

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

Policy # 00624

Original Effective Date: 11/01/2018

Current Effective Date: 08/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

Note: Catheter Ablation as Treatment for Atrial Fibrillation is addressed separately in medical policy 00267.

Note: Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation is addressed separately in medical policy 00296.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider the maze or modified maze procedure to be **eligible for coverage**** when **ALL** of the following criteria are met:

- For treatment of symptomatic atrial fibrillation (AF) or flutter; **AND**
- When performed on a non-beating heart during cardiopulmonary bypass; **AND**
- Performed with concomitant cardiac surgery.

When Services Are Considered Not Medically Necessary

The use of the maze or modified maze procedure when coverage criteria are not met is considered to be **not medically necessary****, including but not limited to ANY of the following:

- Stand-alone minimally invasive, off-pump maze procedures (i.e., modified maze procedures), including those done via mini-thoracotomy for treatment of atrial fibrillation (AF) or flutter;
- An open maze or modified maze procedure performed on a non-beating heart during cardiopulmonary bypass without concomitant cardiac surgery for the treatment of atrial fibrillation or flutter.

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

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers hybrid ablation (defined as a combined percutaneous and thoracoscopic approach) for the treatment of atrial fibrillation (AF) or flutter to be **investigational**.*

Based on review of available data, the Company considers the maze or modified maze procedures for any indication not listed above to be **investigational**.*

Policy Guidelines

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

Clinical input obtained for the March 2025 update did not address hybrid ablation procedures.

Per the 2024 Expert Consensus Statement by the Heart Rhythm Society, European Heart Rhythm Association, Asia Pacific Heart Rhythm Society, and Latin American Heart Rhythm Society (Tzeis et al, 2024 , referenced in the Supplemental Information section), the indication for concomitant open cardiac surgery with surgical ablation is individuals with paroxysmal or persistent atrial fibrillation regardless of prior antiarrhythmic drug failure or intolerance. For closed cardiac surgery with concomitant surgical ablation, the recommended indication is in individuals with paroxysmal or persistent atrial fibrillation intolerant or refractory to previous antiarrhythmic drug therapy. Stand-alone surgical or hybrid ablation is reasonable in symptomatic individuals with persistent atrial fibrillation with prior unsuccessful catheter ablation and also in those who are intolerant or refractory to antiarrhythmic drug therapy and prefer a surgical or hybrid approach after careful consideration of relative safety and efficacy of treatment options.

Background/Overview

Atrial Fibrillation

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.

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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. 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. 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 women⁵. 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.

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 (CA) 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 CA.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Several ablation systems have been approved or cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process for cardiac tissue ablation (product code OCL) or premarket approval (PMA) process (product code OCM). Table 1 provides a select list.

Table 1. Radiofrequency Ablation Approved or Cleared by the U.S. Food and Drug Administration

Device	Manufacturer
Epi-Sense Guided Coagulation System	Atricure
Medtronic DiamondTemp ^{TM†} System	Medtronic
Cobra Fusion Ablation System	AtriCure
Medtronic Cardioblate ^{®†} and Cardioblate Gemini ^{TM†} Systems	Medtronic
Cardima Ablation System	Cardima
Epicor ^{TM†} Medical Ablation System	Epicor Medical
Isolator ^{TM†} Systems	AtriCure
Estech COBRA ^{®†} Cardiac Electrosurgical Unit	Endoscopic Technologies

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Coolrail ^{TM†} 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 2.

Table 2. Cryoablation Systems Approved or Cleared by the U.S. Food and Drug Administration

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

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

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.

Summary of Evidence

For individuals who have symptomatic atrial fibrillation (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 patients with AF who are undergoing mitral

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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 1-year with surgical ablation but also reported significantly higher rates of serious adverse events. The remaining 2 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 5 RCTs (sample sizes ranging from 41 to 154), comparative observational studies, single-arm case series, and systematic reviews of these studies. Relevant outcomes are overall survival, medication use, and treatment-related morbidity. Evidence from randomized and nonrandomized studies found an increased rate of AF-free survival, reduced risk of cardioversion, and increased risk of periprocedural adverse events with hybrid procedures relative to standard ablation. The largest RCT (CEASE-AF) reported composite major complications at 1 year in 9% vs 6% and at 2 years in 10.8% and 9.6% with hybrid vs standard ablation. Although the surgical ablation lesion sets varied across studies and have not been standardized in practice, many professional organizations including the American Heart Association and the Heart Rhythm Society make conditional recommendations that hybrid ablation procedures might be reasonable to reduce the risk of recurrent atrial arrhythmia after careful consideration of relative safety and efficacy of treatment options based on available evidence. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

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Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

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 2 physician specialty societies and 6 academic medical centers (4 reviewers) while this policy was under review in 2013. There was consensus on the medically necessary statements. For subgroups of populations (eg, those who have failed percutaneous catheter ablation), there was mixed support without consensus. There was also mixed support for the use of hybrid ablation.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in ‘Supplemental Information’ if they were issued by, or jointly by, a US professional society, an international society with US representation, or 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 2023, the Society of Thoracic Surgeons published guidelines on the surgical treatment of atrial fibrillation (AF). Recommendations are provided in Table 3.

