Policy Statement

Use of baroreflex stimulation implanted devices is considered investigational in all situations, including but not limited to treatment of hypertension and heart failure.

Policy Guidelines

Coding

The following are category III CPT codes for implantation of the baroreflex activation device:

- **0266T**: Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
- **0267T**: Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
- **0268T**: Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
- **0269T**: Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
- **0270T**: Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
- **0271T**: Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
- **0272T**: Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)
- **0273T**: Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming

Description

Baroreflex stimulation devices provide electrical stimulation of the baroreceptors in the carotid arteries using an implanted device. Activation of the baroreflex inhibits the sympathetic nervous system, resulting in various physiologic changes, including slowed heart rate and lower blood pressure. A device for baroreflex stimulation has been developed, but has not received U.S. Food and Drug Administration approval other than a humanitarian device exemption for patients who had previously participated in a clinical trial.
Related Policies

- Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

In 2014, the Barostim neo® Legacy System (CVRx) received a humanitarian device exemption from the Food and Drug Administration for use in patients with treatment-resistant hypertension who received Rheos® Carotid Sinus leads as part of the Rheos pivotal trial and were considered responders in that trial.\(^1\)

In 2015, CVRx received expedited access pathway designation from the Food and Drug Administration for Barostim Therapy® to treat heart failure.\(^2\) This pathway designation does not guarantee that an application to the Food and Drug Administration will ultimately be approved.

Rationale

Background

Baroreceptors are pressure sensors contained within the walls of the carotid arteries. They are part of the autonomic nervous system that regulates basic physiologic functions such as heart rate and blood pressure. When these receptors are stretched, as occurs with increases in blood pressure, the baroreflex is activated. Activation of the baroreflex signals the brain, which responds by inhibiting sympathetic nervous system output and increasing parasympathetic nervous system output. The effect of this activation is to reduce heart rate and blood pressure, thereby helping to maintain homeostasis of the circulatory system.

The use of baroreflex stimulation devices (also known as baroreflex activation therapy) is a potential alternative treatment for resistant hypertension and heart failure. Both hypertension and heart failure are relatively common conditions, and are initially treated with medications and lifestyle changes. A substantial portion of patients are unresponsive to conventional therapy and treating these patients is often challenging, expensive, and can lead to adverse events. As a result, there is a large unmet need for additional treatments.

One device is approved for sale in Europe for hypertension and heart failure patients. This second-generation system consists of a unilateral electrode and lead attached to the carotid sinus and a pulse generator implanted subcutaneously in the chest wall. Programming is performed using radiofrequency telemetry with an external laptop computer and software. The first-generation system had bilateral leads attached to each carotid sinus and a larger pulse generator.
Literature Review
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, 2 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.

Hypertension
The Rheos pivotal RCT evaluated the efficacy of baroreflex stimulation for lowering BP. This double-blind trial, reported by Bisognano et al (2011), included patients with treatment-resistant hypertension defined as at least 1 systolic blood pressure (SBP) measurement of 160 mm Hg or more with diastolic blood pressure (DBP) measurement of 80 mm Hg or more after at least 1 month of maximally tolerated medical therapy. A total of 322 patients had the Rheos system implanted, and 265 patients underwent randomization. Participants were randomized in a 2:1 fashion to the device turned on or off for a 6-month period. After 6 months, all patients had the device turned on. The primary efficacy end points were the percentage of patients achieving at least a 10 mm Hg decrease in SBP at 6 months (acute efficacy) and the percentage of patients who maintained their BP response over the 6- to 12-month time period (sustained efficacy). Primary safety outcomes were defined thresholds for procedural safety (at least 82% of patients free from procedural adverse events at 30 days), therapy safety (not more than 15% excess treatment-related adverse events in the experimental group), and device safety (at least 72% of patients free from procedural or therapy-related adverse events at 12 months).

