MASSACHUSETTS

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Medical Policy

Leadless Cardiac Pacemakers

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Policy Number: 038

BCBSA Reference Number: 2.02.32 (For Plan internal use only)

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

The Micra™ VR or Aveir™ single-chamber transcatheter pacing system may be considered **MEDICALLY NECESSARY** in patients when **both** conditions below are met:

1. The individual has high-grade atrioventricular (AV) block in the presence of atrial fibrillation or has significant bradycardia and:
   - Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines); **OR**
   - Chronic atrial fibrillation; **OR**
   - Severe physical disability.
2. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as **any** of the following:
   - History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection.
   - Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis
   - Presence of a bioprosthetic tricuspid valve.

The Micra™ AV single-chamber transcatheter pacing system may be considered **MEDICALLY NECESSARY** in individuals when **both** conditions below are met:

1. The individual has high-grade atrioventricular (AV) block in the presence of atrial fibrillation or has significant bradycardia and:
   - Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines); **OR**

- Chronic atrial fibrillation; **OR**
- Severe physical disability **OR**
- There is an indication for VDD pacing and the individual may benefit from maintenance of AV synchronous ventricular pacing.

2. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following:
   - History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection
   - Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis
   - Presence of a bioprosthetic tricuspid valve.

The Micra™ and Aveir™ single-chamber transcatheter pacing systems are considered **INVESTIGATIONAL** in all other situations in which the above criteria are not met.

The Aveir™ DR dual-chamber pacing system is considered **INVESTIGATIONAL**.

Policy Guidelines

Policy criteria are informed by U.S. Food and Drug Administration (FDA) labeled indications for use and clinical input.

Physical Disability and Infection Risk

Clinical input suggests that severe physical disability encompasses a variety of comorbidities where conventional pacemaker placement would confer undue short- or long-term risk or further compromise a limited ability to meet activities of daily living, including compliance with postoperative care instructions. Examples include individuals with short, expected lifespan, individuals with end-stage heart, lung, neurologic, or skeletal conditions, and individuals with mental health or developmental challenges.

The 2019 European Heart Rhythm Association (EHRA) international consensus paper on the prevention, diagnosis, and treatment of cardiac implantable electronic device (CIED) infections has been endorsed by the Heart Rhythm Society (HRS) and lists the following non-modifiable patient-related risk factors for CIED infections:

- End-stage renal disease
- Corticosteroid use
- Renal failure
- History of device infection
- Chronic obstructive pulmonary disease
- Heart failure (New York Heart Association [NYHA] Class ≥II)
- Malignancy
- Diabetes mellitus.

Device Contraindications

As per the FDA label, the Aveir™ Leadless Pacemaker Models LSP112V, LSP201A, and LSP202V are contraindicated in the following situations:

- Use of any pacemaker is contraindicated in individuals with a co-implanted implantable cardioverter-defibrillator because high-voltage shocks could damage the pacemaker, and the pacemaker could reduce shock effectiveness.
- Single-chamber ventricular demand pacing is relatively contraindicated in individuals who have demonstrated pacemaker syndrome, have retrograde ventriculoatrial conduction, or suffer a drop in arterial blood pressure with the onset of ventricular pacing.
- Programming of rate-responsive pacing is contraindicated in individuals with intolerance of high sensor-driven rates.
- Use is contraindicated in individuals with an implanted vena cava filter or mechanical tricuspid valve because of interference between these devices and the delivery system during implantation.

- Persons with known history of allergies to any of the components of this device may suffer an allergic reaction to this device. Prior to use on the patient, the patient should be counseled on the materials contained in the device and a thorough history of allergies must be discussed.

The Aveir™ Leadless Pacemaker is conditionally safe for use in the magnetic resonance imaging (MRI) environment when used according to the instructions in the MRI-Ready Leadless System Manual (which includes equipment settings, scanning procedures, and a listing of conditionally approved components). Scanning under different conditions may result in severe patient injury, death, or device malfunction.

