

# Catheter Ablation for Atrial Fibrillation (for Nebraska Only)

**Policy Number:** CS197NE.J  
**Effective Date:** February 1, 2026

[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 aged < 18 years or those with 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 +/- Catheter 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 services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

## 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).

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 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 September 9, 2025)

## References

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

## Policy History/Revision Information

Date	Summary of Changes
02/01/2026	<p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>Replaced reference to “InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Radiofrequency Ablation (RFA) or Cryothermal Ablation, Cardiac” with “InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Catheter Ablation, Cardiac”</li> </ul> <p><b>Medical Records Documentation Used for Reviews</b></p> <ul style="list-style-type: none"> <li>Removed reference link to the guidelines titled <i>Medical Records Documentation Used for Reviews</i></li> <li>Added language to indicate: <ul style="list-style-type: none"> <li>The patient's medical record must contain documentation that fully supports the medical necessity for the requested services</li> <li>This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures</li> <li>Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request</li> </ul> </li> </ul>

Date	Summary of Changes
	<p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Archived previous policy version CS197NE.I</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, 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.