At 6 months, 54% of patients in the stimulation group had an SBP decrease of 10 mm Hg or more compared with 46% of patients in the control group (p=0.97), indicating that the primary acute efficacy outcome was not met. The primary sustained efficacy outcome was met, with 88% of patients who responded at 6 months maintaining a response at 12 months. A secondary efficacy outcome (the percentage of patients reaching target SBP) showed a significant between-group difference. A total of 42% of the patients in the active treatment group reached a target SBP of 140 mm Hg compared with 24% in the control group (p=0.005). For the primary procedural safety end point, the predefined threshold of 82% was not met. At 30 days, the percentage of patients free of procedural adverse events was 74.8%. The primary safety end point for therapy safety was met, with a similar percentage of patients free of treatment-related adverse events at 6 months (91.7% vs 89.3%, p<0.001 for noninferiority). The primary safety end
point for device safety was also met, with 87.2% of patients free of device-related adverse events at 12 months, exceeding the predefined threshold of 72%.

Patients who actively participated in the Rheos pivotal trial were followed after 12 months, and additional data were reported in an extension trial by Bakris et al (2012). A total of 276 (86%) of the 322 implanted patients consented to long-term open-label follow-up. After a mean follow-up of 28 months, 244 (88%) of 276 were considered to be clinically significant responders. Response was defined as sustained achievement of the target SBP (≤140 mm Hg, or ≤130 mm Hg for patients with diabetes or renal disease), or a reduction in SBP of 20 mm Hg or more from device activation. Alternatively, patients could qualify as responders if their implanted device was deactivated and if they had an increase in SBP of at least 20 mm Hg in the 30 days after device deactivation. The extension study lacked a comparison group.

Several uncontrolled observational studies have also been published. The largest of these, the DEBut-HT trial, was a multicenter, single-arm feasibility study of the Rheos baroreflex activation therapy system reported by Scheffers et al (2010). This trial enrolled 45 patients with treatment-resistant hypertension defined as a BP greater than 160/90 mm Hg, despite treatment with at least 3 antihypertensive drugs, including a diuretic. The planned follow-up was 3 months, with a smaller number of patients followed up to 2 years. In 37 patients completing the 3-month protocol, office SBP was reduced by 21 mm Hg (p<0.001) and DBP was reduced by 12 mm Hg (p<0.002). There was also a smaller reduction in 24-hour ambulatory BP (n=26), with a decrease of 6 mm Hg in SBP (p=0.10) and a decrease of 4 mm Hg in DBP (p=0.04). In 26 patients followed for 1 year, the declines in office BP were 30 mm Hg for systolic (p<0.001) and 20 mm Hg for diastolic (p<0.001). For ambulatory BP (n=15), the 1-year declines were 13 mm Hg for systolic (p<0.001) and 8 mm Hg for diastolic (p=0.001). A total of 7 (16.7%) of 42 patients experienced adverse events. Three patients required device removal due to infection, one experienced perioperative stroke, one experienced tongue paresis due to hypoglossal nerve injury, one had postoperative pulmonary edema, and another required reintervention for device explantation.

A single-arm study using the second-generation Neo device to treat uncontrolled hypertension was published by Wallbach et al (2016). The study reported on 44 patients with resistant hypertension, defined as an office BP at least 140 mm Hg or 130 mm Hg for patients with chronic kidney disease and proteinuria, despite treatment with at least 3 antihypertensive medications including a diuretic. Mean baseline office BP was 171/91 mm Hg. After 6 months of baroreflex activation therapy, mean office BP decreased to 151 mm Hg over 82 mm Hg (pre to post, p<0.001). At 6 months, the mean number of BP medications used per patient decreased from 6.5 at baseline to 6.0 (p<0.03). One procedure-related major adverse event occurred, a contralateral stroke. Ten (23%) of the 44 patients experienced a minor procedure-related complication. The most common minor adverse events were disturbance of wound healing (n=5 [11%]) and postoperative hematoma (n=4 [9%]). One patient had revision surgery but explantation was not needed.