As per the U.S. Food and Drug Administration (FDA) label, the Micra Model MC1VR01 (Micra VR) and Model MC1AVR1 (Micra AV) pacemakers are contraindicated for individuals who have the following types of devices implanted:

- An implanted device that would interfere with the implant of the Micra device in the judgment of the implanting physician
- An implanted inferior vena cava filter
- A mechanical tricuspid valve
- An implanted cardiac device providing active cardiac therapy which may interfere with the sensing performance of the Micra device.

As per the FDA label, the Micra Model MC1VR01 and Model MC1AVR1 pacemakers are also contraindicated for individuals who have the following conditions:

- Femoral venous anatomy unable to accommodate a 7.8 mm (23 French) introducer sheath or implant on the right side of the heart (for example, due to obstructions or severe tortuosity)
- Morbid obesity that prevents the implanted device to obtain telemetry communication within <12.5 cm (4.9 in)
- Known intolerance to titanium, titanium nitride, parylene C, primer for parylene C, polyether ether ketone, siloxane, nitinol, platinum, iridium, liquid silicone rubber, silicone medical adhesive, and heparin or sensitivity to contrast medical which cannot be adequately premedicated

As per the FDA label, Micra pacemakers should not be used in individuals for whom a single dose of 1.0 mg dexamethasone acetate cannot be tolerated because the device contains a molded and cured mixture of dexamethasone acetate with the target dosage of 272 µg dexamethasone acetate. It is intended to deliver the steroid to reduce inflammation and fibrosis.

For the MRI contraindications for patients with a Micra MRI device, refer to the Medtronic MRI Technical Manual.

As per the FDA label, some individuals will not benefit from the AV synchronous (VDD) mode supported by the Micra Model MC1AVR1 pacemaker. Individuals with the following conditions should instead be considered for a dual-chamber transvenous pacing system:

- Sinus node dysfunction
- High sinus rates requiring atrial tracking
- Weak atrial contraction
- Symptoms during loss of atrioventricular (AV) synchrony
- Frequent premature atrial or ventricular contractions.

High-Grade Atrioventricular Block

Atrioventricular block occurs when there is interference of the electrical signals from the atrium to the ventricle. AV block is categorized based on severity. First degree AV block occurs when signals are transferred more slowly than normal. Second-degree AV block is divided into Type I and Type II. Type I is also called Mobitz Type I or Wenckebach's AV block. There is gradually slower activity which may produce skipped heartbeats. Second-degree Type II is also called Mobitz Type II where more signals fail to reach the ventricles, resulting in a slower and more abnormal heart rhythm. Second-degree AV block can be paroxysmal (not persistent) or permanent. Additionally, high-degree AV block is a form of second-degree AV block in which the conduction ratio is high representing multiple atrial contractions that are not

conducting to the ventricle; however, there is still some AV conduction and as such is not a third-degree AV block. Third-degree AV block is a complete block of the electrical signals; while the ventricles contract on their own, the consequences are reduced and irregular heart rate and reduced cardiac output.

Individuals with rare episodes of AV block or sinus arrest generally do not require pacing intervention, although symptomatic individuals might have significant need for pacing. The Micra™ VR and Aveir™ devices are indicated when there is infrequent AV block. The Micra™ AV device is indicated with infrequent or chronic AV block. These definitions come from the intended use definitions of the devices and clinical input. Note that there is no strict definition of the frequency of episodes or the degree of symptoms.

VDD Pacing
VDD pacing is a pacing mode used in pacemakers whereby sensing occurs in both the atrium and ventricle, with pacing only occurring in the ventricle. The first letter (V) indicates that the Ventricle is the pacing chamber, the second letter (D) indicates that both the atrium and ventricle are the sensing chambers, and the third letter (D) indicates that the mode of operation is dual (inhibited and triggered). Uses of VDD pacing include pacemaker syndrome where there is reduced coordination between the atrial and ventricular contractions resulting in lower cardiac output, and when individuals with an implant have complete AV block with preserved sinus functioning. VDD is used in dual chamber transvenous pacemakers and in single-chamber ventricular pacemakers with leads that float in the atrium for sensing. The Micra™ AV leadless pacemaker supports VDD pacing.

