



Catheter Ablation for Atrial Fibrillation

Policy Number: 2023T0609L
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[Instructions for Use](#)

Table of Contents	Page
Application	1
Coverage Rationale	1
Documentation Requirements	1
Applicable Codes	2
U.S. Food and Drug Administration	2
References	3
Policy History/Revision Information	3
Instructions for Use	3

Community Plan Policy
• Catheter Ablation for Atrial Fibrillation

Application

UnitedHealthcare Commercial

This Medical Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado.

Coverage Rationale

Note: This policy does not apply to members ages < 18 years or to arrhythmias other than atrial fibrillation.

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) or Cryothermal Ablation, Cardiac.

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

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.

CPT Codes*	Required Clinical Information
Catheter Ablation for Atrial Fibrillation	
93653 93656	Medical notes documenting the following, when applicable: <ul style="list-style-type: none"> • Diagnosis • Signs and symptoms • History of present illness • Results of diagnostic testing • Treatments tried and failed • Physician treatment plan

*For code descriptions, refer to the [Applicable Codes](#) section.

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 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 transeptal 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)

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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 25, 2022)

References

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

Policy History/Revision Information

Date	Summary of Changes
10/01/2023	<p data-bbox="337 361 487 388">Application</p> <p data-bbox="337 396 678 424"><i>Individual Exchange Plans</i></p> <ul data-bbox="337 432 1458 491" style="list-style-type: none"><li data-bbox="337 432 1458 491">• Removed language indicating this Medical Policy does not apply to Individual Exchange benefit plans in the states of Massachusetts, Nevada, and New York <p data-bbox="337 499 643 527">Supporting Information</p> <ul data-bbox="337 535 902 562" style="list-style-type: none"><li data-bbox="337 535 902 562">• Archived previous policy version 2023T0609K

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare 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 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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. 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.