Section Summary: Hypertension

One RCT has evaluated baroreflex stimulation devices. This trial, which compared the first-generation Rheos device plus medical management with medical management alone, met some but not all of its efficacy end points. Baroreflex stimulation-treated patients were no more likely to achieve at least a 10 mm Hg decrease in SBP at 6 months, but were more likely to reach the target SBP of 140 mm Hg or less at 6 months. The trial met 2 of its 3 predefined safety end points (therapy safety and device safety but not procedural safety). In addition, several uncontrolled studies have reported short-term reductions in blood pressure, together with adverse events such as infection, hypoglossal nerve injury, and wound complications. Additional RCTs—particularly those using the second-generation device—are needed to draw conclusions about safety and efficacy.
Heart Failure
Halbach et al (2018) published a post hoc subgroup analysis, from a randomized trial evaluating baroreflex activation therapy (BAT) as a treatment for heart failure, comparing patients with and without coronary artery disease (CAD). Patients (n=146) from 45 centers with left ventricular ejection fraction (LVEF) <35% and NYHA Class III were randomized to the BAT group (n=76) or control group (n=70). The rate of system- or procedure-related major adverse neurological or cardiovascular events was 3.8% for the CAD group and 0% for CAD group (p=1.0); while the system- or procedure-related complication rate was 11.5% for patients with CAD and 21.1% for those without CAD (p=0.44). In the BAT group, from baseline to 6 months, QOL scores decreased by 16.8±3.4 points for CAD patients and by 18.9±5.3 for no-CAD patients, and NYHA Class decreased by 0.6±0.1 for CAD patients and by 0.4±0.2 for no-CAD patients. LVEF increased by 1.2±1.4 for the CAD group and 5.2±1.9 for the no-CAD group. No interaction was found between the presence of CAD and effect of BAT (p>0.05). The study was limited by its small sample size and by the subgroup analysis not being prespecified.

A single RCT has evaluated baroreflex stimulation for the treatment of heart failure. This trial, reported by Abraham et al (2015), was nonblinded and included 146 patients with New York Heart Association (NYHA) class III heart failure and an ejection fraction of 35% or less despite guideline-directed medical therapy. Patients were randomized to baroreflex stimulation (Barostim Neo system) plus medical therapy (n=76) or to continued medical therapy alone (n=70) for 6 months. The primary safety outcome was the proportion of patients free from major adverse neurologic and cardiovascular events. The trialists specified 3 primary efficacy end points: changes in NYHA functional class, quality of life (QOL) score, and 6-minute walk distance (6MWD).

The overall major adverse neurologic and cardiovascular events-free rate was 97.2%; rates were not reported separately for the baroreflex stimulation and control groups. In terms of the efficacy outcomes, there was significant improvement in the baroreflex stimulation group vs the control group on each of the 3 outcomes. Significantly more patients in the treatment group (55%) improved by at least 1 level in NYHA functional class than in the control group (24%; p<0.002). Mean QOL scores, as assessed by the Minnesota Living with Heart Failure Questionnaire, improved significantly more in the treatment group (-17.4 points) than in the control group 2.1 points; p<0.001). Similarly, mean 6MWD improved significantly more in the treatment group (59.6 meters) than in the control group (1.5 meters; p=0.004.).

Twelve-month results for 101 (69%) of 146 patients were reported by Weaver et al (2016). No additional system- or procedure-related major adverse neurologic and cardiovascular events occurred between 6 and 12 months. Moreover, outcomes for NYHA functional class improvement, QOL score, and 6MWD were all significantly better in the treatment group than in the control group at 12 months. This analysis had a substantial amount of missing data. Overall, the limitations of this RCT included a relatively small sample size for a common condition, relatively short intervention period, and lack of blinding; some of the positive findings on the subjective patient-reported outcomes might have been due at least in part to a placebo effect. Additional RCTs with larger sample sizes and longer follow-up are needed to confirm these positive findings.

Another RCT evaluating baroreflex stimulation for heart failure is underway (see Table 1). The Baroreflex Activation Therapy for Heart Failure Clinical Trial (BeAT-HF), which has a stated completion date of 2021, will have a much larger sample size (estimated enrollment, 800) than the Abraham trial and will assess cardiovascular mortality and heart failure morbidity as well as safety, functional, and QOL outcomes. This trial is being conducted as part of the data plan for Food and Drug Administration approval under an expedited access pathway designation.

