Sentara Health Plans

Medicaid

# Automated External Defibrillators (AED), DME 63

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|---|---|
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| Coverage Policy | DME 63 |
| Version | 5 |

**All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.**

## Description & Definitions:

Automated external defibrillator (AED) also known as a portable, non-wearable cardioverter defibrillator is an electronic device that is attached to the chest area with adhesive electrode pads to deliver a shock when ventricular tachycardia or ventricular fibrillation is detected.

## Criteria:

**Automated External Defibrillator, AED** (E0617) is considered medically necessary for **ALL** of the following:

- Individual for high risk for sudden cardiac death and
- Defibrillator is indicated for **1 or more** of the following:
  - A previously implanted defibrillator now requires surgical removal
  - Implantation surgery is contraindicated **(Temporary or permanent), and** individual has documentation of **1 or more** of the following conditions:
    - Episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause
    - Ventricular tachyarrhythmia (sustained, lasting 30 seconds or longer), either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute myocardial infarction, and not due to a transient or reversible cause
    - Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrythmias such as long QT syndrome or hypertrophic cardiomyopathy

- Coronary artery disease with a documented prior myocardial infarction with a measured left ventricular ejection fraction less than or equal to 0.35, and inducible, sustained ventricular tachycardia (VT) or ventricular fibrillation (VF) during an EP study and **ALL** of the following:
    - The myocardial infarction must have occurred more than 4 weeks prior to the external defibrillator prescription
    - The EP test must have been performed more than 4 weeks after the qualifying myocardial infarction.
- Prior myocardial infarction and measured left ventricular ejection fraction (LVEF) less than or equal to 0.30 and **ALL** of the following:
    - No cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm
    - No coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within past 3 months
    - No enzyme-positive MI within past month
    - No clinical symptoms or findings that would make them a candidate for coronary revascularization
    - No irreversible brain damage from preexisting cerebral disease
    - No disease, other than cardiac disease (e.g. cancer, uremia, liver failure), associated with a likelihood of survival less than one year
- Ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejection fraction (LVEF) ≤ 35%.
- Nonischemic dilated cardiomyopathy (NIDCM) for greater than 3 months, NYHA Class II and III heart failure, and measured LVEF ≤ 35%NYHA Class IV heart failure

## Document History:

Revised Dates:

- 2026: June – Implementation date of October 1, 2026. Changes made to criteria to condense and more clear verbiage.

Reviewed Dates:

- 2025: July – Implementation date of October 1, 2025. No changes references updated.
- 2024: August – no changes references updated
- 2023: August

Origination Date: August 2022

## Coding:

Medically necessary with criteria:

| Coding | Description |
|---|---|
| E0617 | External defibrillator with integrated electrocardiogram analysis |

Considered Not Medically Necessary:

| Coding | Description |
|---|---|
| | None |

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

## Special Notes: *

- Coverage:
    - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
    - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements:
    - Pre-certification by the Plan is required.
    - Please refer to Prior Authorization List for most up to date requirement Search PAL List: Sentara Health Plans
- Special Notes:
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22) Final.pdf
    - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

## References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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## Keywords:

SHP Automated External Defibrillators (AED), SHP Durable Medical Equipment 63, Implantation surgery, Coronary artery disease, Ischemic dilated cardiomyopathy, Nonischemic dilated cardiomyopathy, NYHA Class IV heart failure