Catheter and Surgical Ablation of Atrial Fibrillation

I. Policy

University Health Alliance (UHA) will reimburse for Catheter and Surgical Ablation of Atrial Fibrillation when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Background

Atrial fibrillation (AF) is a common cardiac disorder occurring in at least 0.4% of the general population, increasing with age.

Several very important treatment decisions arise in patients with both new onset and established atrial fibrillation and it is UHA’s position that adequacy of informed consent is heightened for treatments of this condition in view of direct Internet marketing to patients and distinctly different outcomes of treatment in people with different clinical backgrounds (e.g. CHADS scoring) and age and associated conditions. Operator experience is almost certainly an important determinant of outcome, particularly in repeated attempts at ablative control.

As with many medical conditions, patients with AF can challenge providers with their unrealistic expectations. A detailed informed consent required by a payor can serve the needs of all parties.

Therefore, UHA will require prior authorization for all ablative treatment of AF, to include, but not necessarily be limited to, AV nodal ablation with pacing, pulmonary vein isolation, left atrial appendage ligation, maze procedures, and for placement of biventricular pacers.

III. Criteria/Guidelines

A. Transcatheter radiofrequency ablation or cryoablation to treat atrial fibrillation is covered (subject to Limitations and Administrative Guidelines) as a treatment for either of the following indications which have failed to respond to adequate trials of antiarrhythmic medications:

1. Symptomatic paroxysmal or symptomatic persistent atrial fibrillation; or

2. As an alternative to atroventricular nodal ablation and pacemaker insertion in patients with class II or III congestive heart failure and symptomatic atrial fibrillation.

B. Transcatheter radiofrequency ablation or cryoablation to treat atrial fibrillation is covered (subject to Limitations and Administrative Guidelines) as an initial treatment for patients with recurrent symptomatic paroxysmal atrial fibrillation (>1 episode, with 4 or fewer episodes in the previous 6 months) in whom a rhythm-control strategy is desired.

C. Repeat radiofrequency ablation or cryoablation is covered (subject to Limitations and Administrative Guidelines) in patients with recurrence of atrial fibrillation and/or development of atrial flutter following the initial procedure.
D. The MAZE procedure:

UHA considers the Maze procedure, performed with cardiopulmonary bypass on a beating heart, medically necessary for members with atrial fibrillation when any of the following criteria are met:

1. a. Medical records indicate that the patient did not respond to other medical treatments or those treatments were contraindicated; and.

2. Member cannot tolerate the side effects of drug therapy (adequate documentation of the nature and extent of the intolerance is required); or.

3. Member is suffering the hemodynamic consequences of chronic Atrial Fibrillation despite adequate attempts at medical management; or.

4. Member is at high risk for thromboembolism as evidenced as either:
   a. A previous episode of thromboembolism when other sources of emboli have been ruled out or,
   b. Documented long-standing atrial fibrillation in members with mitral valve disease undergoing open surgical repair of the mitral valve.

NOTE:
This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

IV. Limitations

A. Transcatheter radiofrequency ablation or cryoablation to treat atrial fibrillation as a treatment for cases of atrial fibrillation that do not meet the criteria outlined above is not covered as it is not known to improve health outcomes.

B. Because of the highly invasive nature of the maze procedure, it is generally reserved for patients who are undergoing open heart surgery for other reasons, (e.g. valve repair or coronary artery bypass grafting). Minimally invasive, off-pump Maze procedures, also known as thorascoscopic off-pump surgical ablation (TOPS), are not considered medically necessary for atrial fibrillation because there is insufficient evidence of effectiveness.

V. Administrative Guidelines

A. Prior authorization is required.

B. Prior Authorization will rest upon standard clinical criteria (e.g. current Milliman Care Guidelines) and documented evidence that detailed informed consent has been obtained.
C. The following issues must be addressed and the nature and outcome of the physician patient encounter must be described:

1. Approximate likelihood of long-term success based upon personal experience of the interventional cardiologist or cardiac surgeon, duration of AF, and the likelihood of success in second or third procedures should they become necessary.

2. Significance of radiation exposure.

3. Quantitative risk of thromboembolic events with anti-arrhythmia drug therapy, rate control or ablative therapy.

4. Actual physiologic benefit of restoring atrial function, especially in cases of atrial enlargement.

5. Risks of the contemplated procedure relative to the risks of drug or no therapy

D. Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record and must be made available to UHA upon request. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made.

E. To request prior authorization, please go to UHA’s website: https://uhahealth.com/page/prior-authorization-forms to submit online.

F. This policy may apply to the following codes. Inclusion of a code in the table below does not guarantee that it will be reimbursed.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>33254</td>
<td>Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)</td>
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<tr>
<td>33255</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass</td>
</tr>
<tr>
<td>33256</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33257</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)</td>
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<tr>
<td>33258</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>33259</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>33265</td>
<td>Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass</td>
</tr>
<tr>
<td>33266</td>
<td>Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass</td>
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<tr>
<td>75572</td>
<td>Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)</td>
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<tr>
<td>93613</td>
<td>Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)</td>
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| 93656    | Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and
repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation

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<tr>
<td>93657</td>
<td>Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)</td>
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</tbody>
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V. Policy History

**Policy Number:** M.SUR.14.120717

**Current Effective Date:** 09/01/2016

**Original Document Effective Date:** 07/17/2012

**Previous Revision Dates:** 09/01/2016

**PAP Approved:** 07/17/2012

References:


HRS/EHRA/ECAS Expert Consensus Statement on Catheter and Surgical Ablation of Atrial Fibrillation