Medical Policy

Open and Thoracoscopic Approaches to Treat Atrial Fibrillation and Atrial Flutter (Maze and Related Procedures)

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Policy Number: 356
BCBSA Reference Number: 7.01.14
NCD/LCD: N/A

Related Policies
- Catheter Ablation as Treatment of Atrial Fibrillation, #141
- Percutaneous 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

The maze procedure or modified procedure, performed on a non-beating heart during cardiopulmonary bypass with cardiac surgery, is considered MEDICALLY NECESSARY for the treatment of symptomatic atrial fibrillation or flutter.

Minimally invasive, off-pump maze procedures (ie, modified maze procedures), including those done via mini-thoracotomy, are considered INVESTIGATIONAL for treatment of atrial fibrillation or flutter.

Hybrid ablation (defined as a combined percutaneous and thoracoscopic approach) is considered INVESTIGATIONAL for the treatment of atrial fibrillation or flutter.

The use of an open maze or modified maze procedure performed on a non–beating heart during cardiopulmonary bypass without concomitant cardiac surgery is considered NOT MEDICALLY NECESSARY for treatment of symptomatic or flutter.

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.

1
Outpatient

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Prior Authorization Required</th>
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</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Not required</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
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<tr>
<td>Medicare HMO Blue<strong>SM</strong></td>
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<tr>
<td>Medicare PPO Blue<strong>SM</strong></td>
<td>Not required</td>
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**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>33256</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (e.g., 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 (e.g., modified maze procedure) (List separately in addition to code for primary procedure)</td>
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<tr>
<td>33259</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (e.g., maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)</td>
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</table>

**ICD-10 Procedure Codes**

<table>
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<th>ICD-10 procedure codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>02560ZZ</td>
<td>Destruction of Right Atrium, Open Approach</td>
</tr>
<tr>
<td>02563ZZ</td>
<td>Destruction of Right Atrium, Percutaneous Approach</td>
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<tr>
<td>02570ZZ</td>
<td>Destruction of Left Atrium, Open Approach</td>
</tr>
<tr>
<td>02573ZZ</td>
<td>Destruction of Left Atrium, Percutaneous Approach</td>
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</tbody>
</table>

The following CPT codes are considered investigational 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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<tr>
<td>33254</td>
<td>Operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure)</td>
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<tr>
<td>33255</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); without cardiopulmonary bypass</td>
</tr>
<tr>
<td>33258</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (e.g., maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)</td>
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Description
Atrial Fibrillation
AF is a supraventricular tachyarrhythmia characterized by disorganized atrial activation with ineffective atrial ejection. The underlying mechanism of AF involves the interplay between electrical triggering events that initiate AF 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. The atria are frequently abnormal in patients with AF and demonstrate enlargement or increased conduction time. Atrial flutter is a variant of AF.

Treatment
The first-line treatment for AF usually includes medications to maintain sinus rhythm and/or control the ventricular rate. Antiarrhythmic medications are only partially effective; therefore, medical treatment is not sufficient for many patients. Percutaneous catheter ablation, using endocardial ablation, is an accepted second-line treatment for patients who are not adequately controlled on medications and may also be used as first-line treatment. Catheter ablation is successful in maintaining sinus rhythm for most patients, but long-term recurrences are common and increase over time. Performed either by open surgical techniques or thoracoscopy, surgical ablation is an alternative approach to percutaneous catheter ablation.

Open Surgical Techniques
The classic Cox maze III procedure is a complex surgical procedure for patients with AF. It involves sequential atriotomy incisions that interrupt the aberrant atrial conduction pathways in the heart. The procedure is also intended to preserve atrial pumping function. It is indicated for patients who do not respond to medical or other surgical antiarrhythmic therapies and is often performed in conjunction with correction of structural cardiac conditions such as valve repair or replacement. This procedure is considered the criterion standard for the surgical treatment of drug-resistant AF, with a success rate of approximately 90%.

The maze procedure entails making incisions in the heart that:

- direct an impulse from the sinoatrial node to the atrioventricular node;
- preserve activation of the entire atrium; and
- block re-entrant impulses responsible for AF or atrial flutter.

The classic Cox maze procedure is performed on a nonbeating heart during cardiopulmonary bypass. Simplification of the maze procedure has evolved with the use of different ablation tools such as microwave, cryotherapy, ultrasound, and radiofrequency energy sources to create the atrial lesions instead of employing the incisional technique used in the classic maze procedure. The Cox maze IV procedure involves the use of radiofrequency energy or cryoablation to create transmural lesions analogous to the lesions created by the “cut-and-sew” maze.

Minimally Invasive (Thoracoscopic) Techniques
Less invasive, transthoracic, endoscopic, off-pump procedures to treat drug-resistant AF have been developed. The evolution of these procedures involves both different surgical approaches and different lesion sets. Alternative surgical approaches include mini-thoracotomy and total thoracoscopy with video assistance. Open thoracotomy and mini-thoracotomy employ cardiopulmonary bypass and open-heart surgery, while thoroscopic approaches are performed on the beating heart. Thoroscopic approaches do not enter the heart and use epicardial ablation lesion sets, whereas the open approaches use either the classic “cut-and-sew” approach or endocardial ablation. Lesion sets may vary independent of the surgical approach, with a tendency toward less extensive lesion sets targeted to areas most likely to be triggers of AF. The most limited lesion sets involve pulmonary vein
isolation and exclusion of the left atrial appendage. More extensive lesion sets include linear ablations of the left and/or right atrium and ablation of ganglionic plexi. Some surgeons perform left atrial reduction in cases of left atrial enlargement.

