Catheter Ablation for Atrial Fibrillation (for Nebraska Only)

Policy Number: CS197NE.I
Effective Date: February 1, 2025

Instructions for Use

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Related Policies
None

Application

This Medical Policy only applies to the State of Nebraska.

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.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews.

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, 2024).

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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 with transseptal catheterizations, insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography with imaging supervision and interpretation, 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 August 13, 2024)

References

American Medical Association (AMA). Current Procedural Terminology (CPT®). 2024.

Policy History/Revision Information

Date	Summary of Changes
10/01/2025	• Created state-specific policy version for the state of Nebraska (no change to coverage guidelines)
06/01/2025	**Medical Records Documentation Used for Reviews** • Updated reference link to the guidelines titled *Medical Records Documentation Used for Reviews*

02/01/2025	**Medical Records Documentation Used for Reviews**
	• Added language to indicate:
	  ○ Benefit coverage for health services is determined by federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service
	  ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the protocol titled Medical Records Documentation Used for Reviews
	Applicable Codes
	• Updated list of applicable CPT codes to reflect annual edits; revised description for CPT code 93656
	Supporting Information
	• Updated *References* section to reflect the most current information
	• Archived previous policy version CS197.H

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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® 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.

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