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Medical Benefit		Effective Date: 07/01/16	Next Review Date: 03/19
Preauthorization	No	Review Dates: 11/15, 03/16, 03/17, 03/18	

Preauthorization is not required.

The following protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient's contract at the time the services are rendered.

Populations	Interventions	Comparators	Outcomes
Individuals: • With atrial fibrillation who are at increased risk for embolic stroke	Interventions of interest are: • Watchman percutaneous left atrial appendage closure device	Comparators of interest are: • Anticoagulation	Relevant outcomes include: • Overall survival • Morbid events • Treatment-related morbidity
Individuals: • With atrial fibrillation who are at increased risk for embolic stroke	Interventions of interest are: • Percutaneous left atrial appendage closure device other than the Watchman device	Comparators of interest are: • Anticoagulation	Relevant outcomes include: • Overall survival • Morbid events • Treatment-related morbidity

Description

Stroke prevention in atrial fibrillation (AF) is an important goal of treatment. Treatment with anticoagulant medications is the most common approach to stroke prevention. Most embolic strokes originate from the left atrial appendage (LAA); therefore, occlusion of the left atrial appendage may offer a nonpharmacologic alternative to anticoagulant medications for this purpose. Multiple percutaneously deployed devices are being investigated for left atrial appendage closure (LAAC). One LAA device (the Watchman device) has approval from the U.S. Food and Drug Administration (FDA) for stroke prevention in patients with AF.

Summary of Evidence

For individuals who have AF who are at increased risk for embolic stroke who receive the Watchman percutaneous LAAC device, the evidence includes two randomized controlled trials (RCTs) and meta-analyses of these trials. Relevant outcomes are overall survival, morbid events, and treatment-related morbidity. The most relevant evidence comes from two industry-sponsored RCTs that compared the Watchman device with anticoagulation. One trial reported noninferiority on a composite outcome of stroke, cardiovascular/unexplained death, or systemic embolism after two years of follow-up, with continued benefits with the Watchman device after four years of follow-up. The second trial did not demonstrate noninferiority for the same composite outcome, but did demonstrate noninferiority of the Watchman device to warfarin for late ischemic stroke and systemic embolization. Patient-level meta-analyses of the two trials reported that the Watchman device is noninferior to warfarin on the composite outcome of stroke, systemic embolism, and cardiovascular death. Also,

the Watchman was associated with a higher periprocedural risk of bleeding and ischemic stroke, but a lower risk of hemorrhagic stroke over the long term. The published evidence indicates that the Watchman device is efficacious in preventing stroke for patients with AF who are at increased risk for embolic stroke. When it is determined on an individualized basis that the long-term risk of systemic anticoagulation exceeds the procedural risk of device implantation, the net health outcome will be improved. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have AF who are at increased risk for embolic stroke who receive a percutaneous LAAC device other than the Watchman device (e.g., the Lariat, Amplatzer, and PLAATO devices), the evidence includes uncontrolled case series. Relevant outcomes are overall survival, morbid events, and treatment-related morbidity. Case series of these devices have reported high procedural success, but also numerous complications. In addition, these devices do not have U.S. Food and Drug Administration (FDA) approval for LAAC. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy

The use of a device with U.S. Food and Drug Administration (FDA) approval for percutaneous left atrial appendage closure (e.g., the Watchman) may be considered **medically necessary** for the prevention of stroke in patients with atrial fibrillation when the following criteria are met:

- There is an increased risk of stroke and systemic embolism based on CHADS₂ or CHA₂DS₂-VASc score and systemic anticoagulation therapy is recommended; and
- The long term risks of systemic anticoagulation outweigh the risks of the device implantation (see Policy Guidelines).

The use of a device with FDA approval for percutaneous left atrial appendage closure (e.g., the Watchman) for stroke prevention in patients who do not meet the above criteria is considered **investigational**.

The use of other percutaneous left atrial appendage closure devices, including but not limited to the Lariat, PLAATO, and Amplatzer devices, for stroke prevention in patients with atrial fibrillation is considered **investigational**.

Policy Guidelines

The balance of risks and benefits associated with implantation of the Watchman device for stroke prevention, as an alternative to systemic anticoagulation with warfarin, must be made on an individual basis.

Bleeding is the primary risk associated with systemic anticoagulation. A number of risk scores have been developed to estimate the risk of significant bleeding in patients treated with systemic anticoagulation. An example is the HAS-BLED score, which is validated to assess the annual risk of significant bleeding in patients with AF treated with warfarin (Pisters et al, 2010). The score ranges from zero to nine based on a number of clinical characteristics (see Table PG1).