Atrioventricular Synchrony
Devices that support maintenance of AV synchrony can sense atrial electrical activity and pace the ventricular chamber accordingly. Pacemakers maintaining AV synchrony may lead to less morbidity and mortality than ventricular stimulation alone and reduce the risk of pacemaker syndrome. The Micra™ AV device provides AV synchronous ventricular pacing similar to a transvenous VDD system. The implanted device depends on the appropriate sensing of atrial mechanical signals to achieve AV synchrony. The level of AV synchrony may vary in individual patients and may not be predictable prior to implant. The manufacturer cautions that loss of AV synchrony can be caused by the interference of mechanical vibrations stemming from patient activities and environments.

Pacemaker Syndrome
In pacemaker syndrome there is reduced coordination between atrial contraction and ventricular contraction, resulting in reduced cardiac output. The syndrome is most commonly seen in the setting of a single-chamber ventricular pacemaker with ventricular sensing and pacing, as with no atrial sensing the ventricles contract at the programmed rate independently from atrial contraction.

Device Retrieval and Replacement
Leadless pacemakers have a limited lifespan. Removal of devices can be complicated by encapsulation due to fibrosis. Devices can instead be deactivated and remain in place, with another device implanted. Use of deactivated and activated devices might result in electromagnetic interference. Based on bench testing, the current recommendation for device end of service care includes adding a replacement device with or without explantation of the deactivated implant. Explantation of the deactivated implant should be performed by a clinician with expertise in the removal of implanted leads. Use of co-implanted deactivated and activated devices has not been clinically tested, and as such Plans will need to consider the medical necessity of repeat implantation. The Aveir™ device features helix-based active fixation designed to facilitate device removal with a dedicated retrieval catheter; however, limited data are available on retrieval success rates.

Mechanical Interference
For axillary transvenous pacemakers, there is a concern that leads, or the generator could be impacted by the recoil of using a firearm (e.g., rifles or shotguns). Thus, leadless cardiac pacemakers can provide an alternative for patients who suffer lead fracture or malfunction from mechanical stress and may be considered when axillary venous access is present only on a side of the body that would not allow use of equipment producing such mechanical stress (e.g., a firearm).

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **not required**.
Commercial PPO and Indemnity	Prior authorization is **not required**.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT code above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

ICD-10-CM diagnosis codes:	Code Description
I44.1	Atrioventricular block, second degree
I44.2	Atrioventricular block, complete
I45.5	Other specified heart block
I49.5	Sick sinus syndrome
R00.1	Bradycardia, unspecified

The following CPT and HCPCS codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

0823T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy

0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed
0826T	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, leadless pacemaker system in single-cardiac chamber

HCPCS Codes

C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation

Description

Conventional Pacemakers

Pacemakers are intended to be used as a substitute for the heart's intrinsic pacing system to correct cardiac rhythm disorders. By providing an appropriate heart rate and heart rate response, cardiac pacemakers can reestablish effective circulation and more normal hemodynamics that are compromised by a slow heart rate. Pacemakers vary in system complexity and can have multiple functions as a result of the ability to sense and/or stimulate both the atria and the ventricles.

Transvenous pacemakers or pacemakers with leads (hereinafter referred to as conventional pacemakers) consist of 2 components: a pulse generator (ie, battery component) and electrodes (ie, leads). The pulse generator consists of a power supply and electronics that can provide periodic electrical pulses to stimulate the heart. The generator is commonly implanted in the infraclavicular region of the anterior chest wall and placed in a pre-pectoral position; in some cases, a subpectoral position is advantageous. The unit generates an electrical impulse, which is transmitted to the myocardium via the electrodes affixed to the myocardium to sense and pace the heart as needed.