The type of energy used for ablation also varies; radiofrequency energy is most commonly applied. Other energy sources such as cryoablation and high-intensity ultrasound have been used. For our purposes, the variations on surgical procedures for AF will be combined under the heading of "modified maze" procedures.

**Hybrid Techniques**
"Hybrid" ablation refers to the use of both thoracoscopic and percutaneous approaches in the same patient. Ablation is performed on the outer surface of the heart (epicardial) via the thoracoscopic approach, and on the inner surface of the heart (endocardial) via the percutaneous approach. The rationale for a hybrid procedure is that a combination of both techniques may result in a complete ablation. Thoracoscopic epicardial ablation is limited by the inability to perform all possible ablation lines because the posterior portions of the heart are not accessible via thoracoscopy. Percutaneous, endoscopic ablation is limited by incomplete ablation lines that often require repeat procedures. By combining both procedures, a full set of ablation lines can be performed, and incomplete ablation lines can be minimized.

The hybrid approach first involves thoracoscopy with epicardial ablation. Following this procedure, an electrophysiologic study is performed percutaneously followed by endocardial ablation as directed by the results of electrophysiology. Most commonly, the electrophysiology study and endocardial ablation are done immediately after the thoracoscopy as part of a single procedure. However, some hybrid approaches perform the electrophysiology study and endocardial ablation on separate days, as directed by the electrophysiology study.

**Summary**
There are various surgical approaches to treat atrial fibrillation (AF) that work by interrupting abnormal electrical activity in the atria. Open surgical procedures, such as the Cox maze procedure were first developed for this purpose and are now generally performed in conjunction with valvular or coronary artery bypass graft surgery. Surgical techniques have evolved to include minimally invasive approaches that use epicardial radiofrequency ablation, a thoracoscopic or mediastinal approach, and hybrid catheter ablations/open procedures.

For individuals who have symptomatic AF or flutter who are undergoing cardiac surgery with bypass who received a Cox maze or a modified maze procedure, the evidence includes several randomized controlled trials (RCTs) and nonrandomized comparative studies, along with systematic reviews of these studies. The relevant outcomes are overall survival, medication use, and treatment-related morbidity. Several small RCTs have provided most of the direct evidence confirming the benefit of a modified maze procedure for patients with AF who are undergoing mitral valve surgery. These trials have established that the addition of a modified maze procedure results in a lower incidence of atrial arrhythmias following surgery, with minimal additional risks. Observational studies have supported these RCT findings. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have symptomatic, drug-resistant AF or flutter who are not undergoing cardiac surgery with bypass who receive minimally invasive, off-pump thoracoscopic maze procedures, the evidence includes RCTs and observational studies, some of which identify control groups. The relevant outcomes are overall survival, medication use, and treatment-related morbidity. One RCT has provided most of the direct evidence comparing surgical AF ablation using video-assisted thoracoscopy with percutaneous catheter ablation. This trial reported higher success at maintaining sinus rhythm at one year of follow-up with thoracoscopic ablation but also reported higher adverse event rates compared with catheter ablation. The case series have generally reported high success rates, and a few with matched comparison groups have reported higher success rates with surgical treatment than with catheter ablation. However, this evidence does not permit definitive conclusions whether a specific approach is
superior to the other. Factors, such as previous treatment, the probability of maintaining sinus rhythm, the risk of complications, contraindications to anticoagulation, and patient preference, may all affect the risk-benefit ratio for each procedure. At present, it is not possible to define a subgroup of patients who would benefit more from thoracoscopic (or other minimally invasive) surgical ablation compared with percutaneous ablation, so the risks and benefits of surgical ablation compared with catheter ablation are not well-defined. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have symptomatic, drug-resistant AF or flutter who are not undergoing cardiac surgery with bypass who receive hybrid thoracoscopic and endocardial ablation procedures, the evidence includes a nonrandomized comparative study and single-arm case series. The relevant outcomes are overall survival, medication use, and treatment-related morbidity. The studies have suggested that hybrid ablation procedures are associated with high rates of freedom from AF; but direct comparisons with catheter ablation are lacking. Comparative studies are needed to permit direct comparisons of the benefits and harms of hybrid ablation procedures with alternatives. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>7/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>12/2015</td>
<td>BCBSA National medical policy review. New not medically necessary indications described. The phrase “without concomitant cardiac surgery” was removed from the medically necessary policy statement. Title revised to include Atrial Flutter. Clarified coding information. Effective 12/1/2015.</td>
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<tr>
<td>9/2014</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.</td>
</tr>
<tr>
<td>12/2013</td>
<td>Removed ICD-9 diagnosis codes 427.31, 427.32 as the policy is requires prior authorization.</td>
</tr>
<tr>
<td>7/2013</td>
<td>BCBSA National medical policy review. Added “or modified” and “(i.e., modified maze procedures)” to the policy statements. Effective 7/1/2013.</td>
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**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


45. Civello KC, Smith CA, Boedefeld W. Combined endocardial and epicardial ablation for symptomatic atrial fibrillation: single center experience in 100+ consecutive patients. J Innovations Cardiac Rhythm Manage. 2013;August


