD is reasonable”</td>
<td>IIA</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with an LVAD and sustained VA, an ICD can be beneficial.”</td>
<td>IIA</td>
<td>C-LD</td>
</tr>
<tr>
<td>“In patients with a heart transplant and severe allograft vasculopathy with LV dysfunction.....”</td>
<td>IIb</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with neuromuscular disorders, primary and secondary prevention ICDs are recommended for the same indications as for patients with NICM....”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>In patients with a cardiac channelopathy (see Guideline Tables 7.9 and 7.9.1)</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>In patients with catecholaminergic polymorphic ventricular tachycardia and recurrent sustained VT or syncope (see Guideline Table 7.9.1)</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with Brugada syndrome with spontaneous type 1 Brugada electrocardiographic pattern and cardiac arrest, sustained VA or a recent history of syncope presumed due to VA....”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with early repolarization pattern on ECG and cardiac arrest or sustained VA.....”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients resuscitated from SCA due to idiopathic polymorphic VT or VF....”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“For older patients and those with significant comorbidities, who meet indications for a primary prevention ICD, an ICD is reasonable.”</td>
<td>IIA</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with adult congenital heart disease with SCA due to VT or VF in the absence of reversible causes....”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with repaired moderate or severe complexity adult congenital heart disease with unexplained syncope and at least moderate ventricular dysfunction or marked hypertrophy, either ICD implantation or an electrophysiological study with ICD implantation for inducible sustained VA is reasonable....”</td>
<td>IIA</td>
<td>B-NR</td>
</tr>
</tbody>
</table>

COR: class of recommendation; ECG: electrocardiogram; HFrEF: heart failure with reduced ejection fraction; ICD: implantable cardioverter defibrillator; LOE: level of evidence; LV: left ventricle; LVAD: left ventricular assist device; LVEF: left ventricular ejection fraction; NICM: nonischemic cardiomyopathy; NYHA: New York Heart Association; SCA: sudden cardiac arrest; VA: ventricular arrhythmia; VF: ventricular fibrillation; VT: ventricular tachycardia.

a No benefit.
Table 11. Guidelines on Use of Subcutaneous ICDs

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In patients who meet criteria for an ICD who have inadequate vascular access or are at high risk for infection, and in whom pacing for bradycardia or VT termination or as part of CRT is neither needed nor anticipated, a subcutaneous implantable cardioverter-defibrillator is recommended.”</td>
<td>I</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients who meet indication for an ICD, implantation of a subcutaneous implantable cardioverter-defibrillator is reasonable if pacing for bradycardia or VT termination or as part of CRT is neither needed nor anticipated.”</td>
<td>IIa</td>
<td>B-NR</td>
</tr>
<tr>
<td>“In patients with an indication for bradycardia pacing or CRT, or for whom antitachycardia pacing for VT termination is required, a subcutaneous implantable cardioverter-defibrillator should not be implanted.”</td>
<td>IIIa</td>
<td>B-NR</td>
</tr>
</tbody>
</table>

CRT: cardiac resynchronization therapy; COR: class of recommendation; ICD: implantable cardioverter defibrillator; LOE: level of evidence; VT: ventricular tachycardia.

The 2013 update made the following recommendations on ICD therapy for children (see Table 12).

Table 12. Guidelines on ICD Therapy for Children

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD implantation is indicated in the survivor of cardiac arrest after evaluation to define the cause of the event and to exclude any reversible causes.</td>
<td>I</td>
<td>B</td>
</tr>
<tr>
<td>ICD implantation is indicated for patients with symptomatic sustained VT in association with congenital heart disease who have undergone hemodynamic and electrophysiological evaluation. Catheter ablation or surgical repair may offer possible alternatives in carefully selected patients.</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>ICD implantation is reasonable for patients with congenital heart disease with recurrent syncope of undetermined origin in the presence of either ventricular dysfunction or inducible ventricular arrhythmias at electrophysiological study.</td>
<td>IIa</td>
<td>B</td>
</tr>
<tr>
<td>ICD implantation may be considered for patients with recurrent syncope associated with complex congenital heart disease and advanced systemic ventricular dysfunction when thorough invasive and noninvasive investigations have failed to define a cause.</td>
<td>IIb</td>
<td>C</td>
</tr>
</tbody>
</table>

All class III recommendations found in Section 3, “Indications for Implantable Cardioverter-Defibrillator Therapy,” apply to pediatric patients and patients with congenital heart disease, and ICD implantation is not indicated in these patient populations.