Table 3. Guidelines on Surgical Treatment of Atrial Fibrillation

Recommendation	COR	LOE
Surgical ablation for AF is recommended for first-time non-emergent concomitant mitral operations to restore sinus rhythm and improve long-term outcomes.	I	A
Surgical ablation for AF is recommended for any first-time non-emergent concomitant non-mitral operation to restore sinus rhythm and improve long-term outcomes.	I	B
Surgical ablation for symptomatic AF in the absence of structural heart disease that is refractory to class I/III antiarrhythmic drugs, catheter-based therapy or both is reasonable as a primary stand-alone procedure to restore sinus rhythm.	IIa	B
Surgical ablation for symptomatic persistent or longstanding persistent AF in the absence of structural heart disease is reasonable as a stand-alone procedure using the Cox-Maze III/IV lesion set as the preferred procedure.	IIa	B

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

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American Heart Association et al

In 2023, the American Heart Association, American College of Cardiologists, American College of Clinical Pharmacy, and Heart Rhythm Society issued joint guidelines on the diagnosis and management of patients with AF. Recommendations on the use of surgical ablation to maintain sinus rhythm are provided in Table 4.

Table 4. Guidelines on the Management of Atrial Fibrillation

Recommendation	COR	LOE
For patients with AF who are undergoing cardiac surgery, concomitant surgical ablation can be beneficial to reduce the risk of recurrent AF.	2a	B
For patients with symptomatic, persistent AF refractory to antiarrhythmic drug therapy, a hybrid epicardial and endocardial ablation might be reasonable to reduce the risk of recurrent atrial arrhythmia.	2b	B

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

Heart Rhythm Society et al

A 2024 expert consensus statement on catheter and surgical ablation of atrial fibrillation was developed by the Heart Rhythm Society, European Heart Rhythm Association, Asia Pacific Heart Rhythm Society, and Latin American Heart Rhythm Society. Recommendations on concomitant surgical ablation in patients undergoing cardiac surgery for other purposes and who have symptomatic AF are provided in Table 5.

Table 5. Guidelines on Concomitant Surgical Ablation in Patients Undergoing Cardiac Surgery

Recommendation	Category of advice	Type of Evidence
Concomitant surgical AF ablation is beneficial in patients with paroxysmal or persistent AF undergoing left atrial open cardiac surgery regardless of prior antiarrhythmic drug failure or intolerance	Advice to do	META
Concomitant surgical AF ablation is beneficial in patients with paroxysmal or persistent AF intolerant or refractory to previous antiarrhythmic drug therapy, undergoing close (non-left atrial open) cardiac surgery	Advice to do	META
Bilateral Cox maze procedure or a minimum of PVI plus left atrial posterior wall isolation is beneficial in patients undergoing surgical AF ablation concomitant to left atrial open cardiac surgery	Advice to do	RAND
Concomitant surgical AF ablation is reasonable in patients with paroxysmal or persistent AF prior to initiation of Class I or III	May be appropriate to do	META

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antiarrhythmic therapy, undergoing close (non-left atrial open) cardiac surgery		
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AF: atrial fibrillation; META: Evidence from >1 high-quality RCT or meta-analyses of high-quality RCTs; PVI: pulmonary vein isolation; RAND: Evidence from 1 high-quality RCT or Evidence from >1 moderate-quality RCT or meta-analyses of moderate-quality RCTs; RCT: randomized controlled trial.

The following recommendations were made on stand-alone and hybrid surgical ablation (Table 6).

