



*National Imaging Associates, Inc.	
Clinical guidelines CARDIAC RESYNCHRONIZATION THERAPY (CRT)	Original Date: February 2013
CPT Codes: 33221, 33224, 33225, 33231	Last Revised Date: April 2023
Guideline Number: NIA_CG_320	Implementation Date: January 2024

GENERAL INFORMATION

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines and state/national recommendations.*

INDICATIONS FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)¹⁻⁸

Indications for CRT for patients are based upon LV ejection fraction (LVEF), QRS duration, New York Heart Association (NYHA) functional class (presence or absence of symptoms) and need for ventricular pacing regardless of etiology (ischemic or non-ischemic cardiomyopathy). The beneficial effects of CRT have been extensively proven in patients with NYHA class II, III, and IV; there is limited evidence of CRT benefit in patients with NYHA functional class I. Other special situations, such as patients with atrial fibrillation or who require an upgrade from a conventional pacing or ICD system, will be addressed below as well.

Patients with cardiomyopathy on GDMT for 3 months or on GDMT and 40 days after MI; or with implantation of pacing or defibrillation device for special indications

CRT-D Indications by NYHA Heart Failure Class (see full definitions further below in document). See [Background](#) for Algorithm for CRT Indications/Recommendations in patients with cardiomyopathy or HFrEF chart.

- Class II- Ambulatory IV
 - LVEF \leq 35%, QRS \geq 120ms, LBBB, Sinus Rhythm
 - LVEF \leq 35%, QRS \geq 150ms, non-LBBB, Sinus Rhythm

Special Situations

- Independent/Regardless of NYHA Heart Failure Class
 - Patients who have an indication for ventricular pacing and high degree AV block or are expected to be paced more than 40% of the time; this includes patients with Atrial fibrillation
- Atrial fibrillation and LVEF \leq 35% if:
 - Patient requires ventricular pacing or otherwise meets CRT criteria; **AND**
 - AV nodal ablation or pharmacologic rate control will allow nearly 100% ventricular pacing with CRT
 - For patients with atrial fibrillation and LVEF \leq 50%, if a rhythm control strategy fails and ventricular rates remain rapid despite medical therapy, atrioventricular nodal ablation with implantation of a CRT device is reasonable
- In patients with nonobstructive HCM who have NYHA class II to IV heart failure with LBBB, LVEF $<$ 50%, CRT therapy for symptom reduction is reasonable

NOT Indicated for Cardiac Resynchronization Therapy (CRT)

- NYHA class I and non-LBBB pattern with QRS duration $<$ 150 ms,³ except as in Special Situations section above
- Inotrope-dependent patients who have a higher risk need for cardiac transplant and LVAD support, are less likely to benefit from CRT
- Comorbidities and/or frailty expected to limit survival with good functional capacity to $<$ 1 year
- Active bloodstream infection
- Reversible causes are present such as toxic-, metabolic- or tachycardic-mediated cardiomyopathy, would require reassessment once the situation is corrected
- CRT has not been studied in ATTR-CM with HFrEF

Indications for CRT in Adult Congenital Heart Disease⁹⁻¹¹

Systemic LV

- Systemic LV EF \leq 35%, sinus rhythm, wide QRS complex \geq 130 ms NYHA function Class II—IV

Any Systemic V

- Systemic ventricle any EF (not restricted to \leq 35%), intrinsic narrow QRS complex, NYHA function Class I—IV and are undergoing new device placement or replacement with anticipated requirement for significant ($>$ 40%) ventricular pacing.

Any CHD

- CRT may be considered for patients with a severe subpulmonary RV dysfunction and dilatation despite interventions to decrease RV volume overload, NYHA function Class II—ambulatory IV and wide QRS complex ≥ 150 ms due to a complete RBBB
- NYHA function Class IV and severe ventricular dysfunction who would otherwise be candidates for heart transplantation or mechanical circulatory support

NOT Indicated for CRT in Adult Congenital Heart Disease

- Patients whose co-morbidities and/or frailty limit survival with good functional capacity to less than 1 year

INDICATIONS FOR CRT AS THE APPROPRIATE PACING MODALITY IN SPECIAL SITUATIONS WITH < 3 MONTHS OF GDMT^{5, 12, 13}

Criteria are met for a non-elective implantable cardioverter defibrillator (ICD) or pacemaker and based upon the low likelihood of improvement in symptoms and adequate recovery of LVEF, despite less than 3 months GDMT for heart failure or < 40 days post myocardial infarction or 3 months post revascularization, criteria for CRT are otherwise met. This avoids a second implantation procedure within less than 3 months.

