Medical Policy
Catheter Ablation as Treatment for Atrial Fibrillation

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Policy Number: 141
BCBSA Reference Number: 2.02.19
NCD/LCD: N/A

Related Policies
- Open and Thoracoscopic Approaches to Treat Atrial Fibrillation - Maze and Related Procedures, #356
- Left-Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation, #334

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

Transcatheter radiofrequency ablation or cryoablation to treat atrial fibrillation may be MEDICALLY NECESSARY as a treatment for either of the following indications which have failed to respond to adequate trials of antiarrhythmic medications:
- Symptomatic paroxysmal or symptomatic persistent atrial fibrillation, or
- As an alternative to atioventricular nodal ablation and pacemaker insertion in patients with class II or III congestive heart failure and symptomatic atrial fibrillation.

Transcatheter radiofrequency ablation or cryoablation to treat atrial fibrillation may be considered MEDICALLY NECESSARY 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.

Up to 3 repeat radiofrequency ablations or cryoablations may be considered MEDICALLY NECESSARY in patients with recurrence of atrial fibrillation and/or development of atrial flutter following the initial procedure.

Transcatheter radiofrequency ablation or cryoablation to treat atrial fibrillation is considered INVESTIGATIONAL as a treatment for cases of atrial fibrillation that do not meet the criteria outlined above.

Transcatheter treatment of atrial fibrillation may include pulmonary vein isolation and/or focal ablation.
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**.

<table>
<thead>
<tr>
<th>Product/Treatment</th>
<th>Requires Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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</table>

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

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>93656</td>
<td>Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation</td>
</tr>
<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>
</tr>
</tbody>
</table>

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

### ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I48.0</td>
<td>Paroxysmal atrial fibrillation</td>
</tr>
<tr>
<td>I48.11</td>
<td>Longstanding persistent atrial fibrillation</td>
</tr>
<tr>
<td>I48.19</td>
<td>Other persistent atrial fibrillation</td>
</tr>
<tr>
<td>I48.20</td>
<td>Chronic atrial fibrillation, unspecified</td>
</tr>
<tr>
<td>I48.21</td>
<td>Permanent atrial fibrillation</td>
</tr>
<tr>
<td>I48.3</td>
<td>Typical atrial flutter</td>
</tr>
</tbody>
</table>
Description

**ATRIAL FIBRILLATION**

Atrial fibrillation (AF) is the most common cardiac arrhythmia, with an estimated prevalence of 0.4% of the population, increasing with age. The underlying mechanism of AF involves the interplay between electrical triggering events and the myocardial substrate that permits propagation and maintenance of the aberrant electrical circuit. The most common focal trigger of AF appears to be located within the cardiac muscle that extends into the pulmonary veins.

AF accounts for approximately one-third of hospitalizations for cardiac rhythm disturbances. Symptoms of AF (e.g., palpitations, decreased exercise tolerance, dyspnea) are primarily related to poorly controlled or irregular heart rate. The loss of atrioventricular (AV) synchrony results in a decreased cardiac output, which can be significant in patients with compromised cardiac function. Also, patients with AF are at higher risk for stroke, with anticoagulation typically recommended. AF is also associated with other cardiac conditions, such as valvular heart disease, heart failure, hypertension, and diabetes. Although episodes of AF can be converted to normal sinus rhythm using pharmacologic or electroshock conversion, the natural history of AF is that of recurrence, thought to be related to fibrillation-induced anatomic and electrical remodeling of the atria.

AF can be subdivided into 3 types:
- paroxysmal (episodes that last <7 days and are self-terminating),
- persistent (episodes that last for >7 days and can be terminated pharmacologically or by electrical cardioversion), or
- permanent.

**Treatment Strategies**

Treatment strategies can be broadly subdivided into rate control, in which only the ventricular rate is controlled, and the atria are allowed to fibrillate, or rhythm control, in which there is an attempt to reestablish and maintain normal sinus rhythm. Rhythm control has long been considered an important treatment goal for management of AF, although its primacy has recently been challenged by the results of several randomized trials reporting that pharmacologically maintained rhythm control offered no improvement in mortality or cardiovascular morbidity compared with rate control.