COR: class of recommendation; ICD: implantable cardioverter defibrillator; LOE: level of evidence; VT: ventricular tachycardia.

ICD Therapy in Patients Not Well Represented in Clinical Trials

The HRS, ACC, and AHA (2014) published an expert consensus statement on the use of ICD therapy for patients not included or poorly represented in ICD clinical trials. The statement presented a number of consensus-based guidelines on the use of ICDs in select patient populations.

American Heart Association

AHA (2010) issued a scientific statement, endorsed by HRS, on cardiovascular implantable electronic device infections and their management. This statement
made the following recommendations on the removal of device-related infections (see Table 13).

### Table 13. Guidelines on the Management of CIED Infections

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete device and lead removal is recommended for all patients with definite CIED infection, as evidenced by valvular and/or lead endocarditis or sepsis.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Complete device and lead removal is recommended for all patients with CIED pocket infection as evidenced by abscess formation, device erosion, skin adherence, or chronic draining sinus without clinically evident involvement of the transvenous portion of the lead system.</td>
<td>I</td>
<td>B</td>
</tr>
<tr>
<td>Complete device and lead removal is recommended for all patients with valvular endocarditis without definite involvement of the lead(s) and/or device.</td>
<td>I</td>
<td>B</td>
</tr>
<tr>
<td>Complete device and lead removal is recommended for patients with occult staphylococcal bacteremia.</td>
<td>I</td>
<td>B</td>
</tr>
</tbody>
</table>

CIED: cardiovascular implantable electronic device; COR: class of recommendation; LOE: level of evidence.

### European Society of Cardiology

The European Society of Cardiology (2015) and endorsed by the Association for European Paediatric and Congenital Cardiology, issued guidelines on the management of patients with ventricular arrhythmias and the prevention of sudden cardiac death. These guidelines make the following statements on use of device-based therapy for ventricular arrhythmia and prevention of sudden cardiac death (see Table 14).

### Table 14. Guidelines on the Management of Ventricular Arrhythmia and Sudden Cardiac Death

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“ICD implantation is recommended in patients with documented VF or haemodynamically not tolerated VT in the absence of reversible causes or within 48 h after myocardial infarction who are receiving chronic optimal medical therapy and have a reasonable expectation of survival with a good functional status &gt;1 year.”</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>“ICD implantation should be considered in patients with recurrent sustained VT (not within 48 h after myocardial infarction) who are receiving chronic optimal medical therapy, have a normal LVEF and have a reasonable expectation of survival with good functional status for &gt; 1 year.”</td>
<td>IIa</td>
<td>C</td>
</tr>
<tr>
<td>“Subcutaneous defibrillators should be considered as an alternative to transvenous defibrillators in patients with an indication for an ICD when pacing therapy for bradycardia support, cardiac resynchronization or antitachycardia pacing is not needed.”</td>
<td>IIa</td>
<td>C</td>
</tr>
<tr>
<td>“The subcutaneous ICD may be considered as a useful alternative to the transvenous ICD system when venous access is difficult, after the removal of a transvenous ICD for infections or in young patients with a long-term need for ICD therapy.”</td>
<td>IIb</td>
<td>C</td>
</tr>
</tbody>
</table>

COR: class of recommendation; ICD: implantable cardioverter defibrillator; LOE: level of evidence; LVEF: left ventricular ejection fraction; VF: ventricular fibrillation; VT: ventricular tachycardia.

