

# Catheter Ablation for Atrial Fibrillation

**Policy Number:** 2025T0609P**Effective Date:** May 1, 2025 [Instructions for Use](#)

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## Community Plan Policy

- [Catheter Ablation for Atrial Fibrillation](#)

## Application

### UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

### UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

## 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 member specific benefit plan document 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

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, 2024).

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)

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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
05/01/2025	<p><b>Template Update</b></p> <ul style="list-style-type: none"><li>Created shared policy version to support application to Rocky Mountain Health Plans membership</li></ul> <p><b>Application</b></p> <p><b>Individual Exchange</b></p> <ul style="list-style-type: none"><li>Removed language indicating this Medical Policy does not apply to the state of Colorado</li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>Archived previous policy version 2025T0609O</li></ul>

## 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.