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MEDICAL POLICY – 7.01.587

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

BCBSA Ref. Policy:	7.01.14
Effective Date:	Sept. 1, 2023
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Replaces:	7.01.14

RELATED MEDICAL POLICIES:

2.02.26 Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation

Select a hyperlink below to be directed to that section.

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Introduction

A condition where your heartbeat is irregular, or flutters is called atrial fibrillation (AF). AF may be treated with surgery that stops the abnormal activity in the heart. One type of surgery to treat AF is called the Cox maze procedure, which is done by cutting through the chest to access the heart. This procedure was first developed to treat AF, and now is mostly done with another surgery, like valvular or coronary bypass graft surgery. A hybrid ablation is when a mini-maze procedure is performed outside of the heart without cutting into the chest, then a catheter ablation is performed on the inside of the heart by a specialist. Many other procedures to treat AF have been developed that can be done through very small cuts using special tools and techniques, removing the need for larger cuts. This policy explains when the Cox maze procedure may be considered medically necessary to treat AF or flutter.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Surgery	Medical Necessity
Maze or modified maze procedure with other cardiac surgery (33257, 33259)	**The maze or modified maze procedure, performed on a non-beating heart during cardiopulmonary bypass with concomitant cardiac surgery is considered medically necessary for the treatment of symptomatic atrial fibrillation or flutter.**
Maze or modified maze procedure without other cardiac surgery (33254, 33256)	**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 the treatment of atrial fibrillation or flutter.**

Surgery	Investigational
Stand-alone minimally invasive, off-pump maze procedures (33255,33258)	**Stand-alone minimally invasive, off-pump maze procedures (i.e., modified maze procedures), including those done via mini-thoracotomy, are considered investigational for the treatment of atrial fibrillation or flutter.**
Hybrid ablation (33254, 33265, 33266)	**Hybrid ablation (defined as a combined percutaneous endocardial and thoracoscopic epicardial approach) (a.k.a. convergent hybrid procedure) is considered investigational for the treatment of atrial fibrillation or flutter.**

Documentation Requirements
The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following: • Office visit notes that contain the relevant history and physical with the requested procedure (maze or modified maze) and the concomitant cardiac surgery that will be performed at the same time

Coding

Code	Description
CPT	
33254	Operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure or hybrid ablation)
33255	Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); without cardiopulmonary bypass
33256	Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); with cardiopulmonary bypass
33257	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)
33258	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)
33259	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)
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure), without cardiopulmonary bypass
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure), without cardiopulmonary bypass

Related Information

Given the availability of less-invasive alternative approaches to treat atrial fibrillation, performing the maze procedure without concomitant cardiac surgery should rarely be needed.

Per the 2017 Expert Consensus Statement by the Heart Rhythm Society, European Heart Rhythm Association, and European Cardiac Arrhythmia Society (Calkins et al, 2017), the indication for concomitant open or closed surgical ablation, stand-alone, and hybrid surgical ablation of atrial fibrillation is symptomatic disease refractory or intolerant to at least one Class I or III antiarrhythmic medication.

Evidence Review

Description

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.

Background

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 individuals with AF and demonstrate enlargement or increased conduction time. Atrial flutter is a variant of AF.

Epidemiology

In the US, more than 3 to 6 million people have AF and it has been estimated that more than 12 million people will have AF by 2030.[1,2,3] Age, body mass index, height, hypertension, diabetes mellitus, obstructive sleep apnea, myocardial infarction, heart failure, hyperthyroidism, chronic kidney disease, smoking, moderate to heavy alcohol consumption, and genetic predisposition are all risk factors for AF.[4,3] Age-adjusted AF incidence and prevalence is higher among men than women, although the lifetime risk is similar at 24% for men and 22% for women[5]. AF incidence and prevalence appear lower in individuals who are Black compared to White, despite a higher burden of comorbidities. However, this difference is likely largely explained by differential detection of AF by race/ethnicity.[6]

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 individuals. Percutaneous catheter ablation, using endocardial ablation, is an accepted second-line treatment for individuals who are not adequately controlled on medications and may also be used as first-line treatment. Catheter ablation (CA) is successful in maintaining sinus rhythm for most individuals, 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 CA.

