

Clinical Policy: Percutaneous Left Atrial Appendage Closure Device for Stroke Prevention

Reference Number: CP.MP.147

Date of Last Revision: 03/26

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Atrial fibrillation (AF), the most commonly encountered sustained tachyarrhythmia, is associated with a five-fold increased risk of stroke, and stroke risk increases with age.¹ Among patients with non-valvular AF, the vast majority of thrombus material is located within or involves the left atrial appendage (LAA). Most patients with AF should receive anticoagulant therapy to reduce the risk of systemic embolization, however, not all individuals are candidates for this therapy. LAA occlusion devices have been researched as an alternative to pharmacological therapy to reduce the risk of stroke in these individuals.

NOTE: *Per state requirements, any determination that a requested service or item is not medically necessary shall be made by a PHW/Centene Medical Director.*

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that Federal Drug Administration (FDA) approved percutaneous devices (i.e., WATCHMAN[™], WATCHMAN FLX[™], and Amplatzer[™] Amulet[™]) for occlusion of the left atrial appendage (LAA) are **medically necessary** to reduce the risk of stroke in adults with non-valvular atrial fibrillation (AF) when all of the following criteria are met:
 - A. There is an increased risk for stroke and systemic embolism based on CHADS₂ or CHA₂DS₂-VASc scores, and long-term anticoagulation therapy is recommended;
 - B. Contraindications or unacceptable high risk of bleeding from long-term oral anticoagulants;
 - C. Ability to tolerate short-term anticoagulants.

- II. It is the policy of health plans affiliated with Centene Corporation that current research does not support the use of percutaneous devices other than those noted above for occlusion of the LAA to reduce the risk of stroke in adults with non-valvular AF. There is a paucity of evidence regarding the long-term safety and efficacy of all other percutaneous devices for occlusion of the LAA, and at this time, no other devices are FDA approved for this indication.

Background

The individualized assessment of the risk-benefit balance is central to decision making regarding pharmacotherapy for stroke reduction in atrial fibrillation (AF). To estimate stroke risk, the ACC/American Heart Association/HRS Guideline for the Management of Patients with Atrial Fibrillation recommends the use of the CHA₂DS₂-VASc point score [Congestive heart failure, Hypertension, Age ≥ 75 years (doubled), Diabetes mellitus, prior Stroke, transient ischemic attack, or thromboembolism (doubled), Vascular disease, Age 65 to 74 years, Sex category), which provides an estimate of the potential benefits of therapy. Per the guideline, oral

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anticoagulation is a class I recommendation for patients with prior stroke, transient ischemic attack (TIA), or a CHA₂DS₂-VASc score ≥ 2 (estimated annual stroke risk of 2.2%) in the context of shared decision making, including a discussion of risks of stroke and bleeding, and the patient's preferences.²

Some patients with AF, whose stroke risk profiles would favor anticoagulation, have relative or absolute contraindications to anticoagulation. Others are unable or unwilling to adhere to long-term anticoagulation therapy. As a result, a number of percutaneous techniques that mechanically prevent embolization of left atrial appendage (LAA) thrombi, often referred to as LAA exclusion procedures, have been studied as an alternative to pharmacological therapy to reduce the risk of stroke. The percutaneous devices include two broad categories: endocardial plug devices to occlude the ostium of the LAA and epicardial LAA ligation procedures to exclude the LAA.

Currently, the WATCHMAN, WATCHMAN FLX, and the Amplatzer Amulet are the only FDA-approved percutaneous LAA closure devices.

The WATCHMAN device is deployed percutaneously via transseptal puncture and has a polyethylene membrane that covers a self-expanding nitinol cage with barbs to anchor the device in the LAA. The early findings for the WATCHMAN device suggest noninferiority to warfarin for the composite endpoint of stroke, systemic embolism, and cardiovascular death; however, early adverse events occur in approximately 10% of patients, including pericardial bleeding. Longer-term follow-up of the WATCHMAN device at 1588 patient-years suggests noninferiority of this device to warfarin.³ A subsequent registry study demonstrated that the WATCHMAN device achieved noninferiority in patients who could not receive warfarin. Quality of life was assessed in a subset of patients (361 device and 186 warfarin patients) enrolled in the PROTECT AF (Percutaneous Closure of the Left Atrial Appendage Versus Warfarin Therapy for Prevention of Stroke in Patients With Atrial Fibrillation) trial at baseline and 12 months. It was reported that patients with non-valvular AF at risk for stroke, treated with left atrial appendage closure, had favorable quality of life changes at 12 months versus patients treated with warfarin.⁴

The PREVAIL study was mandated by the US FDA to further evaluate the safety profile and confirm the efficacy of the WATCHMAN device for regulatory approval. This study randomly assigned 407 patients in a 2:1 ratio to WATCHMAN or warfarin. Results from the five-year outcomes of the PREVAIL trial and the PROTECT AF trial demonstrated that LAA closure with the WATCHMAN device provided stroke prevention in nonvalvular AF that was comparable to warfarin and included additional reductions in major bleeding and mortality.²⁰