### Heart Rhythm Society et al

HRS, the European Heart Rhythm Association, and the Asia-Pacific Heart Rhythm Society (2013) issued a consensus statement on the diagnosis and management of patients with inherited primary arrhythmia syndromes, which included
recommendations on ICD use in patients with long QT syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia, and short QT syndrome (see Table 15).92

Table 15. Guidelines on the Diagnosis and Management of Inherited Primary Arrhythmia Syndromes

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long QT syndrome</strong></td>
<td></td>
</tr>
<tr>
<td>ICD implantation is recommended for patients with a diagnosis of LQTS who are survivors of a cardiac arrest</td>
<td>I</td>
</tr>
<tr>
<td>ICD implantation can be useful in patients with a diagnosis of LQTS who experience recurrent syncopal events while on beta-blocker therapy</td>
<td>IIa</td>
</tr>
<tr>
<td>Except under special circumstances, ICD implantation is not indicated in asymptomatic LQTS patients who have not been tried on beta-blocker therapy</td>
<td>IIIa</td>
</tr>
<tr>
<td><strong>Brugada syndrome</strong></td>
<td></td>
</tr>
<tr>
<td>ICD implantation is recommended in patients with a diagnosis of BrS who:</td>
<td>I</td>
</tr>
<tr>
<td>- Are survivors of a cardiac arrest and/or</td>
<td></td>
</tr>
<tr>
<td>- Have documented spontaneous sustained VT with or without syncope.</td>
<td>IIa</td>
</tr>
<tr>
<td>ICD implantation can be useful in patients with a spontaneous diagnostic type I ECG who have a history of syncope judged to be likely caused by ventricular arrhythmias.</td>
<td></td>
</tr>
<tr>
<td>ICD implantation may be considered in patients with a diagnosis of BrS who develop VF during programmed electrical stimulation (inducible patients).</td>
<td>IIb</td>
</tr>
<tr>
<td>ICD implantation is not indicated in asymptomatic BrS patients with a drug-induced type I ECG and on the basis of a family history of SCD alone.</td>
<td>IIIa</td>
</tr>
<tr>
<td><strong>Catecholaminergic polymorphic ventricular tachycardia</strong></td>
<td></td>
</tr>
<tr>
<td>ICD implantation is recommended for patients with a diagnosis of CPVT who experience cardiac arrest, recurrent syncope or polymorphic/bidirectional VT despite optimal medical management, and/or left cardiac sympathetic denervation.</td>
<td>I</td>
</tr>
<tr>
<td>ICD as a standalone therapy is not indicated in an asymptomatic patient with a diagnosis of CPVT</td>
<td>IIIa</td>
</tr>
<tr>
<td><strong>Short QT syndrome</strong></td>
<td></td>
</tr>
<tr>
<td>ICD implantation is recommended in symptomatic patients with a diagnosis of SQTS who:</td>
<td>I</td>
</tr>
<tr>
<td>- Are survivors of cardiac arrest and/or</td>
<td></td>
</tr>
<tr>
<td>- Have documented spontaneous VT with or without syncope.</td>
<td>IIb</td>
</tr>
<tr>
<td>ICD implantation may be considered in asymptomatic patients with a diagnosis of SQTS and a family history of sudden cardiac death.</td>
<td></td>
</tr>
<tr>
<td>BrS: Brugada syndrome; COR: class of recommendation; CPVT: catecholaminergic polymorphic ventricular tachycardia; ECG: electrocardiogram; ICD: implantable cardioverter defibrillator; LQTS: long QT syndrome; SCD: sudden cardiac death; SQTS: short QT syndrome; VF: ventricular fibrillation; VT: ventricular tachycardia.</td>
<td></td>
</tr>
</tbody>
</table>

*Not recommended.*

**Pediatric and Congenital Electrophysiology Society and Heart Rhythm Society**
The Pediatric and Congenital Electrophysiology Society and HRS (2014) issued an expert consensus statement on the recognition and management of arrhythmias in adult congenital heart disease. The statement made the following recommendations on the use of ICD therapy in adults with congenital heart disease (see Table 16).93

Table 16. Guidelines on the Management of CHD

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD therapy is indicated in adults with CHD who are survivors of cardiac arrest</td>
<td>I</td>
<td>B</td>
</tr>
</tbody>
</table>
due to ventricular fibrillation or hemodynamically unstable ventricular
tachycardia after evaluation to define the cause of the event and exclude any
completely reversible etiology.