Open Surgical Techniques

The classic Cox maze III procedure is a complex surgical procedure for individuals 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 individuals who do not respond to medical or other surgical antiarrhythmic therapies and is often performed in conjunction with the 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 non-beating 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, and 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 thoracoscopic approaches are performed on the beating heart. Thoracoscopic 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 individual. 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 of Evidence

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. 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 individuals 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 an 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. Relevant outcomes are overall survival, medication use, and treatment-related morbidity. Two RCTs reported significantly higher rates of freedom from AF at one-year with surgical ablation but also reported significantly higher rates of serious adverse events. The remaining two RCTs found no significant differences between treatment groups in rates of freedom from AF and either did not assess or did not find significant differences in serious adverse events. The comparative observational studies consistently found significantly higher rates of freedom from atrial arrhythmias but lacked assessment of serious adverse events. The noncomparative studies generally only reported short-term outcomes and did not consistently report adverse events. Therefore, this evidence does not permit definitive conclusions about 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. Additionally, the studies do not permit conclusions about harm due to heterogeneous measurement across studies, with mixed results. The evidence is insufficient to determine that the technology results in an 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 hybrid thoracoscopic and endocardial ablation procedures, the evidence includes four RCTs (sample sizes ranging from 41 to 153) ,

nonrandomized studies that compared a 'convergent' hybrid approach (i.e., epicardial approach combined with endocardial ablation) to catheter ablation (CA) , and one observational study that compared a thoracoscopic epicardial ablation with a percutaneous trans-septal procedure hybrid approach to CA. Pooled evidence from randomized and nonrandomized studies found an increased rate of AF-free survival and increased risk of periprocedural adverse events with hybrid procedures relative to standard ablation. Adverse events after the periprocedural period have not been reported. Multicenter RCTs are needed that assess both benefits and harms with at least one year of follow-up. At least two RCTs of hybrid procedures have been completed but not published. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

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

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT04506814	Comparison of Repeat Endocardial PVI Vs Epicardial Posterior Wall Isolation and LAA Clip Plus PVI for Recurrent Atrial Fibrillation After Prior PVI	162	Dec 2025
NCT03546374	Irrigated Radio Frequency Ablation to Terminate Non-Paroxysmal Atrial Fibrillation (Terminate AF Study)	160	Aug 2024
NCT05723536	LAI-AF Trial: Hybrid Endo-epicardial Partial Left Atrial Isolation vs. Endocardial Ablation in Patients With Persistent Atrial Fibrillation (PLAI-AF)	80	Dec 2025
NCT03732794	AtriCure CryoICE Lesions for Persistent and Long-standing Persistent Atrial Fibrillation Treatment During Concomitant On-Pump Endo/Epicardial Cardiac Surgery	150	Dec 2026

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT02393885	Pivotal Study Of A Dual Epicardial & Endocardial Procedure (DEEP) Approach for Treatment of Subjects With Persistent or Long Standing Persistent Atrial Fibrillation With Radiofrequency Ablation	220	Dec 2027
NCT04715425	Thoracoscopic Surgical Versus Catheter Ablation Approaches for Primary Treatment of Persistent Atrial Fibrillation	170	Sep 2028
Unpublished			
NCT02047279	Left Atrium Reduction Versus no Left Atrium Reduction for Patients With Enlarged Left Atria and Persistent or Long Standing Persistent Atrial Fibrillation Undergoing Mitral Valve Surgery	120	Sep 2017 (completed)
NCT02441738	Hybrid Thoracoscopic Surgical and Transvenous Catheter Ablation Versus Transvenous Catheter Ablation in Persistent and Longstanding Persistent Atrial Fibrillation	41	Dec 2018 (completed)
NCT03737929	Comparison of the Efficacy of Hybrid Ablative Therapy for Patients With Persistent Atrial Fibrillation Versus Conventional Catheter Ablation	228	Jan 2022 (unknown)
NCT04237389	Comparative Assessment of Catheter and Thoracoscopic Approaches in Patients With Persistent and Long-standing Persistent Atrial Fibrillation	60	Aug 2022 (unknown)

NCT: national clinical trial.

[a] Denotes industry-sponsored or cosponsored trial.

Clinical Input Received from Physician Specialty Societies and Academic Medical Centers

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate

reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2013 Input

In response to requests, input was received from two physician specialty societies and six academic medical centers (four reviewers) while this policy was under review in 2013. There was consensus on the medically necessary statements. For subgroups of populations (e.g., those who have failed percutaneous catheter ablation), there was mixed support without consensus. There was also mixed support for the use of hybrid ablation.

2010 Input

In response to requests, input was received from one physician specialty society and three academic medical centers (four reviewers) while this policy was under review in 2010. There was unanimous support for the policy statement regarding cardiopulmonary bypass maze procedure. There was mixed support for the policy statement on off-bypass (off-pump) maze procedure; some providing input indicated off-pump procedures might be useful in select individuals (e.g., those who cannot tolerate anticoagulation). Several providing input also commented on the limited long-term data for off-pump procedures.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or the National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Society of Thoracic Surgeons

In 2017, the Society of Thoracic Surgeons published guidelines on the surgical treatment of AF.[74] Recommendations are provided in **Table 2**.