Conventional pacemakers are also referred to as single-chamber or dual-chamber systems. In single-chamber systems, only 1 lead is placed, typically in the right ventricle. In dual-chamber pacemakers, 2 leads are placed 1 in the right atrium and the other in the right ventricle. Single-chamber ventricular pacemakers are more common.

Annually, approximately 200,000 pacemakers are implanted in the U.S. and 1 million worldwide.[1] Implantable pacemakers are considered life-sustaining, life-supporting class III devices for patients with a variety of bradyarrhythmias. Pacemaker systems have matured over the years with well-established, acceptable performance standards. As per the U.S. Food and Drug Administration (FDA), the early performance of conventional pacemaker systems from implantation through 60 to 90 days have usually demonstrated acceptable pacing capture thresholds and sensing. Intermediate performance (90 days through more than 5 years) has usually demonstrated the reliability of the pulse generator and lead technology. Chronic performance (5 to 10 years) includes a predictable decline in battery life and mechanical reliability, but a vast majority of patients receive excellent pacing and sensing free of operative or mechanical reliability failures.

Even though the safety profile of conventional pacemakers is excellent, they are associated with complications particularly related to leads. Most safety data on the use of conventional pacemakers come from registries from Europe, particularly from Denmark where all pacemaker implants are recorded in a national registry. These data are summarized in Table 1. It is important to recognize that valid comparison of complication rates is limited by differences in definitions of complications, which results in a wide variance

of outcomes, as well as by the large variance in follow-up times, use of single-chamber or dual-chamber systems, and data reported over more than 2 decades.[2] As such, the following data are contemporary and limited to single-chamber systems when reported separately.

In many cases when a conventional pectoral approach is not possible, alternative approaches such as epicardial pacemaker implantation and trans-iliac approaches have been used.[3] Cohen et al (2001) reported outcomes from a retrospective analysis of 123 patients who underwent 207 epicardial lead implantations.[4] Congenital heart disease was present in 103 (84%) of the patients. Epicardial leads were followed for 29 months (range, 1 to 207 months). Lead failure was defined as the need for replacement or abandonment due to pacing or sensing problems, lead fracture, or phrenic/muscle stimulation. The 1-, 2-, and 5-year lead survival was 96%, 90%, and 74%, respectively. Epicardial lead survival in those placed by a subxiphoid approach was 100% at 1 year and at 10 years, by the sternotomy approach (93.9% at 1 year and 75.9% at 10 years) and lateral thoracotomy approach (94.1% at 1 year and 62.4% at 10 years).

Doll et al (2008) reported results of a randomized controlled trial comparing epicardial implantation versus conventional pacemaker implantation in 80 patients with indications for cardiac resynchronization therapy.[5] The authors reported that the conventional pacemaker group had a significantly shorter intensive care unit stay, less blood loss, and shorter ventilation times while the epicardial group had less exposure to radiation and less use of contrast medium. The left ventricular pacing threshold was similar in the 2 groups at discharge but longer in the epicardial group during follow-up. Adverse events were also similar in the 2 groups. The following events were experienced by 1 (3%) patient each in the epicardial group: pleural puncture, pneumothorax, wound infection, acute respiratory distress syndrome, and hospital mortality.

As a less invasive alternative to the epicardial approach, the trans-iliac approach has also been utilized. Data using trans-iliac approach is limited. Multiple other studies with smaller sample size report a wide range of lead longevity.