Table PG1: Clinical Components of the HAS-BLED Bleeding Risk Score (Pisters et al, 2010)

Letter	Clinical Characteristic	Points Awarded
H	Hypertension	1
A	Abnormal renal and liver function (one point each)	1 or 2
S	Stroke	1
B	Bleeding	1
L	Labile international normalized ratios	1

Letter	Clinical Characteristic	Points Awarded
E	Elderly (older than 65)	1
D	Drugs or alcohol (one point each)	1 or 2

Risk of major bleeding in patients with scores of three, four, and five have been reported at 3.74 per 100 patient-years, 8.70 per 100 patient-years, and 12.5 per 100 patient-years, respectively. Scores of three or greater are considered to be associated with high risk of bleeding, potentially signaling the need for closer monitoring of the patient for adverse risks, closer monitoring of international normalized ratio (INR), or differential dose selections of oral anticoagulants or aspirin (January et al, 2014).

Medicare Advantage

For Medicare Advantage percutaneous left atrial appendage closure (LAAC) for nonvalvular atrial fibrillation (NVAf) is **medically necessary** through Coverage with Evidence Development (CED) with the following conditions:

The device has received Food and Drug Administration (FDA) Premarket Approval (PMA) for that device's FDA-approved indication and meets all of the conditions specified below:

The patient must have:

- A CHADS₂ score greater than or equal to two (Congestive heart failure, Hypertension, Age greater than 75, Diabetes, Stroke/transient ischemia attack/thromboembolism) or CHA₂DS₂-VASc score greater than or equal to three (Congestive heart failure, Hypertension, Age greater than or equal to 65, Diabetes, Stroke/transient ischemia attack/thromboembolism, Vascular disease, Sex category).
- A formal shared decision making interaction with an independent non-interventional physician using an evidence based decision tool on oral anticoagulation in patients with NVAf prior to LAAC (see Medicare Advantage Policy Guidelines).
- A suitability for short-term warfarin but deemed unable to take long term oral anticoagulation following the conclusion of shared decision making, as LAAC is only covered as a second line therapy to oral anticoagulants. The patient (preoperatively and postoperatively) is under the care of a cohesive, multidisciplinary team (MDT) of medical professionals. The procedure must be furnished in a hospital with an established structural heart disease (SHD) and/or electrophysiology (EP) program.
- The procedure must be performed by an interventional cardiologist(s), electrophysiologist(s) or cardiovascular surgeon(s) that meet the following criteria:
 - Has received training prescribed by the manufacturer on the safe and effective use of the device prior to performing LAAC; and
 - Has performed greater than or equal to 25 interventional cardiac procedures that involve transeptal puncture through an intact septum; and
 - Continues to perform greater than or equal to 25 interventional cardiac procedures that involve transeptal puncture through an intact septum, of which at least 12 are LAAC, over a two year period.

The patient is enrolled in, and the MDT and hospital must participate in a prospective, national, audited registry (see Medicare Advantage Policy Guidelines).

LAAC is **investigational** for the treatment of NVAf when not furnished under CED according to the above-noted criteria.

Medicare Advantage Policy Guidelines

The shared decision making interaction must be documented in the medical record.

Registries must be reviewed and approved by CMS. All approved registries will be posted on the CED website located at <https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html>.

Background

Stroke

Stroke is the most serious complication of AF. The estimated incidence of stroke in nontreated patients with AF is 5% per year. Stroke associated with AF is primarily embolic in nature, tends to be more severe than the typical ischemic stroke, and causes higher rates of mortality and disability. As a result, stroke prevention is a main goal of AF treatment.

Stroke in AF occurs primarily as a result of thromboembolism from the left atrium. The lack of atrial contractions in AF leads to blood stasis in the left atrium, and this low flow state increases the risk for thrombosis. The area of the left atrium with the lowest blood flow in AF, and, therefore, the highest risk of thrombosis, is the LAA. It has been estimated that 90% of left atrial thrombi occur in the LAA.