Table 6. Guidelines on Stand-Alone and Hybrid Surgical Ablation for Symptomatic Atrial Fibrillation

Recommendation	Category of advice	Type of Evidence
Stand-alone surgical or hybrid ablation is reasonable in symptomatic patients with persistent AF with prior unsuccessful catheter ablation and also in those who are intolerant or refractory to antiarrhythmic drug therapy and prefer a surgical/hybrid approach, after careful consideration of relative safety and efficacy of treatment options.	May be appropriate to do	META
Stand-alone surgical or hybrid ablation may be reasonable in symptomatic patients with paroxysmal AF with prior unsuccessful catheter ablations who prefer a surgical/hybrid approach, after careful consideration of relative safety and efficacy of treatment options	Area of uncertainty	RAND

AF: atrial fibrillation; META: Evidence from >1 high-quality RCT or meta-analyses of high-quality RCTs; RAND: Evidence from 1 high-quality RCT or Evidence from >1 moderate-quality RCT or meta-analyses of moderate-quality RCTs; RCT: randomized controlled trial.

American Association for Thoracic Surgery

In 2017, the American Association for Thoracic Surgery published guidelines on surgical ablation for AF. Recommendations on concomitant surgical ablation in patients with AF are provided in Table 7.

Table 7. 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

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"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
"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)."

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 8.

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Table 8. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT03546374 ^a	Irrigated Radio Frequency Ablation to Terminate Non-Paroxysmal Atrial Fibrillation (Terminate AF Study)	160	Dec 2026
NCT06165510	Convergent Ablation Plus Left Atrial Appendage Isolation for the Treatment of Persistent Atrial Fibrillation (CLIP-AF)	48	Oct 2026
NCT03737929	Comparison of the Efficacy of Hybrid Ablative Therapy for Patients With Persistent Atrial Fibrillation Versus Conventional Catheter Ablation (HT2AF)	228	Dec 2025
NCT05393180 ^a	Hybrid Convergent of Epicardial and Endocardial RF Ablation for the Treatment of Symptomatic Longstanding Persistent AF: CONVERGE Post-Approval Study (PAS)	53	Jan 2029
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
NCT05411614	A Randomised Controlled Trial Comparing Hybrid Convergent Ablation to Standard Catheter Ablation in Patients With Non-Paroxysmal Atrial Fibrillation (HALT-AF)	120	Oct 2027
NCT04715425	Thoracoscopic Surgical Versus Catheter Ablation Approaches for Primary Treatment of Persistent Atrial Fibrillation	170	Sep 2028
<i>Unpublished</i>			
NCT04237389	Comparative Assessment of Catheter and Thoracoscopic Approaches in Patients With Persistent and Long-standing Persistent Atrial Fibrillation (TACAAF)	60	Aug 2022 (unknown)

NCT: national clinical trial.

^a Denotes industry-sponsored or cosponsored trial.

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- with paroxysmal, permanent or persistent atrial fibrillation undergoing valvular and/or coronary bypass surgery. *J Cardiovasc Electrophysiol*. May 2010; 21(5): 511-20. PMID 19925605
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Policy History

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08/09/2018	Medical Policy Committee review
08/15/2018	Medical Policy Implementation Committee approval. New policy
08/01/2019	Medical Policy Committee review
08/14/2019	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/06/2020	Medical Policy Committee review
08/12/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/05/2021	Medical Policy Committee review
08/11/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/04/2022	Medical Policy Committee review
08/10/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/03/2023	Medical Policy Committee review
08/09/2023	Medical Policy Implementation Committee approval. Not medically necessary language for the use of an open maze or modified maze procedure performed on a non-beating heart during cardiopulmonary bypass without concomitant cardiac surgery for the treatment of atrial fibrillation or flutter changed to Investigational; intent unchanged.
09/05/2024	Medical Policy Committee review
09/11/2024	Medical Policy Implementation Committee approval. No change to coverage.
07/03/2025	Medical Policy Committee review
07/09/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

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04/01/2026 Code update
07/02/2026 Medical Policy Committee review
07/08/2026 Medical Policy Implementation Committee review
07/16/2026 Medical Quality Management Committee approval. The following was changed from investigational to not medically necessary:
“The use of the maze or modified maze procedure when coverage criteria are not met is considered to be not medically necessary, including but not limited to ANY of the following:

- Stand-alone minimally invasive, off-pump maze procedures (i.e., modified maze procedures), including those done via mini-thoracotomy for treatment of atrial fibrillation (AF) or flutter;
- An open maze or modified maze procedure performed on a non-beating heart during cardiopulmonary bypass without concomitant cardiac surgery for the treatment of atrial fibrillation or flutter.”

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

Next Scheduled Review Date: 07/2027

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®), copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.*

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Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	33254, 33255, 33256, 33257, 33258, 33259, 33265, 33266
HCPCS	No codes
ICD-10 Diagnosis	All Related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.