Currently, the main indications for a rhythm-control strategy are for patients with paroxysmal or persistent AF who have hemodynamic compromise associated with episodes of AF or who have bothersome symptoms, despite adequate rate control. A rhythm-control strategy involves initial pharmacologic or electronic cardioversion, followed by pharmacologic treatment to maintain normal sinus rhythm. However, antiarrhythmic medications are often not effective in maintaining sinus rhythm. As a result, episodes of recurrent AF are typical, and patients with persistent AF may require multiple episodes of cardioversion.
Implantable atrial defibrillators, which are designed to detect and terminate an episode of AF, are an alternative in patients otherwise requiring serial cardioversions, but they have not yet achieved widespread use. Patients with paroxysmal AF, by definition, do not require cardioversion but may be treated pharmacologically to prevent further arrhythmic episodes.

Treatment of permanent AF focuses on rate control, using either pharmacologic therapy or ablation of the AV node, followed by ventricular pacing. Although AV nodal ablation produces symptomatic improvement, it entails lifelong anticoagulation (due to ongoing fibrillation of the atria), loss of AV synchrony, and lifelong pacemaker dependency. Implantable defibrillators are contraindicated in patients with permanent AF.

The treatment options above are not curative. A variety of ablative procedures have been investigated as potentially curative approaches or modifying the arrhythmia so that drug therapy becomes more effective. Ablative approaches focus on interruption of the electrical pathways that contribute to AF through modifying the arrhythmia triggers and/or the myocardial substrate that maintains the aberrant rhythm. The maze procedure, an open surgical procedure often combined with other cardiac surgeries (eg, valve repair), is an ablative treatment that involves sequential atriotomy incisions designed to create electrical barriers that prevent the maintenance of AF. Because of the highly invasive nature of this procedure, it is currently mainly reserved for patients undergoing open heart surgery for other reasons (eg, valve repair, coronary artery bypass grafting).

**Catheter Ablation for AF**

Radiofrequency ablation (RFA) using a percutaneous catheter-based approach is widely used to treat a variety of supraventricular arrhythmias, in which intracardiac mapping identifies a discrete arrhythmogenic focus that is the target of ablation. The situation is more complex for AF because there is no single arrhythmogenic focus. Since the inception of ablation techniques in the early 1990s, there has been a progressive understanding of the underlying electrical pathways in the heart associated with AF. In the late 1990s, it was recognized that AF most frequently arises from an abnormal focus at or near the junction of the pulmonary veins and the left atrium, thus leading to the feasibility of more focused, percutaneous ablation techniques. Strategies that have emerged for focal ablation within the pulmonary veins originally involved segmental ostial ablation guided by pulmonary vein potential (electrical approach) but currently more typically involve circumferential pulmonary vein ablation (anatomic approach).

The individual lesion set (in addition to the pulmonary vein isolation) and the degree to which the pulmonary vein antrum is electrically isolated vary. Research into specific ablation and pulmonary vein isolation techniques is ongoing. Evidence from a randomized controlled trial comparing pulmonary vein isolation alone with pulmonary vein isolation plus ablation to treat patients who had electrograms showing complex fractionated activity, and to pulmonary vein isolation plus additional linear ablation across the left atrial roof and mitral valve isthmus, has suggested that the more extensive lesion sets do not reduce the AF recurrence rate. Meta-analyses have found that the addition of complex fractionated atrial electrogram ablation to pulmonary vein isolation alone has not improved rates of freedom from recurrent AF, although the randomized controlled trial by Theis et al (2015) reported that patients with ablation of dormant conduction sources outside the pulmonary veins had fewer arrhythmia recurrences than those treated with pulmonary vein isolation alone.

Circumferential pulmonary vein ablation using radiofrequency energy is the most common approach at present. The procedure also can be done using cryoablation technology. Use of current radiofrequency catheters for AF has a steep learning curve because they require extensive guiding to multiple ablation points. One of the potential advantages of cryoablation is that cryoablation catheters have a circular or shaped end point, permitting a “one-shot” ablation. Other types of radiofrequency catheters, which incorporate circular or otherwise shaped end points, may also be used.