ICD therapy is indicated in adults with CHD and spontaneous sustained
ventricular tachycardia who have undergone hemodynamic and
electrophysiologic evaluation.

ICD therapy is indicated in adults with CHD and a systemic left ventricular
ejection fraction <35%, biventricular physiology, and NYHA class II or III
symptoms.

ICD therapy is reasonable in selected adults with tetralogy of Fallot and multiple
risk factors for sudden cardiac death, such as left ventricular systolic or diastolic
dysfunction, nonsustained ventricular tachycardia, QRS duration >180 ms,
extensive right ventricular scarring, or inducible sustained ventricular
tachycardia at electrophysiologic study.

ICD therapy may be reasonable in adults with a single or systemic right
ventricular ejection fraction <35%, particularly in the presence of additional risk
factors such as complex ventricular arrhythmias, unexplained syncope, NYHA
functional class II or III symptoms, QRS duration >140 ms, or severe systemic
AV valve regurgitation.

ICD therapy may be considered in adults with CHD and a systemic ventricular
ejection fraction <35% in the absence of overt symptoms (NYHA class I) or
other known risk factors.

ICD therapy may be considered in adults with CHD and syncope of unknown
origin with hemodynamically significant sustained ventricular tachycardia or
fibrillation inducible at electrophysiologic study.

ICD therapy may be considered for nonhospitalized adults with CHD awaiting
heart transplantation.

ICD therapy may be considered for adults with syncope and moderate or
complex CHD in whom there is a high clinical suspicion of ventricular arrhythmia
and in whom thorough invasive and noninvasive investigations have failed to
define a cause.

Adults with CHD and advanced pulmonary vascular disease (Eisenmenger
syndrome) are generally not considered candidates for ICD therapy.

Endocardial leads are generally avoided in adults with CHD and intracardiac
shunts. Risk assessment regarding hemodynamic circumstances, concomitant
anticoagulation, shunt closure prior to endocardial lead placement, or alternative
approaches for lead access should be individualized.

AV: arteriovenous; CHD: coronary heart disease; COR: class of recommendation; ICD: implantable
cardioverter defibrillator; LOE: level of evidence; NYHA: New York Heart Association.

a Not recommended.

**National Institute for Health and Care Excellence**
The National Institute for Health and Care Excellence (2014) published guidance
on ICDs and cardiac resynchronization therapy for arrhythmias and heart failure. The guidance made the following evidence-based recommendations:

"Implantable cardioverter defibrillators (ICDs) are recommended as options for:

- Treating people with previous serious ventricular arrhythmia, that is, people
  who, without a treatable cause:
  - have survived a cardiac arrest caused by either ventricular tachycardia
    (VT) or ventricular fibrillation or
  - have spontaneous sustained VT causing syncope or significant
    haemodynamic compromise or
have sustained VT without syncope or cardiac arrest, and also have an associated reduction in left ventricular ejection fraction (LVEF) of 35% or less but their symptoms are no worse than class III of the New York Heart Association (NYHA) functional classification of heart failure.

- Treating people who:
  - have a familial cardiac condition with a high risk of sudden death, such as long QT syndrome, hypertrophic cardiomyopathy, Brugada syndrome or arrhythmogenic right ventricular dysplasia or
  - have undergone surgical repair of congenital heart disease.”

