

Medicare Medical Policy

Cardiac: Left Atrial Appendage Devices Closure

MEDICARE MEDICAL POLICY NUMBER: 74

Effective Date: 8/1/2022

Last Review Date: 6/2022

Next Annual Review: 6/2023

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
<i>Percutaneous left atrial appendage closure for the treatment of non-valvular atrial fibrillation</i>	National Coverage Determination (NCD) for Percutaneous Left Atrial Appendage Closure (LAAC) (20.34)
<i>Non-percutaneous surgical LAA procedures (open or thoracoscopic)</i>	Company medical policy for Cardiac: Left Atrial Appendage Devices I. These services are considered not medically necessary for Medicare based on the Company medical policy. <u>Services deemed “investigational” are considered not medically necessary for Medicare Plan members. See Policy Guidelines below.</u>

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member’s benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (*Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021*)

POLICY CROSS REFERENCES

- [Cardiac: Left Atrial Appendage Devices](#), MP66
- [Clinical Trials and IDE Studies](#), MP233

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

MEDICARE AND MEDICAL NECESSITY

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. (*Medicare Managed Care Manual, Ch. 4, §90.5*)

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. (*Medicare Claims Processing Manual, Ch. 23, §30 A*)

BACKGROUND

Patients with atrial fibrillation (AF), an irregular heartbeat, are at an increased risk of stroke. The left atrial appendage (LAA) is a tubular structure that opens into the left atrium and has been shown to be one potential source for blood clots that can cause strokes. While thinning the blood with anticoagulant medications has been proven to prevent strokes, percutaneous LAA closure (LAAC) has been studied as a non-pharmacologic alternative for patients with AF.

The Medicare NCD 20.34 allows for coverage of **percutaneous** left atrial appendage (LAA) closure under Coverage with Evidence Development (CED) with certain conditions. The current registries and clinical trials approved by CMS can be found at the [Percutaneous Left Atrial Appendage Closure \(LAAC\) Coverage with Evidence Development](#) website. See the NCD for additional details.

For more information, please see the "Clinical Trials and IDE Studies (Medicare Only)" policy in the [Medical Policy Cross References](#) section above.

There is no Medicare coverage guidance for **non-percutaneous** procedures to occlude the LAA. Therefore, Company policy criteria will be applied

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

Additional billing guidance can be found in the following resources:

- CMS Manual System, Pub 100-04 Medicare Claims Processing, [Transmittal 3515](#), SUBJECT: Percutaneous Left Atrial Appendage Closure (LAAC)
- Medicare Claims Processing Manual Chapter 32, Section 69.6 - Requirements for Billing Routine Costs of Clinical Trials

CODES*		
CPT	33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation
	33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)
	33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)
	33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)
HCPCS	C1760	Closure device, vascular (implantable/insertable)
	C2628	Catheter, occlusion

*Coding Notes:

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services*)
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and

Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

None

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
8/2022	Annual review (converted to new format 2/2023)