**Repeat Procedures**

Repeat procedures following initial RFA are commonly performed if AF recurs or if atrial flutter develops postprocedure. The need for repeat procedures may, in part, depend on the clinical characteristics of the patient (eg, age, persistent vs paroxysmal AF, atrial dilatation), and the type of ablation initially performed. Repeat procedures are generally more limited in scope than the initial procedure. For example, in cases
where electrical reconnections occur as a result of incomplete ablation lines, a “touch up” procedure is done to correct gaps in the original ablation. In other cases when atrial flutter has developed after ablation, a “flutter ablation” is performed, which is more limited than the original AF procedure. A number of clinical and demographic factors are associated with the need for a second procedure, including age, length of AF, permanent AF, left atrial size, and left ventricular ejection fraction.

Outcome Assessment in AF

Various outcomes for the treatment of AF may be considered. The mortality and morbidity related to AF (eg, cardiovascular mortality, stroke, heart failure) are the most important clinical outcomes. However, they are uncommon events, and currently available trials have not been powered to detect differences in these outcomes. Quality of life (QOL) is also an important outcome because QOL measures reflect important manifestations of AF, such as symptoms and reduced exercise tolerance. AF has been shown to be associated with lower QOL scores, and maintenance of sinus rhythm has been associated with higher QOL scores for patients with paroxysmal AF.

Recurrence of AF is a more problematic outcome measure because the intermittent and often transient nature of recurrences makes accurate measurement difficult. This outcome measure has been reported in different ways. For example, the proportion of patients in sinus rhythm at the end of the study, the time to the first recurrence, and the number of recurrences within a period have been reported. Shemin et al (2007) highlighted the difficulties in measuring AF recurrence and recommended a measure of AF “burden,” defined as the percentage of time an individual is in AF, as the optimal measure of treatment efficacy. However, this parameter requires continuous monitoring over a relatively long period, which is inconvenient for patients, resource intensive, and usually not pragmatic in patients who do not already have an implanted pacemaker.

Recommendations for outcome assessment in trials of AF treatment were included in the 2006 American College of Cardiology, American Heart Association, and European Society of Cardiology practice guidelines for the treatment of AF. These guidelines pointed out that the appropriate end points for evaluation of treatment efficacy in patients with paroxysmal or persistent AF have little in common. For example, in studies of persistent AF, the proportion of patients in sinus rhythm at the end of follow-up is a useful end point, but this end point is less useful in studies of paroxysmal AF. Given all these variables, ideally, controlled clinical trials would report a range of outcomes (including QOL) and complications in homogeneous patient groups and compare them with the most relevant treatment alternatives (eg, pharmacologic therapy, defibrillator therapy, AV nodal ablation), depending on the classification of AF (paroxysmal, persistent, permanent).