BACKGROUND^{1, 3-5, 8}

CRT, which paces the left and right ventricle in rapid sequence, also known as biventricular pacing, improves coordination of ventricular contraction in the presence of a wide QRS complex in systolic heart failure.

CRT improves cardiac function and quality of life, and it decreases cardiac events and mortality among appropriately chosen patients. In the proper patient population, improved survival in patients with CRT can be greater than that provided by ICD insertion alone.

Guiding principles in the consideration of CRT:

- NYHA class is an important qualifying factor, with candidacy based on functional class, EF, and QRS duration.
- Bundle branch block or intraventricular conduction delay should be persistent, not rate related.⁵
- GDMT should have been in place continuously for at least 3 months^{3, 4, 8} and recovery of LVEF from myocardial infarction (40 days) if no intervening revascularization or > 3 months if revascularization was performed. Reversible causes (e.g., ischemia) should be excluded.
- The patient should have expected survival with reasonably good functional status for more than 1 year.^{3, 4, 10}

OVERVIEW

NYHA Class Definitions^{5, 14}

- Class I: No limitation of functional activity. Ordinary physical activity does not cause symptoms of HF
- Class II: Slight limitation of activity. Comfortable at rest but ordinary physical activity results in symptoms of HF
- Class III: Marked limitation of activity. Comfortable at rest but less than ordinary activity causes symptoms of HF
- Class IV: Unable to continue any physical activity without symptoms of HF, or symptoms of HF at rest

Heart Block Definitions³

- First Degree: All atrial beats are conducted to the ventricles, but with a delay of > 200 ms.
- Second Degree: Intermittent failure of conduction of single beats from atrium to ventricles.
 - Type I: Conducted beats have variable conduction times from atrium to ventricles.
 - Type II: Conducted beats have uniform conduction times from atrium to ventricles.
 - Advanced: Two or more consecutive non-conducted beats (premature atrial beats might not normally be conducted).
- Third Degree: No atrial beats are conducted from atrium to ventricle.

Guideline-Directed (or Optimal) Medical Therapy in Heart Failure⁸

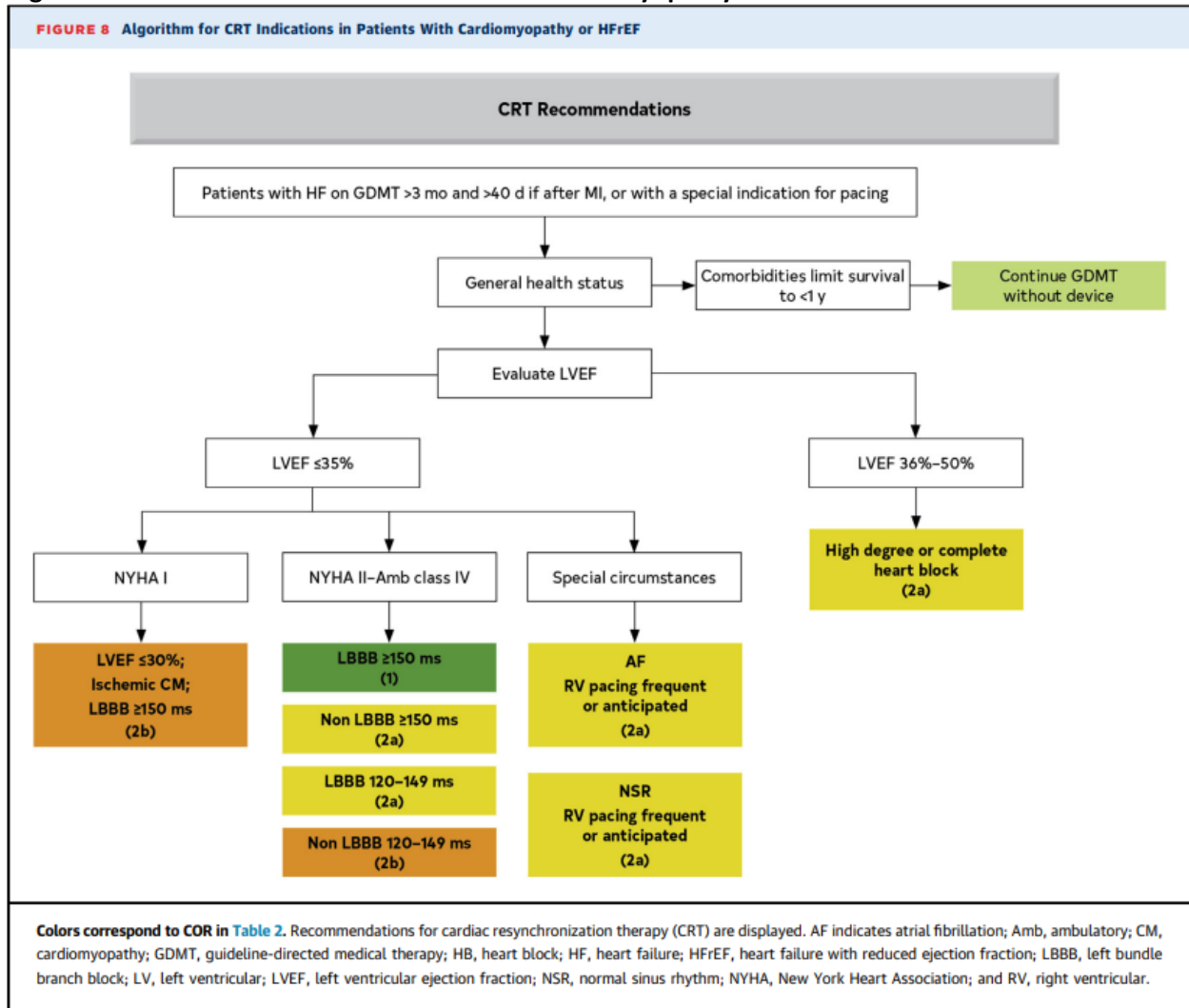
- Angiotensin converting enzyme inhibitor (ACE-I), angiotensin receptor blocker (ARB), or combined angiotensin receptor inhibitor and neprilysin inhibitor (ARNI)
- Beta blocker