Harake et al (2018) reported a retrospective analysis of 5 patients who underwent a transvenous iliac approach (median age, 26.9 years).[6] Pacing indications included AV block in 3 patients and sinus node dysfunction in 2 patients. After a median follow-up of 4.1 years (range, 1.0 to 16.7 years), outcomes were reported for 4 patients. One patient underwent device revision for lead position-related groin discomfort; a second patient developed atrial lead failure following a Maze operation and underwent lead replacement by the iliac approach. One patient underwent heart transplantation 6 months after implant with only partial resolution of pacing-induced cardiomyopathy. Tsutsumi et al (2010) reported a case series of 4 patients from Japan in whom conventional pectoral approach was precluded due to recurrent lead infections (n=1), superior vena cava obstruction following cardiac surgery (n=2) and a postoperative dermal scar (n=1). The mean follow-up was 24 months, and the authors concluded the iliac vein approach was satisfactory and less invasive alternative to epicardial lead implantation. However, the authors reported that the incidence of atrial lead dislodgement using this approach in the literature ranged from 7% to 21%. Experts who provided clinical input reported that trans-iliac or surgical epicardial approach requires special expertise and long-term performance is suboptimal.[7]

Table 1. Reported Complication Rates with Conventional Pacemakers

Complications	**Rates, %[8,9,10a]**
Traumatic complications	
RV perforation	0.2-to 0.8
RV perforation with tamponade	0.07-to 0.4
Pneumo(hemo)thorax	0.7-to 2.2
Pocket complications	
Including all hematomas, difficult to control bleeding, infection, discomfort, skin erosion	4.75
Including only those requiring invasive correction or reoperation	0.66-to 1.0
Lead-related complications	

Including lead fracture, dislodgement, insulation problem, infection, stimulation threshold problem, diaphragm or pocket stimulation, other	1.6-to 3.8
All system-related infections requiring reoperation or extraction	0.5- to 0.7

Adapted from Food and Drug Administration executive summary memorandum (2016).[11]

[a] Rates are for new implants only and ventricular single-chamber devices when data were available. Some rates listed in this column are for single- and dual-chamber devices when data were not separated in the publication. Note that Micra transcatheter pacing system is a single-chamber device.

Potential Advantages of Leadless Cardiac Pacemakers Over Conventional Pacemakers

The potential advantages of leadless pacemakers fall into 3 categories: avoidance of risks associated with intravascular leads in conventional pacemakers, avoidance of risks associated with pocket creation for placement of conventional pacemakers, and an additional option for patients who require a single-chamber pacer.[12.]

Lead complications include lead failure, lead fracture, insulation defect, pneumothorax, infections requiring lead extractions and replacements that can result in a torn subclavian vein or the tricuspid valve. In addition, there are risks of venous thrombosis and occlusion of the subclavian system from the leads. Use of a leadless system eliminates such risks with the added advantage that a patient has vascular access preserved for other medical conditions (eg, dialysis, chemotherapy).

Pocket complications include infections, erosions, and pain that can be eliminated with leadless pacemakers. Further, a leadless cardiac pacemaker may be more comfortable and appealing because unlike conventional pacemakers, patients are unable to see or feel the device or have an implant scar on the chest wall.

Leadless pacemakers may also be a better option than surgical endocardial pacemakers for patients with no vascular access due to renal failure or congenital heart disease.

Atrioventricular Synchrony

The Micra AV device supports maintenance of AV synchrony by sensing atrial mechanical contraction (A4 signal). Several small-cohort studies have investigated the relationship between parameters (eg, clinical and echocardiographic) and A4 signal amplitude. Briongos-Figuero et al (2023) investigated clinical and echocardiographic predictors of optimal AV synchrony, defined as ≥85% of total cardiac cycles being synchronous, in individuals with successful Micra AV implant (N=43). The authors performed univariate analyses followed by multivariate analysis. They found diabetes and chronic obstructive pulmonary disease to be associated with A4 signal amplitude, however no echocardiographic parameters were associated with A4 signal amplitude.[13.] Troisi et al (2024) studied the relationship between echocardiographic parameters and A4 signal amplitude in individuals implanted with Micra AV (N=21). The authors concluded echocardiographic parameters, particularly related to left atrial function, may be related to successful AV synchrony.[14.] Kawatani et al (2024) et al studied predictors of AV synchrony in individuals with Micra AV implants (N=50). Participants were stratified into 2 groups, high and low A4 amplitude. In a multivariate analysis, maximum deflection index was the only parameter associated with low A4 amplitude.[15.] These studies were exploratory and results among the studies were inclusive. More research is in larger cohort studies is needed to produce more conclusive evidence on parameters that are predictive of AV synchrony.