Summary

For individuals who have symptomatic paroxysmal or persistent AF who have failed antiarrhythmic drugs who receive RFA or cryoablation, the evidence includes multiple randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are overall survival, symptoms, morbid events, and quality of life. RCTs that compare RFA with antiarrhythmic medications have reported that freedom from AF is more likely after ablation than after medications. Results of long-term follow-up (5-6 years) after ablation has demonstrated that late recurrences continue to occur in patients who are free of AF at 1 year. However, most patients who are AF-free at 1 year remain AF-free at 5 to 6 years. Multiple RCTs comparing cryoablation and RFA have found that cryoablation is noninferior to RFA for AF control. RFA and cryoablation differ in adverse effect profiles; for example, cryoablation is associated with higher rates of phrenic nerve paralysis but may allow a shorter procedure time. Given currently available data, it would be reasonable to consider both RFA and cryoablation effective for catheter ablation of AF foci or pulmonary vein isolation, provided that there is a discussion about the risks and benefits of each. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals who have symptomatic AF and congestive heart failure who have failed rate control and antiarrhythmic drugs who receive RFA or cryoablation, the evidence includes a TEC Assessment, supported by RCTs. Relevant outcomes are overall survival, symptoms, morbid events, and quality of life. Based on 1 available multicenter RCT, the TEC Assessment found that the evidence was sufficient to
conclude that catheter ablation improves outcomes more than the alternative, atrioventricular (AV) nodal ablation and pacemaker insertion. Findings from this RCT have been supported by other comparative studies, which have reported improvements in AF. It is reasonable to consider both RFA and cryoablation effective for catheter ablation of AF foci or pulmonary vein isolation, provided that there is a discussion about the risks and benefits of each. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals who have recurrent symptomatic paroxysmal AF who receive RFA or cryoablation as an initial rhythm-control strategy, the evidence includes RCTs and systematic reviews. Relevant outcomes are overall survival, symptoms, morbid events, and quality of life. Two RCTs with low risk of bias compared catheter ablation for pulmonary vein isolation to antiarrhythmic medications. One RCT demonstrated reduced rates of AF recurrence, while the other reported reduced cumulative overall AF burden. Together, these results suggest that, when a rhythm-control strategy is desired, catheter ablation is a reasonable alternative to antiarrhythmic drug therapy. While the RCTs comparing ablation to medical therapy were conducted using RFA, it is reasonable to consider both RFA and cryoablation effective for catheter ablation of AF foci or pulmonary vein isolation, provided that there is a discussion about the risks and benefits of each. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>10/2019</td>
<td>Clarified coding information.</td>
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<tr>
<td>2/2018</td>
<td>Clarified coding information.</td>
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<tr>
<td>6/2017</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>8/2016</td>
<td>BCBSA National medical policy review. Last paragraph in Background section revised to remove redundant language and add clarity.</td>
</tr>
<tr>
<td>7/2016</td>
<td>BCBSA National medical policy review. Policy statement for ablation as first-line therapy for paroxysmal atrial fibrillation clarified to state that the atrial fibrillation should be recurrent.</td>
</tr>
<tr>
<td>5/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
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<tr>
<td>5/2014</td>
<td>New references from BCBSA National medical policy; policy title changed.</td>
</tr>
<tr>
<td>5/2013</td>
<td>New references from BCBSA National medical policy.</td>
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<tr>
<td>12/2009</td>
<td>BCBS Association National Policy Review. Clarified repeat procedures; non-coverage language was clarified.</td>
</tr>
<tr>
<td>11/1/2009</td>
<td>Medical Policy 141 effective 11/1/2009. This treatment was previously addressed on medical policy #123, Catheter Ablation of Other Arrhythmogenic Foci.</td>
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</tbody>
</table>
Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References


49. Bunch TJ, May HT, Bair TL, et al. Atrial fibrillation ablation patients have long-term stroke rates similar to patients without atrial fibrillation regardless of CHADS2 score. *Heart Rhythm.* Sep 2013;10(9):1272-1277. PMID 23835257


102. Calkins H, Kuck KH, Cappato R, et al. 2012 HRS/EHRA/ECAS expert consensus statement on catheter and surgical ablation of atrial fibrillation: recommendations for patient selection, procedural techniques, patient management and follow-up, definitions, endpoints, and research trial design: a report of the Heart Rhythm Society (HRS) Task Force on Catheter and Surgical Ablation of Atrial Fibrillation. Developed in partnership with the European Heart Rhythm Association (EHRA), a registered branch of the European Society of Cardiology (ESC) and the European Cardiac Arrhythmia Society (ECAS); and in collaboration with the American College of Cardiology (ACC), American Heart Association (AHA), the Asia Pacific Heart Rhythm Society (APHRS), and the Society of Thoracic Surgeons (STS). Endorsed by the governing bodies of the American College of Cardiology Foundation, the American Heart Association, the European Cardiac Arrhythmia Society, the European Heart Rhythm Association, the Society of Thoracic Surgeons, the Asia Pacific Heart Rhythm Society, and the Heart Rhythm Society. *Heart Rhythm.* Apr 2012;9(4):632-696 e621. PMID 22386883