**U.S. Preventive Services Task Force Recommendations**
Not applicable.

**Medicare National Coverage**
In February 2018, Medicare issued an update with minor changes to its 2005 national coverage guideline for the use of ICDs. The Centers for Medicare & Medicaid Services determined that the evidence is adequate to conclude that an ICD is reasonable and necessary for the following:

1. “Patients with ischemic dilated cardiomyopathy (IDCM), documented prior MI [myocardial infarction], NYHA [New York Heart Association] Class II and III heart failure, and measured LVEF [left ventricular ejection fraction] of ≤ 35%;
2. Patients with non-ischemic dilated cardiomyopathy (NIDCM) >9 months, NYHA Class II and III heart failure, and measured LVEF ≤ 35%;
3. Patients who meet all current Centers for Medicare & Medicaid Services (CMS) coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA class IV heart failure;”

For each group, patients must not have:

- “Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
- Had a CABG [coronary artery bypass graft] or PTCA [percutaneous transluminal coronary angioplasty] within the past 3 months;
- Had an acute MI within the past 40 days;
- Clinical symptoms or findings that would make them a candidate for coronary revascularization;
- Irreversible brain damage from preexisting cerebral disease;
- Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year;”

Also, the Centers for Medicare & Medicaid Services specified that the beneficiary receiving an ICD for primary prevention must be enrolled in an approved clinical trial or a qualifying data collection system.

**Ongoing and Unpublished Clinical Trials**
Ongoing trials that may influence this review are listed in Table 17.
Table 17. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02121158</td>
<td>Efficacy and Safety of ICD Implantation in the Elderly</td>
<td>100</td>
<td>Aug 2019</td>
</tr>
<tr>
<td>NCT01296022</td>
<td>A Prospective, rAndomizEd Comparison of subcuTaneOus and tRansvenous ImplANtable Cardioverter Defibrillator Therapy (PRAETORIAN)</td>
<td>850</td>
<td>Dec 2019</td>
</tr>
<tr>
<td>NCT00673842</td>
<td>Efficacy of Implantable Defibrillator Therapy After a Myocardial Infarction (REFINE-ICD)</td>
<td>1000</td>
<td>Dec 2021</td>
</tr>
<tr>
<td>NCT02845531</td>
<td>Implantable Cardioverter Defibrillator Versus Optimal Medical Therapy In Patients With Variant Angina Manifesting as Aborted Sudden Cardiac Death (VARIANT ICD)</td>
<td>140</td>
<td>Jun 2023</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

* Denotes industry-sponsored or cosponsored trial.

References


93. Khairy P, Van Hare GF, Balaji S, et al. PACES/HRS expert consensus statement on the recognition and management of arrhythmias in adult congenital heart disease: developed in partnership between the Pediatric and Congenital Electrophysiology Society (PACES) and the Heart Rhythm Society (HRS). Endorsed by the governing bodies of PACES, HRS, the American College of Cardiology (ACC), the American Heart Association (AHA), the European Heart Rhythm Association (EHRA), the Canadian Heart Rhythm Society (CHRS), and the International Society for Adult Congenital Heart Disease (ISACHD). Can J Cardiol. Oct 2014;30(10):e1-e63. PMID 25262867


**Billing Coding/Physician Documentation Information**

33216 Insertion of a transvenous electrode; permanent pacemaker or cardioverter-defibrillator

33217 Insertion of 2 transvenous electrode; permanent pacemaker or cardioverter-defibrillator

33218 Repair of single transvenous electrode, permanent pacemaker or pacing cardioverter-defibrillator

33220 Repair of 2 transvenous electrodes for permanent pacemaker or pacing cardioverter-defibrillator

33223 Relocation of skin pocket for cardioverter-defibrillator
33240 Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead
33230 Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads
33231 Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads
33240 Insertion of implantable defibrillator pulse generator only; with existing single lead
33241 Removal of pacing cardioverter-defibrillator pulse generator only
33262 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system
33263 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system
33264 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system
33243 Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy
33244 Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by transvenous extraction
33249 Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber
33270 Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed
33271 Insertion of subcutaneous implantable defibrillator electrode
33272 Removal of subcutaneous implantable defibrillator electrode
33273 Repositioning of previously implanted subcutaneous implantable defibrillator electrode
93260 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system
93261 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system
93282 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead implantable cardioverter-defibrillator system
93283 Programming device evaluation (in person) with iterative adjustment of
the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead implantable cardioverter-defibrillator system