Battery Life and Device Retrieval

Currently, real-world evidence of long-term battery life for leadless pacemakers is limited. Breeman et al (2023) studied the battery life of the Micra VR after implantation (N=153). The manufacturer's predicted battery life for the Micra VR is 12 years. Using mixed models to assess changes in electrical parameters over time, the authors concluded that for a majority of individuals the expected batter longevity is >8 years.[16.] Due to the limited lifespan of leadless pacemakers, they are designed to be retrievable (eg, the helix fixation design of the Aveir devices). However, evidence on the safety and success of device retrieval is limited to case reports.[17.18.19.]

Anatomical Placement
Li et al (2023) studied different anatomical placements in the ventricular septum of the Micra VR (N=15) and found no impact on safety or electrical characteristics of the device.[20] In a large cohort study in individuals with Micra AV or Micra VR implants (N=358) by Shantha et al (2023), the authors found apical septum placement was associated with a higher risk of pacing-induced cardiomyopathy compared to mid/high septum placement.[21] Larger randomized studies are needed to confirm how anatomical placement of the device impacts safety and effectiveness.

Leadless Cardiac Pacemakers in Clinical Development
Leadless pacemakers are self-contained in a hermetically sealed capsule. The capsule houses a battery and electronics to operate the system. Similar to most pacing leads, the tip of the capsule includes a fixation mechanism and a monolithic controlled-release device. The controlled-release device elutes a glucocorticosteroid to reduce acute inflammation at the implantation site. Leadless pacemakers have rate-responsive functionality, and current device longevity estimates are based on bench data. Estimates have suggested that these devices may last over 10 years, depending on the programmed parameters.[11]

Four systems are currently being evaluated in clinical trials: (1) the Micra Transcatheter Pacing System (Medtronic), (2) the Aveir VR Leadless Pacemaker (Abbott; formerly Nanostim, St. Jude Medical); (3) the Aveir DR Dual Chamber Leadless Pacemaker System (Abbott); and (4) the WiCS Wireless Cardiac Stimulation System (EBR Systems). The first 3 devices are free-standing capsule-sized devices that are delivered via femoral venous access using a steerable delivery sheath. However, the fixing mechanism differs between the Micra and Aveir devices. In the Micra Transcatheter Pacing System, the fixation system consists of 4 self-expanding nitinol tines, which anchor into the myocardium; for the Aveir devices, there is a screw-in helix that penetrates into the myocardium. In the Micra and Aveir devices, the cathode is steroid eluting and delivers pacing current; the anode is located in a titanium case. The fourth device, WiCS system differs from the other devices; this system requires implanting a pulse generator subcutaneously near the heart, which then wirelessly transmits ultrasound energy to a receiver electrode implanted in the left ventricle. The receiver electrode converts the ultrasound energy and delivers electrical stimulation to the heart sufficient to pace the left ventricle synchronously with the right.[11]

Of these 4, only the Micra and Aveir single-chamber transcatheter pacing systems and the Aveir dual-chamber transcatheter pacing system are approved by the FDA and commercially available in the U.S. Multiple clinical studies of the Aveir predecessor device, Nanostim, have been published[1,22,23,24,25,25,26] but trials have been halted due to the migration of the docking button in the device and premature battery depletion. These issues have since been addressed with the Aveir device.[27]

The Micra is about 25.9 mm in length and introduced using a 23 French catheter via the femoral vein to the right ventricle. It weighs about 1.75 grams and has an accelerometer-based rate response.[28]