Table 2. Guidelines on Surgical Treatment of Atrial Fibrillation

Recommendation	COR	LOE
Surgical ablation for AF is recommended at the time of concomitant mitral operations to restore sinus rhythm.	I	A
Surgical ablation for AF is recommended at the time of concomitant isolated aortic valve replacement, isolated CABG surgery, and aortic valve replacement plus CABG operations to restore sinus rhythm.	I	B
Surgical ablation for symptomatic AF in the absence of structural heart disease that is refractory to class I/III antiarrhythmic drugs or catheter-based therapy of both is reasonable as a primary stand-alone procedure to restore sinus rhythm.	IIa	B

AF: atrial fibrillation; CABG: coronary artery bypass graft; COR: class of recommendation; LOE: level of evidence.

American Heart Association et al

In 2019, the American Heart Association, American College of Cardiologists, and Heart Rhythm Society issued joint guidelines in collaboration with the Society of Thoracic Surgeons on the management of patients with AF.[75] Recommendations on the use of surgical ablation to maintain sinus rhythm are provided in **Table 3**.

Table 3. Guidelines on the Management of Atrial Fibrillation

Recommendation	COR	LOE
"AF catheter ablation may be reasonable in selected patients with symptomatic AF and HF with reduced left ventricular (LV) ejection fraction (HFrEF) to potentially lower mortality rate and reduce hospitalization for HF (S6.3.4-1, S6.3.4-2)."	IIb	B-R

AF: atrial fibrillation; COR: class of recommendation; HF: heart failure; LOE: level of evidence.

Heart Rhythm Society et al

A 2017 expert consensus statement on catheter and surgical ablation of atrial fibrillation was developed by the Heart Rhythm Society, European Heart Rhythm Association, and European Cardiac Arrhythmia Society.[7] The statement was endorsed by four other cardiology associations.

Recommendations on concomitant surgical ablation in patients undergoing cardiac surgery for other purposes and who have symptomatic AF are provided in **Table 4**.

Table 4. Guidelines on Concomitant Surgical Ablation in Patients Undergoing Cardiac Surgery[a]

Recommendation	COR	LOE
Paroxysmal: Surgical ablation is recommended for patients undergoing surgery for other indications	II	B-NR
Persistent: Surgical ablation is recommended for patients undergoing surgery for other indications	II	B-NR
Longstanding Persistent: Surgical ablation is recommended for patients undergoing surgery for other indications	II	NR

COR: class of recommendation; LOE: level of evidence; NR: nonrandomized.

[a] For patients with symptomatic AF prior to initiation of antiarrhythmic therapy with Class I or III antiarrhythmic medication and an indication for concomitant closed surgical ablation for AF, surgical ablation is reasonable for paroxysmal, persistent, and long-standing persistent disease (Class: IIa; LOE: B-NR).

The following recommendations were made on stand-alone and hybrid surgical ablation in patients with symptomatic AF refractory or intolerant to at least one class 1 or 3 antiarrhythmic medication (**Table 5**).

Table 5. Guidelines on Stand-Alone and Hybrid Surgical Ablation for Symptomatic Atrial Fibrillation Refractory or Intolerant to Antiarrhythmics

Recommendation[a]	COR	LOE
Paroxysmal		
Stand alone surgical ablation can be considered for patients who have not failed catheter ablation but prefer a surgical approach	IIb	B-NR
Stand alone surgical ablation can be considered for patients who have failed 1 or more attempts at catheter ablation	IIb	B-NR
Persistent		

Recommendation[a]	COR	LOE
Stand alone surgical ablation is reasonable for patients who have not failed catheter ablation but prefer a surgical approach	IIa	B-NR
Stand alone surgical ablation is reasonable for patients who have failed 1 or more attempts at catheter ablation	IIa	B-NR
Longstanding persistent		
Stand alone surgical ablation is reasonable for patients who have not failed catheter ablation but prefer a surgical approach	IIb	B-NR
Stand alone surgical ablation is reasonable for patients who have failed 1 or more attempts at catheter ablation	IIb	B-NR

COR: class of recommendation; LOE: level of evidence; NR: nonrandomized.

[a] The recommendations noted that "it might be reasonable to apply the indication for stand-alone surgical ablation described above to patients being considered for hybrid surgical AF ablation."

