Partial Left Ventriculectomy

Medical Policy

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Policy Number: 438
BCBSA Reference Number: 7.01.66A

Related Policies
None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Partial left ventriculectomy is NOT MEDICALLY NECESSARY.

Medicare Members: Managed Care HMO BlueSM and Medicare PPO BlueSM
BCBSMA does not cover partial left ventriculectomy for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD:

National Coverage Determination (NCD) for Partial Ventriculectomy (20.26)

Prior Authorization Information
Commercial Members: Managed Care (HMO and POS)
This is NOT a covered service.

Commercial Members: PPO, and Indemnity
This is NOT a covered service.

Medicare Members: HMO BlueSM
This is NOT a covered service.

Medicare Members: PPO BlueSM
This is NOT a covered service.
Description

Partial left ventriculectomy (PLV) is a surgical procedure aimed at improving the hemodynamic status of patients with end-stage congestive heart failure (CHF) by directly reducing left ventricular size, and thereby improving the pump function of the left ventricle (LV).

This surgical approach to the treatment of congestive heart failure (CHF) (also known as the Batista procedure, cardio-reduction, or left ventricular remodeling surgery) is primarily directed at patients with an underlying non-ischemic dilated cardiomyopathy. Initially, the procedure was intended for patients awaiting cardiac transplantation, either as a “bridge” to transplantation or as an alternative to transplantation. The theoretical rationale for this procedure is that by reducing left ventricular wall volume, LV wall tension is reduced and LV pumping function will be improved.

The original PLV procedure, as developed by Batista, involves a wide excision of the posterolateral wall and apex of the heart and removal of a wedge-shaped portion of the LV. PLV may be accompanied by repair of the mitral valve, either through valvuloplasty or annuloplasty. A variety of complications of PLV have been reported, including sudden death, progressive heart failure, arrhythmias, bleeding, renal failure, respiratory failure, and infection. More recently, modifications have been suggested that remove the septal-anterior wall preferentially, also called anterior PLV. The decision on the optimal approach may be determined by the degree of fibrosis seen in the apex and lateral walls.

Summary

Some clinical series have reported improvement in ejection fraction and symptoms following PLV; however, there is a lack of controlled trials comparing this procedure to alternative treatments. Perioperative mortality and complications are high, and the improvements reported in symptoms may not be a result of the surgical procedure. The high rates of perioperative morbidity and mortality, the lack of demonstrated long-term outcome benefits, and the high relapse rates, have led to diminished enthusiasm for this procedure. As a result of the lack of evidence on benefits from the procedure, and the possibility of harms, PLV is considered not medically necessary.
Policy History

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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References