The Aveir VR is about 42 mm in length and introduced using a 25 French catheter to the right ventricle. It also weighs about 3 grams and uses a temperature-based rate response sensor.[29]

The atrial Aveir DR is about 32.3 mm in length and weighs about 2.1 grams. The ventricular Aveir DR is about 38.0 mm in length and weighs about 2.4 grams. Both are introduced using a 25 French catheter. The system uses a temperature-based rate response.[30]

Summary

Description
Pacemakers are intended to be used as a substitute for the heart's intrinsic pacing system to correct cardiac rhythm disorders. Conventional pacemakers consist of 2 components: a pulse generator and electrodes (or leads). Pacemakers are considered life-sustaining, life-supporting class III devices for patients with a variety of bradyarrhythmias. Even though the efficacy and safety profile of conventional pacemakers are excellent, in a small proportion of patients, they may result in lead complications and the requirement for a surgical pocket. Further, some patients are medically ineligible for conventional pacemakers due to lack of venous access and recurrent infection. Leadless pacemakers are single-unit

devices that are implanted in the heart via femoral access, thereby eliminating the potential for complications as a result of leads and surgical pocket. The Micra and Aveir single-chamber transcatheter pacing systems and the Aveir dual-chamber pacing system are the only commercially available leadless pacemakers in the U.S. approved by the U.S. Food and Drug Administration.

Summary of Evidence

For individuals with a guidelines-based indication for a ventricular pacing system who are medically eligible for a conventional pacing system who receive a single-chamber transcatheter pacing system, the evidence includes a systematic review, pivotal prospective cohort studies, a postapproval prospective cohort study, a Medicare registry, and a retrospective FDA database analysis. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Results at 6 months and 1 year for the Micra pivotal study reported high procedural success (>99%) and device effectiveness (pacing capture threshold met in 98% of patients). Most of the system- or procedure-related complications occurred within 30 days. At 1 year, the incidence of major complications did not increase substantially from 6 months (3.5% at 6 months vs. 4% at 1 year). Results of the Micra postapproval study were consistent with the pivotal study and showed a lower incidence of major complications up to 30 days postimplantation as well as 1 year (1.5% and 2.7%, respectively). In both studies, the point estimates of major complications were lower than the pooled estimates from 6 studies of conventional pacemakers used as a historical comparator. While Micra device eliminates lead- and surgical pocket-related complications, its use can result in potentially more serious complications related to implantation and release of the device (traumatic cardiac injury) and less serious complications related to the femoral access site (groin hematomas, access site bleeding). Initial data from a Medicare registry found a significantly higher rate of pericardial effusion and/or perforation within 30 days in patients with the leadless Micra pacemaker compared to patients who received a transvenous device; however, overall 6-month complication rates were significantly lower in the Micra group in the adjusted analysis (p=.02). In a real-world study of Medicare patients, the Micra device was associated with a 41% lower rate of reinterventions and a 32% lower rate of chronic complications compared with transvenous pacing, with no significant difference in adjusted all-cause mortality at 3 years despite the higher comorbidity index for patients implanted with a Micra device. However, patients receiving the Micra device experienced significantly more other complications, driven by higher rates of pericarditis. No significant differences were noted in the composite endpoint of time to heart failure hospitalization or death for the full cohort (p=.28) or the subgroup without a history of heart failure (p=.98). It is also unclear whether all patients were considered medically eligible for a conventional pacing system. A single-arm study of the Micra AV device reported that 85.2% of individuals with complete AV block and normal sinus rhythm successfully achieved a >70% resting AV synchrony (AVS) rate at 1 month postimplant and that AVS rates could be further enhanced with additional device programming. However, clinically meaningful rates of AVS are unknown. Longer-term device characterization is planned in the Micra AV Post-Approval Registry through 3 years. The Aveir pivotal prospective cohort study primary safety and efficacy outcomes at 6 weeks exceeded performance goals for complication-free rate and composite success rate (96.0% and 95.9%, respectively). Results at 6 months were similar and at 1 year were 93.2% and 91.5%, respectively. Incidence of major complications at 1 year was 6.7% compared to 4.0% in the Micra pivotal trial. The 2-year survival estimate of 85.3% is based on Phase 1 performance with the predecessor Nanostim device. Considerable uncertainties and unknowns remain in terms of the durability of the devices and device end-of-life issues. Early and limited experience with the Micra device has suggested that retrieval of these devices is unlikely because in due course, the device will be encapsulated. There are limited data on device-device interactions (both electrical and mechanical), which may occur when there is a deactivated Micra device alongside another leadless pacemaker or when a leadless pacemaker and transvenous device are both present. Although the Aveir device is specifically designed to be retrieved when therapy needs evolve or the device needs to be replaced, limited data are available on retrieval outcomes. While the current evidence is encouraging, overall benefit with the broad use of FDA-approved single-chamber transcatheter pacing systems compared with conventional pacemakers has not been shown. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a single-chamber transcatheter pacing system, the evidence includes subgroup analysis of a pivotal prospective cohort study and a postapproval