The newer-generation WATCHMAN FLX is FDA approved and is widely replacing the WATCHMAN device in most centers.²⁰ The WATCHMAN FLX comes in five sizes with a slightly broader range of dimensions than the WATCHMAN. This device has a distal rounded edge and double row stabilizing anchors, which improves the safety of the procedure.^{20,24} A single-arm prospective registry of 400 patients, the PINNACLE FLX study, concluded that LAA closure with the WATCHMAN FLX device was associated with a low incidence of adverse events and a high incidence of anatomic closure.^{20,24}

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The second-generation Amplatzer Cardiac Plug device, the Amulet, received FDA approval in 2021, and includes design advances such as larger lobe size for occluding larger appendages and more stabilizing wires, which improves device stability. A key difference in the Amulet device is the possibility for patients to be discharged without oral anticoagulation immediately after the device has been implanted.²⁵ A multicenter registry report including 1,088 patients showed 99% procedural success with 3.2% of patients having major adverse events.²⁰ The Amulet IDE trial included 1,878 patients with AF who were randomly assigned to receive either the Amulet or WATCHMAN percutaneous LAA occlusion device. Follow up at 18 months showed similar results between the devices with a 2.8% rate of ischemic stroke or systemic embolism.

National Institute for Health and Clinical Excellence (NICE)

Current evidence suggests that percutaneous occlusion of the LAA is efficacious in reducing the risk of thromboembolic complications associated with nonvalvular AF. With regard to safety, there is a risk of life-threatening complications from the procedure, but the incidence of these is low. Therefore, this procedure may be used, provided that normal arrangements are in place for clinical governance, consent and audit.^{5,26} LAA occlusion should not be offered as an alternative unless anticoagulation is contraindicated or not tolerated.²⁶

European Society of Cardiology

Guidelines for the Management of Atrial Fibrillation states LAA occlusion may be considered for stroke prevention in patients with AF and contraindications for long-term anticoagulant treatment. (Class IIb recommendation-usefulness/efficacy is less well established by evidence/opinion.)⁸

American Heart Association/American College of Cardiology/ Heart Rhythm Society

The latest guideline on the management of patients with atrial fibrillation is a 2019 update of the 2014 AHA/ACC/HRS guidelines. This update addresses percutaneous approaches to occlude the LAA and has a new recommendation that percutaneous LAA occlusion may be considered in patients with AF at increased risk of stroke who have contraindications to long-term anticoagulation. FDA approval of the WATCHMAN and clinical trial data necessitated this recommendation.¹

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial

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CPT® Codes	Description
	angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy adopted from Health Net NMP 376, Left Atrial Appendage Devices	06/17	07/17
Replaced “investigational” in II with “there is a paucity of evidence regarding the long-term safety and efficacy of all other percutaneous devices for occlusion of the LAA ...” References reviewed and updated. Verbiage edits to I.B, adding contraindications of 1.-11, in addition to the note regarding Warfarin.	04/21	05/21
Annual Review. Updated criteria I and criteria II to include all FDA approved percutaneous devices for occlusion of the LAA (WATCHMAN, WATCHMAN FLX, Amplatzer Amulet) and removed verbiage that the WATCHMAN is the only FDA approved device. Updated background to include information on WATCHMAN FLX and Amplatzer Amulet devices with updated notation that both devices are FDA approved and removed verbiage that the WATCHMAN is the only FDA approved device. Updated AHA/ACC/HRS recommendation in background. References reviewed and updated. Changed “Review Date” in policy header to “Date of Last Revision,” and “Date” in the revision log header to “Revision Date.” Specialist reviewed.	05/22	05/22
Annual review completed. Minor rewording with no clinical significance. Background updated with no impact to clinical criteria. ICD-10 diagnosis code table removed. References reviewed and updated.	05/23	05/23
Annual review. References reviewed and updated. Reviewed by external specialist.	05/24	05/24
Annual review. Changed “both” to “all” of the following in criteria I. Removed contraindications I.B.1.-I.B.11. Thrombocytopenia or known coagulation... Added criteria I.C. “Ability to tolerate short-term anticoagulants”. Removed Note: Warfarin may be required... References reviewed and updated. Reviewed by internal specialist.	03/25	03/25
Annual review. References reviewed and updated. Added state coverage statement and reviewed by an internal specialist & external specialist.	03/26	6/11//26

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- warfarin therapy: the PREVAIL trial [published correction appears in *J Am Coll Cardiol*. 2014 Sep 16;64(11):1186]. *J Am Coll Cardiol*. 2014;64(1):1 to 12. doi:10.1016/j.jacc.2014.04.029
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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

- Note: *Per state requirements, any determination that a requested service or item is not medically necessary shall be made by a PHW/Centene Medical Director.*

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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