Catheter Ablation for Atrial Fibrillation

Policy Number: SURGERY 115.2 T2
Effective Date: September 1, 2020

Instructions for Use

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Related Policies
None

Coverage Rationale

Catheter ablation for atrial fibrillation is proven and medically necessary in certain circumstances.
For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 24th edition, 2020, Electrophysiologic Study and Intracardiac Catheter Ablation ORG: M-154 (ISC).

Click here to view the MCG™ Care Guidelines.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Required Clinical Information
Catheter Ablation for Atrial Fibrillation
Medical notes documenting all of the following: • Diagnosis • Signs and symptoms • History of present illness • Results of diagnostic testing • Treatments tried and failed • Physician treatment plan

Prior Authorization Requirements

Prior authorization is required in all sites of service.

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 the member specific benefit plan document 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 may apply.

CPT Code	Description
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation
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)

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 March 10, 2020.

References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [*2020T0609A*]

Policy History/Revision Information

Date	Summary of Changes

09/01/2020	**Template Update**
	• Reformatted policy; transferred content to new template
	• Removed and replaced section titled *Conditions of Coverage* with *Prior Authorization Requirements*
	  ○ Simplified and relocated language pertaining to prior authorization guidelines
	  ○ Removed language addressing benefit type and referral requirements (refer to the member specific benefit plan document)
	• Replaced references to “precertification” with “prior authorization”
	Supporting Information
	• Archived previous policy version SURGERY 115.1 T2

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates.

UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical 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.