prospective cohort study for the Micra device. It is unclear whether the Aveir pivotal study enrolled patients medically ineligible for a conventional pacing system. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Information on the outcomes in the subgroup of patients from the postapproval study showed that the Micra device was successfully implanted in 98% to 99% of cases, and safety outcomes were similar to the original cohort. Even though the evidence is limited and long-term effectiveness and safety are unknown, the short-term benefits may outweigh the risks because the complex trade-off of adverse events for these devices needs to be assessed in the context of the life-saving potential of pacing systems for patients ineligible for conventional pacing systems. There are little data available regarding outcomes associated with other alternatives to conventional pacemaker systems such as epicardial leads or transiliac placement. Epicardial leads are most relevant for the patient who is already going to have a thoracotomy for treatment of their underlying condition (e.g., congenital heart disease). Epicardial leads are associated with a longer intensive care unit stay, more blood loss, and longer ventilation times compared to conventional pacemaker systems. The evidence for transiliac placement is limited to small case series and the incidence of atrial lead dislodgement using this approach in the literature ranged from 7% to 21%. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a dual-chamber pacing system who are medically eligible for a conventional pacing system who receive a dual-chamber leadless pacing system, the evidence includes a pivotal prospective single cohort study. Relevant outcomes are freedom from complications and adequate atrial capture threshold and sensing amplitude. Results from 3 months and 6 months or the pivotal study reported freedom from complications in 90.3% and 89.1% of individuals, respectively, and adequate atrial capture threshold and sensing amplitude in 90.2% and 90.8% of individuals, respectively. Acute and long-term events will be captured in a post approval study through 9 years. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a dual-chamber pacing system who are medically ineligible for a conventional pacing system who receive a dual-chamber leadless pacing system, no evidence was identified that exclusively enrolled individuals who were medically ineligible for a conventional pacing system. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
10/2024	Annual policy review. Policy updated with literature review through March 14, 2024; references added. Investigational policy statement added to new indications for Aveir DR dual chamber leadless pacemaker. Other policy statements unchanged. Effective 10/1/2024. Added HCPCS code C1605.
1/2024	Clarified coding information.
10/2023	Annual policy review. Policy revised. Medically necessary statements were added for Aveir and Micra AV transcatheter pacing systems with criteria. Medical necessity criteria were updated for both Micra and Aveir devices based on labeled indications for use and responses to structured requests for clinical input. Effective 10/1/2023.
10/2022	Annual policy review. Investigational policy statement added for the Aveir transcatheter pacing system for all indications. Effective 10/1/2022.
6/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
12/2019	New medical policy describing medically necessary and investigational indications. Micra transcatheter pacing system may be considered medically necessary as a second line treatment in patients who not eligible for conventional pacemakers when all of the specified conditions are met. Effective 12/1/2019.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

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Clinical Exception Process
Medical Technology Assessment Guidelines

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