93284 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead implantable cardioverter-defibrillator system

93289 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements

93640 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;

93641 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator

93642 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)

93644 Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)

C1721 Cardioverter-defibrillator, dual chamber (implantable)
C1722 Cardioverter-defibrillator, single chamber (implantable)
C1882 Cardioverter-defibrillator, other than single or dual chamber (implantable)
C1895 Lead, cardioverter-defibrillator, endocardial dual coil (implantable)
C1896 Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)

ICD-10 Codes
I25.5 Ischemic cardiomyopathy
I42.1- Hypertrophic cardiomyopathy code range.
I42.2
I42.8 Other cardiomyopathies (best choice for nonischemic cardiomyopathy)
I42.9 Cardiomyopathy, unspecified
I45.81 Long QT syndrome
I45.89 Other specified conduction disorders
I46.2, Cardiac arrest code range
I46.8,
I46.9
I47.2 Ventricular tachycardia
I49.01 Ventricular fibrillation
I49.9 Cardiac arrhythmia, unspecified
Q20.0- Congenital malformations of cardiac chambers and connections code range
Q20.9
Q21.0- Congenital malformations of cardiac septa code range
Q21.9
Q22.0- Congenital malformations of pulmonary and tricuspid valves code range
Q22.9
Q23.0- Congenital malformations of aortic and mitral valves code range
Q23.9
Q24.0- Other congenital malformations of heart code range
Q24.9

Deleted Codes: (as of 1/1/2015) 0319T, 0320T, 0321T, 0322T, 0323T, 0324T, 0325T, 0326T, 0327T, 0328T.

**Additional Policy Key Words**

N/A

**Policy Implementation/Update Information**

10/1/88 New policy added to the Surgery section.
6/1/00 No policy statement changes.
6/1/01 Policy archived.
8/1/05 Policy removed from Archives. Policy statement revised to include the following investigational indications:
In patients who:

- have had an acute myocardial infarction (i.e., less than 40 days before AICD treatment)
- have New York Heart Association (NYHA) Class IV congestive heart failure (unless patient is eligible to receive a combination cardiac resynchronization therapy ICD device)
- have had cardiac revascularization procedure in past 3 months (coronary artery bypass graft [CABG] or percutaneous transluminal coronary angioplasty [PTCA]) or are candidates for a cardiac revascularization procedure
- have noncardiac disease that would be associated with life expectancy less than 1 year

8/1/06 No policy statement changes.
8/1/07 No policy statement changes.
8/1/08 Policy statement revised to indicate that use of ICD in certain high-risk patients with hypertrophic cardiomyopathy may be considered medically necessary.
8/1/09  No policy statement changes.
8/1/10  No policy statement changes.
8/1/11  Policy statements specific to ICD indications in pediatric patients added to policy statements and rationale. Policy statement revised to clarify the indications in ischemic cardiomyopathy with separate indications for class II/III and class I patients. Policy statement with waiting time in nonischemic cardiomyopathy was revised based on additional clinical input.
1/1/12  Coding updated.
8/1/12  No policy statement changes.
11/1/12 Policy statement added on the use of subcutaneous ICD, considered investigational for all indications. ACCF/AHA guidelines on management of patients with HCM added to policy.
11/1/13  No policy statement changes.
11/1/14  A clause “…after reversible causes (eg, acute ischemia) have been excluded” added to current statement on secondary prevention in adults. Updated CPT definitions and added new 2015 CPT codes.
10/15/15 Subcutaneous ICD may be considered medically necessary.
11/1/15 Added: Diagnosis of cardiac ion channelopathies and considered to be at high risk for sudden cardiac death to primary prevention medically necessary statement. Added: Hypertrophic cardiomyopathy and diagnosis of cardiac ion channelopathies to pediatrics medically necessary statement.
11/1/16  No policy statement changes.
11/1/17  No policy statement changes.
11/1/18  No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.