

# Catheter Ablation for Atrial Fibrillation

Policy Number: CS197.E  
Effective Date: June 1, 2022

[Instructions for Use](#)

Table of Contents	Page
<a href="#">Application</a> .....	1
<a href="#">Coverage Rationale</a> .....	1
<a href="#">Applicable Codes</a> .....	1
<a href="#">U.S. Food and Drug Administration</a> .....	2
<a href="#">References</a> .....	2
<a href="#">Policy History/Revision Information</a> .....	2
<a href="#">Instructions for Use</a> .....	3

Commercial Policy
• <a href="#">Catheter Ablation for Atrial Fibrillation</a>

## Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	None
Kentucky	<a href="#">Catheter Ablation for Atrial Fibrillation (for Kentucky Only)</a>
Louisiana	<a href="#">Catheter Ablation for Atrial Fibrillation (for Louisiana Only)</a>
Nebraska	<a href="#">Catheter Ablation for Atrial Fibrillation (for Nebraska Only)</a>
New Jersey	<a href="#">Catheter Ablation for Atrial Fibrillation (for New Jersey Only)</a>
Pennsylvania	<a href="#">Catheter Ablation for Atrial Fibrillation (for Pennsylvania Only)</a>
Tennessee	<a href="#">Catheter Ablation for Atrial Fibrillation (for Tennessee Only)</a>

## Coverage Rationale

Catheter ablation for atrial fibrillation is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Radiofrequency Ablation (RFA), Cardiac.

Click [here](#) to view the InterQual® criteria.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarification: American Medical Association (AMA) coding guidelines require diagnosis coding to the highest level of specificity available. Also, per AMA guidelines, CPT code 93653 should not be reported in conjunction with 93656 (AMA, 2020).

CPT Code	Description
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry
93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed
93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)

*CPT® is a registered trademark of the American Medical Association*

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The FDA classifies ablation catheters using any type of energy for the treatment of atrial fibrillation as class III devices. Premarket approval (PMA) prior to marketing is required. For additional information, search the following database using product code OAE: <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm>. (Accessed October 27, 2021)

## References

American Medical Association. 2021 ICD-10-CM Official guidelines for coding and reporting.

## Policy History/Revision Information

Date	Summary of Changes
06/01/2022	<p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>Removed reference to specific InterQual® release date; refer to the most current InterQual® criteria</li> </ul> <p><b>Application</b></p> <p><i>Mississippi and North Carolina</i></p> <ul style="list-style-type: none"> <li>Updated language to indicate this Medical Policy applies to the states of Mississippi and North Carolina (retired state-specific policy versions)</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Archived previous policy version CS197.D</li> </ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice. UnitedHealthcare may also use tools developed by third parties, such as the InterQual<sup>®</sup> criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.