American Association for Thoracic Surgery

In 2017, the American Association for Thoracic Surgery published guidelines on surgical ablation for AF.[78] Recommendations on concomitant surgical ablation in patients with AF are provided in **Table 6**.

Table 6. Guidelines on Concomitant Surgical Ablation in Patients with Atrial Fibrillation

Recommendation	COR	LOE
"Addition of a concomitant surgical ablation procedure for AF does not increase the incidence of perioperative morbidity."	IIa	A, B-R, B-NR[a]
"Addition of a concomitant surgical ablation procedure for AF does not change the incidence of perioperative stroke/TIA."	IIa	A
"Addition of a concomitant surgical ablation procedure for AF does not change the incidence of late stroke/TIA, but subgroup analysis of nonrandomized controlled trials found a significant reduction in late stroke/TIA incidence."	IIa	A, B-NR[b]
"A surgical procedure that includes concomitant surgical ablation for AF does improve HRQL."	IIa	B-R
"Addition of concomitant surgical ablation for AF does improve AF-related symptoms, and this improvement is greater than in patients without surgical ablation for AF."	IIa	C-LD
"Addition of concomitant surgical ablation for AF does improve 30-day operative mortality."	I	A

Recommendation	COR	LOE
"Addition of a concomitant surgical ablation procedure for AF improves long term survival."	IIa	A, B-NR[c]

AF: atrial fibrillation; COR: class of recommendation; HRQL: health-related quality of life; LOE: level of evidence ; NR: nonrandomized; R: randomized; TIA: transient ischemic attack

[a] "LOE A for deep sternal wound infection, pneumonia, reoperation for bleeding, and renal failure requiring dialysis; LOE B-R for intensive care unit length of stay and total hospital length of stay; and LOE B-NR for readmission less than 30 days and renal failure."

[b] "LOE A for no change in incidence of late stroke/ TIA (up to 1 year of follow-up after surgery) and LOE B-NR for reduction in incidence of late stroke/TIA (>1 year of follow-up after surgery)."

[c] "LOE A for no change in long-term survival (up to 1 year after surgery) and LOE B-NR for improvement in long-term survival (>1 year after surgery)."

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Several radiofrequency ablation systems have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process for cardiac tissue ablation (product code OCL). **Table 7** provides a select list.

Table 7. Radiofrequency Ablation Approved by the U.S. Food and Drug Administration

Device	Manufacturer
EPi-Sense Guided Coagulation System	Atricure
Medtronic DiamondTemp System	Medtronic
Cobra Fusion Ablation System	AtriCure
Medtronic Cardioblate System and Cardioblate Gemini Systems	Medtronic
Cardima Ablation System	Cardima
Epicor Medical Ablation System	Epicor Medical
Isolator Pen	AtriCure
Estech COBRA Cardiac Electrosurgical Unit	Endoscopic Technologies

Device	Manufacturer
Coolrail Linear Pen	AtriCure
Numeris Guided Coagulation System with VisiTrax	nContact Surgical
EPi-Sense Guided Coagulation System with VisiTrax	nContact Surgical

A number of cryoablation systems, which may be used during cardiac ablation procedures, have also been cleared for marketing, including those in **Table 8**.

Table 8. Cryoablation Systems Approved by the U.S. Food and Drug Administration

Device	Manufacturer
Cryocare Cardiac Surgery System	Endocare
SeedNet System	Galil Medical
SurgiFrost XL Surgical CryoAblation System	CryoCath Technologies; now Medtronic
Isis cryosurgical unit	Galil Medical
Artic Front Advance and Arctic Front Advance Pro and the Freezer Max Cardiac Cryoablation Catheters	Medtronic

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History

Date	Comments
06/01/23	New policy, approved May 9, 2023, effective for dates of service on or after September 1, 2023, following 90-day provider notification. Add to Surgery section. The maze or modified maze performed during cardiopulmonary bypass with concomitant cardiac surgery is considered medically necessary for the treatment of AF or flutter, all other variations of the procedure are considered investigational. Surgery performed without concomitant cardiac surgery is considered not medically necessary.

Date	Comments
08/01/23	Policy renumbered, approved July 11, 2023, from 7.01.14 to 7.01.587 Open and Thoracoscopic Approaches to Treat Atrial Fibrillation and Atrial Flutter (Maze and Related Procedures). Policy updated with literature review through March 9, 2023; references added. Policy statement unchanged.
08/03/23	Minor revision, removed the word Pharmacy from the policy header as this is a Medical-only policy.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

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Washington residents: You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Alaska residents: Contact the Alaska Division of Insurance via email at insurance@alaska.gov, or by phone at 907-269-7900 or 1-800-INSURAK (in-state, outside Anchorage).

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