Transcoronary Ablation of Septal Hypertrophy (TASH)
Archived Medical Policy

Archived medical policies are no longer subject to periodic review, are maintained for reference, and may be returned to active status if the need is identified.

Policy # 00120
Original Effective Date: 11/21/2001
Archived Date: 01/09/2013

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.

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 transcoronary ablation of septal hypertrophy for the treatment of typical hypertrophic obstructive cardiomyopathy (HOCM) when drug therapy has failed or when surgical treatment is contraindicated to be eligible for coverage.

Patient Selection Criteria
Coverage eligibility will be considered for transcoronary ablation for the treatment of typical hypertrophic obstructive cardiomyopathy when the following selection criteria are met:

- Adult; and
- Documented diagnosis of symptomatic hypertrophic obstructive cardiomyopathy who have at least one branch suitable for intervention; and
- New York Heart Association (NYHA) class III or IV; and
- Drug refractory symptoms despite optimal drug therapy (e.g., beta-blockers, calcium antagonists).

<table>
<thead>
<tr>
<th>NYHA Classification is as follows:</th>
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<tbody>
<tr>
<td>Class I Mild</td>
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<tr>
<td>Class II Mild</td>
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<tr>
<td>Class III Moderate</td>
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<tr>
<td>Class IV Severe</td>
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</tbody>
</table>
When Services Are Considered Investigational

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

The use of transcoronary ablation of septal hypertrophy when patient selection criteria are not met is considered investigational.*

Background/Overview

Hypertrophic cardiomyopathy is a complex cardiac disease associated with diverse clinical, morphologic and pathophysiologic manifestations. However, one of the most characteristic abnormalities is a hypertrophied and nondilated left ventricle, which may impair diastolic filling. When the hypertrophy results in left ventricular outflow obstruction, dyspnea, angina, syncope or the development of congestive heart failure may occur. Pharmacologic therapies include beta-blockers or calcium-channel blockers to decrease the heart rate with a consequent prolongation in diastole and increased passive ventricular filling. If medical therapy is insufficient to control symptoms, strategies to reduce the outflow obstruction may be considered. Surgical reaction focuses on removing a small amount of myocardium at the base of the septum (myotomy-myomectomy). Dual-chamber pacing has also been explored as a means of decreasing the pressure gradient in the outflow tract, although results of randomized trials have been disappointing.

Transcoronary ablation of septal hypertrophy (TASH) has been explored as an alternative to open surgical septal resection. The technique involves infusion of ethanol through an angioplasty catheter threaded into the septal perforator branches of the left anterior descending artery to infarct and subsequently thin the bulging septum. A key component of the procedure is the identification of the target vessels. A balloon catheter is introduced into the septal branches. The balloon is inflated and contrast injected into the balloon lumen to delineate the area supplied by the septal branch and to ensure that the balloon inflation would prevent spillage of the subsequent injection of alcohol into the left anterior descending artery. Myocardial contrast echocardiography has also been used to target septal vessels. Echocardiographic contrast material may be injected into the balloon catheter and, using ultrasonography, the perfused area of the myocardium can be imaged from several different positions.

Transcoronary ablation of septal hypertension may also be referred to as ethanol septal ablation.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, FDA approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, Blue Cross and Blue Shield Association technology assessment program (TEC) and other non-affiliated technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.
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References

Coding
The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines (BCBSLAMPCG) are obtained from Current Procedural Terminology (CPT®), copyright 2012 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:

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
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<tbody>
<tr>
<td>CPT</td>
<td>93799</td>
</tr>
<tr>
<td>HCPCS</td>
<td>No code</td>
</tr>
<tr>
<td>ICD-9 Diagnosis</td>
<td>425.1, 425.2</td>
</tr>
<tr>
<td>ICD-9 Procedure</td>
<td>No code</td>
</tr>
</tbody>
</table>

Policy History
Original Effective Date: 11/21/2001
10/18/2001 Medical Policy Committee review
11/12/2001 Managed Care Advisory Council approval
06/24/2002 Format revision No substance change to policy.
10/21/2003 Medical policy Committee review. Revision to policy included addition of clinical guidelines.
01/26/2004 Managed Care Advisory Council approval
01/04/2005 Medical Director review
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01/18/2005 Medical Policy Committee review. Format revision. No substance change to policy.
01/31/2005 Managed Care Advisory Council approval
02/01/2006 Medical Director Review
02/15/2006 Medical Policy Committee review. Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
02/23/2006 Quality Care Advisory Council approval
02/07/2007 Medical Director review
02/21/2007 Medical Policy Committee approval. Coverage eligibility unchanged.
02/13/2008 Medical Director review
02/20/2008 Medical Policy Committee approval.
02/04/2009 Medical Director review
02/19/2009 Medical Policy Committee approval. No change to coverage eligibility.
02/04/2010 Medical Policy Committee approval
02/17/2010 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/03/2011 Medical Policy Committee review
02/16/2011 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/02/2012 Medical Policy Committee review
02/15/2012 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/03/2013 Medical Policy Committee review
01/09/2013 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: Archived medical policy

*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 the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated 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
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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: 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.