Treatment

ANTICOAGULATION

The main treatment for stroke prevention in AF is anticoagulation, which has proven efficacy. The risk for stroke among patients with AF is stratified by several factors. A commonly used score, the CHADS₂ score, assigns one point each for the presence of heart failure, hypertension, age 75 years or older, diabetes, or prior stroke or transient ischemic attack. The CHADS₂-VASc score includes sex, more age categories, and the presence of vascular disease, in addition to the risk factors used in the CHADS₂ score. Warfarin is the predominant agent in clinical use. A number of newer anticoagulant medications, including dabigatran, rivaroxaban, and apixaban, have received U.S. FDA approval for stroke prevention in nonvalvular AF and have demonstrated noninferiority to warfarin in clinical trials. While anticoagulation is effective for stroke prevention, it carries an increased risk of bleeding. Also, warfarin requires frequent monitoring and adjustments as well as lifestyle changes. Dabigatran does not require monitoring. However, unlike warfarin, the antithrombotic effects of dabigatran are not reversible with any currently available hemostatic drugs. Guidelines from the American College of Chest Physicians (2012) have recommended the use of oral anticoagulation for patients with AF who are at high risk of stroke (i.e., CHADS₂ score \geq two), with more individualized choice of antithrombotic therapy in patients with lower stroke risk.¹

Bleeding is the primary risk associated with systemic anticoagulation. Risk scores have been developed to estimate the risk of significant bleeding in patients treated with systemic anticoagulation, such as the HAS-BLED score, which has been validated to assess the annual risk of significant bleeding in patients with AF treated with warfarin.² The score ranges from zero to nine, based on clinical characteristics, including the presence of hypertension, renal and liver function, history of stroke, bleeding, labile INRs, age, and drug/alcohol use. Scores of three or greater are considered to be associated with high risk of bleeding, potentially signaling the need for closer monitoring of patients for adverse risks, closer monitoring of INRs, or differential dose selections of oral anticoagulants or aspirin.³

SURGERY

Surgical removal, or exclusion, of the LAA is often performed in patients with AF who are undergoing open heart surgery for other reasons. Percutaneous LAAC devices have been developed as a nonpharmacologic alternative

to anticoagulation for stroke prevention in AF. The devices may prevent stroke by occluding the LAA, thus preventing thrombus formation.

Several versions of LAA occlusion devices have been developed. The Watchman Left Atrial Appendage System (Boston Scientific, Marlborough, MA) is a self-expanding nickel titanium device. It has a polyester covering and fixation barbs for attachment to the endocardium. Implantation is performed percutaneously through a catheter delivery system, using venous access and transseptal puncture to enter the left atrium. Following implantation, patients receive anticoagulation with warfarin or alternative agents for approximately one to two months. After this period, patients are maintained on antiplatelet agents (i.e., aspirin and/or clopidogrel) indefinitely. The Lariat Loop Applicator is a suture delivery device that is intended to close a variety of surgical wounds in addition to LAAC. The Cardioblade® closure device (Medtronic) is currently being tested in clinical studies. The Amplatzer cardiac plug (St. Jude Medical, Minneapolis, MN), is FDA-approved for closure of atrial septal defects but not LAAC device. A second-generation device, the Amplatzer Amulet, has been developed. The Percutaneous LAA Transcatheter Occlusion device (ev3, Plymouth, MN) has also been evaluated in research studies but has not received FDA approval. The Occlutech® (Occlutech, Sweden) Left Atrial Appendage Occluder has received a CE mark for coverage in Europe.

Regulatory Status

In March 2015, the Watchman™ Left Atrial Appendage Closure Technology (Boston Scientific, Marlborough, MA) was approved by the FDA through the premarket approval process on the basis of the Left Atrial Appendage Versus Warfarin Therapy for Prevention of Stroke in Patients with Atrial Fibrillation (PROTECT-AF) randomized controlled trial.⁴ This device is indicated to reduce the risk of thromboembolism from the left atrial appendage (LAA) in patients with nonvalvular atrial fibrillation who:

- Are at increased risk for stroke and systemic embolism based on CHADS₂ or CHA₂DS₂-VASc scores and are recommended for anticoagulation therapy;
- Are deemed by their physicians to be suitable for warfarin; and
- Have an appropriate rationale to seek a nonpharmacologic alternative to warfarin, taking into account the safety and effectiveness of the device compared to warfarin.

FDA product code: NGV.

Two other devices have been studied for LAA occlusion, but are not approved in the United States for percutaneous closure of the LAA. In 2006, the Lariat® Loop Applicator device (SentreHEART, Redwood City, CA), a suture delivery system, was cleared for marketing by FDA through the 510(k) process. The intended use is to facilitate suture placement and knot tying in surgical applications where soft tissues are being approximated or ligated with a pretied polyester suture. The Amplatzer Amulet® device (St. Jude Medical, Plymouth, MN) has a CE approval in Europe for LAA closure, but is not currently approved in the United States for any indication.

Related Protocols

Catheter Ablation as Treatment for Atrial Fibrillation

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

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. *For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.*

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. **Some of this protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.**

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We are not responsible for the continuing viability of web site addresses that may be listed in any references below.

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