Section Summary: Heart Failure
One RCT has compared baroreflex stimulation plus medical therapy with medical therapy alone in patients with heart failure. This RCT found a low rate of major adverse events and met all 3 efficacy end points (improvements in NYHA functional class, QOL, and 6MWD). However, the
study had methodologic limitations, including lack of blinding, a relatively small sample size for a common condition, and relatively short intervention period. A second RCT, with a much larger sample size that will assess mortality rates, is underway.

**Summary of Evidence**

For individuals who have treatment-resistant hypertension who receive baroreflex stimulation therapy, the evidence includes an RCT and several small uncontrolled studies. Relevant outcomes are overall survival, functional outcomes, quality of life, hospitalizations, medication use, and treatment-resistant morbidity. The uncontrolled studies have reported short-term reductions in blood pressure in patients treated with baroreflex stimulation devices, as well as adverse events such as infection, hypoglossal nerve injury, and wound complications. The RCT comparing baroreflex stimulation with continued medical management met some efficacy end points but not others as well as 2 of its 3 predefined safety end points. Additional RCTs are needed to permit conclusions on the efficacy and safety. In addition, baroreflex stimulation currently has a very narrow Food and Drug Administration approval (i.e., for patients who previously participated in a pivotal trial) and broader approval or clearance is needed for wider application. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have treatment-resistant heart failure who receive baroreflex stimulation therapy, the evidence includes an RCT. Relevant outcomes are overall survival, functional outcomes, quality of life, hospitalizations, medication use, and treatment-resistant morbidity. The RCT met all 3 efficacy end points but had methodologic limitations, including lack of blinding, a relatively small sample size for a common condition and a relatively short intervention period. A second, larger, RCT designed to assess the effects of the intervention on mortality, safety, functional, and quality of life outcomes, is underway. In addition, the only baroreflex stimulation device with humanitarian device exemption approval currently has only a very narrow Food and Drug Administration approval (i.e., for patients who previously participated in a pivotal trial) and broader approval or clearance is needed for wider application. The evidence is insufficient to determine the effect of the technology on health outcomes.

**Supplemental Information**

**Practice Guidelines and Position Statements**

**National Institute for Health and Care Excellence**

In 2015, National Institute for Health and Care Excellence issued guidance that stated: “Current evidence on the safety and efficacy of implanting a baroreceptor stimulation device for resistant hypertension is inadequate. Therefore, this procedure should only be used in the context of research.”

**U.S. Preventive Services Task Force Recommendations**

Not applicable.

**Medicare National Coverage**

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 1.

**Table 1. Summary of Key Trials**

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<tr>
<th>NCT No.</th>
<th>Trial Name</th>
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<th>Completion Date</th>
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<td>CVRx Barostim Hypertension Pivotal Trial</td>
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<td>Sep 2020 (suspended)</td>
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<td>NC01720160</td>
<td>Barostim HOPE4HF Study</td>
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<td>Jan 2021</td>
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## References


## Documentation for Clinical Review

- No records required
This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

IE
The following services may be considered investigational.

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<thead>
<tr>
<th>Type</th>
<th>Code</th>
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<tr>
<td>CPT®</td>
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<td>Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)</td>
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<td>0267T</td>
<td>Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)</td>
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<td>0268T</td>
<td>Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)</td>
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<td>0269T</td>
<td>Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)</td>
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<td>0270T</td>
<td>Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)</td>
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<td>0271T</td>
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<td>0272T</td>
<td>Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)</td>
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<td>0273T</td>
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<td>ICD-10 Procedure</td>
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<td>Insertion of Stimulator Lead into Right Internal Carotid Artery, Percutaneous Approach</td>
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<td>03HK4MZ</td>
<td>Insertion of Stimulator Lead into Right Internal Carotid Artery, Percutaneous Endoscopic Approach</td>
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### Baroreflex Stimulation Devices

#### Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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<td>BCBSA medical policy adoption</td>
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#### Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

#### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well
as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.