Other options/considerations for GDMT

- Addition of loop diuretic for all NYHA class II – IV patients
- Addition of hydralazine and nitrate for persistently symptomatic African Americans, NYHA class III-IV
- Addition of an aldosterone antagonist, provided eGFR is ≥ 30 ml/min/1.73m² and K⁺ < 5.0, NYHA class II-IV
- Not required for consideration of CRT: Ivabradine for NYHA class II – III, when a beta blocker has failed to reduce a sinus rate to < 70 bpm.

Algorithm for CRT Indications in Patients with Cardiomyopathy or HFrEF chart¹⁵

FIGURE 8 Algorithm for CRT Indications in Patients With Cardiomyopathy or HFrEF



Abbreviations

ACE-I	Angiotensin converting enzyme inhibitor
ARB	Angiotensin receptor blocker
ARNI	Combined angiotensin receptor inhibitor and neprilysin inhibitor
AV	Atrioventricular
CAD	Coronary artery disease, same as ischemic heart disease
CHD	Congenital heart disease
CHF	Congestive heart failure
CRT	Cardiac resynchronization therapy (also known as biventricular pacing)
CRT-D	Cardiac resynchronization therapy defibrillator
ECG	Electrocardiogram
EF	Ejection Fraction
eGFR	Estimated glomerular filtration rate
EPS	Electrophysiologic Study
GDMT	Guideline-Directed Medical Therapy
HCM	Hypertrophic Cardiomyopathy
HF	Heart failure
HFrEF	Heart failure with reduced ejection fraction
HV	His-ventricular
ICD	Implantable cardioverter-defibrillator
LBBB	Left bundle branch block
LV	Left ventricular/left ventricle
LVEF	Left ventricular ejection fraction
MI	Myocardial infarction
ms	Milliseconds
NYHA	New York Heart Association
RBBB	Right bundle branch block
RV	Right ventricle
SND	Sinus node dysfunction
SR	Sinus rhythm
STEMI	ST-Elevation Myocardial Infarction
VT	Ventricular tachycardia

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POLICY HISTORY

Date	Summary
April 2023	<ul style="list-style-type: none">• Added additional statement on atrial fibrillation• Added statement on ATTR• Added additional contraindication for patients with LVAD• Removed indication for Class I and CRT• Combined Class II- IV indications• Removed EF value for requirement for pacemaker• Added statement on clinical indications not addressed in this guideline
February 2022	<ul style="list-style-type: none">• Added blood stream infection and reversibility as contraindication• Reworded NYHA• Removed single ventricle and RV

Reviewed / Approved by NIA Clinical Guideline Committee

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