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MEDICAL POLICY – 2.02.516

Catheter Ablation as Treatment for Atrial Fibrillation

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Effective Date:	**July 3, 2025***	RELATED MEDICAL POLICIES:
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Select a hyperlink below to be directed to that section.

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Atrial fibrillation, or AFib, is a condition where the heart beats irregularly or too fast due to abnormal electrical signals. This can lead to fatigue, shortness of breath, or even serious complications like stroke. Catheter ablation is a minimally invasive procedure designed to correct these irregular signals. The technique involves the insertion of a thin, flexible tube called a catheter into a blood vessel and guiding it to the heart. Once in position, the catheter delivers energy, such as heat or cold, to the specific areas causing the abnormal signals. This process creates small, controlled scars that block the faulty electrical pathways, allowing the heart to return to a normal rhythm. This policy describes when catheter ablation may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Service	Medical Necessity
Transcatheter radiofrequency ablation (RFA), cryoablation or pulsed field ablation to treat atrial fibrillation	**Transcatheter radiofrequency ablation (RFA), cryoablation, or pulsed field ablation to treat atrial fibrillation may be considered medically necessary as a treatment for either of the following indications:** • Symptomatic paroxysmal (intermittent) atrial fibrillation that is recurrent (2 or more episodes) as an alternative to medical therapy; **OR** • Symptomatic persistent atrial fibrillation that is refractory or intolerant to one or more antiarrhythmic medications (or there is a contraindication to all appropriate antiarrhythmic drugs) (See **Definition of Terms**)
Repeat RFA, cryoablation, or pulsed field ablation	**Repeat RFA, cryoablation, or pulsed field ablation may be considered medically necessary in individuals with recurrence of atrial fibrillation and/or development of atrial flutter following the initial procedure (See Related Information).**
Transcatheter RFA, cryoablation, or pulsed field ablation	**Transcatheter RFA, cryoablation, or pulsed field ablation to treat atrial fibrillation is considered not medically necessary as a treatment for cases of atrial fibrillation that do not meet the criteria outlined above.**

Documentation Requirements

The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the relevant history and physical documenting one of these indications
  - Symptomatic paroxysmal (intermittent) atrial fibrillation that is recurrent (2 or more episodes) as an alternative to medical therapy

OR

  - Symptomatic persistent atrial fibrillation that is refractory or intolerant to one or more antiarrhythmic medications (or there is a contraindication to all appropriate antiarrhythmic drugs)

Repeat RFA, cryoablation, or pulsed field ablation may be considered medically necessary when documentation shows recurrence of atrial fibrillation and/or development of atrial flutter following the initial procedure.

Coding

Code	Description
CPT	
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)

Related Information

Definition of Terms

Commonly used antiarrhythmic medications (this list may not be all inclusive)

- Amiodarone
- Dofetilide
- Dronedarone
- Flecainide
- Propafenone

- Sotalol

Heart Rate Control is a common method of treatment of atrial fibrillation that controls the heartbeat through medication that helps slow the rate of the heart and its contractions such as beta blockers, calcium channel blockers, or digoxin.

Heart Rhythm Control is a method of treatment of atrial fibrillation that is used once the heart rate is under control, then medications are used to return the heart rhythm to normal (sinus rhythm) such as sodium or potassium channel blockers. If medication fails to return the heart rhythm to normal then other measures such as electrical cardioversion, catheter ablation of the left atrium or pulmonary vein is performed, or a surgical ablation may be required (i.e., the Maze procedure).

Symptomatic paroxysmal atrial fibrillation is intermittent irregular heartbeats that usually return to normal within seven days or less that may be accompanied by heart palpitations, chest pain or pressure, dizziness, fainting, fatigue or weakness, and shortness of breath.

Symptomatic persistent atrial fibrillation is an irregular heartbeat that lasts longer than 7 days and does not return to normal on its own. This condition may worsen and can become permanent. Symptoms include a racing heart (heart palpitations), feeling like your heart is skipping a beat, or quivering. Persistent atrial fibrillation increases your risk for stroke.

As many as 30% of individuals will require a follow-up (repeat) procedure, due to recurrence of AF or to development of atrial flutter. In most published studies, success rates have been based on having as many as 3 separate procedures, although these repeat procedures may be more limited in scope than the initial procedure.

It is currently unknown whether there is a feature of the pulsed field ablation approach that alters the conventional 3-month blanking period. Pulsed field ablation is purported to have a desirable safety profile through the avoidance of thermal injury compared to other catheter ablation methods.

Transcatheter treatment of atrial fibrillation (AF) may include pulmonary vein isolation and/or focal ablation.

There is no single procedure for catheter ablation. Electrical isolation of the pulmonary vein musculature (pulmonary vein isolation) is the cornerstone of most AF ablation procedures, but additional ablation sites may be included during the initial ablation.

Potential additional ablation procedures include:

- Creation of linear lesions within the left atrium
- Ablation of focal triggers outside the pulmonary veins

- Ablation of areas with complex fractionated atrial electrograms
- Ablation of left atrial ganglionated plexi

The specific ablation sites may be determined by electroanatomic mapping to identify additional sites of excitation. As a result, sites may vary from individual to individual, even if they are treated by the same physician. Individuals with long-standing persistent AF may need more extensive ablation. Similarly, repeat ablation procedures for recurrent AF generally involve more extensive ablation than initial procedures.

Benefit Application

Pulmonary vein ablation for treatment of atrial fibrillation is a specialized procedure that may prompt out-of-network referral.

Evidence Review

Description

Atrial fibrillation (AF) frequently arises from an abnormal focus at or near the junction of the pulmonary veins and the left atrium, thus leading to the feasibility of more focused ablation techniques directed at these structures. Catheter-based ablation, using radiofrequency ablation or cryoablation, is a treatment option for various types of AF. Pulsed field ablation is a novel ablation technique for AF.

Background

Atrial Fibrillation

Atrial fibrillation (AF) is the most common cardiac arrhythmia, with an estimated prevalence of 0.4% of the population, increasing with age. The underlying mechanism of AF involves the interplay between electrical triggering events and the myocardial substrate that permits propagation and maintenance of the aberrant electrical circuit. The most common focal trigger of AF appears to be located within the cardiac muscle that extends into the pulmonary veins.

Atrial fibrillation can be subdivided into three types: paroxysmal, persistent, and permanent. Atrial fibrillation accounts for approximately one-third of hospitalizations for cardiac rhythm disturbances. Symptoms of AF (e.g., palpitations, decreased exercise tolerance, dyspnea) are primarily related to poorly controlled or irregular heart rate. The loss of atrioventricular synchrony results in a decreased cardiac output, which can be significant in patients with compromised cardiac function. Also, patients with AF are at higher risk for stroke, with anticoagulation typically recommended. Atrial fibrillation is also associated with other cardiac conditions, such as valvular heart disease, heart failure, hypertension, and diabetes. Although episodes of AF can be converted to normal sinus rhythm using pharmacologic or electroshock conversion, the natural history of AF is that of recurrence, thought to be related to fibrillation-induced anatomic and electrical remodeling of the atria.

Treatment strategies can be broadly subdivided into rate control, in which only the ventricular rate is controlled, and the atria are allowed to fibrillate, or rhythm control, in which there is an attempt to re-establish and maintain normal sinus rhythm. Rhythm control has long been considered an important treatment goal for the management of AF, although its primacy has recently been challenged by the results of several randomized trials reporting that pharmacologically maintained rhythm control offered no improvement in mortality or cardiovascular morbidity compared with rate control.

However, rhythm control is not curative. A variety of ablative procedures have been investigated as potentially curative approaches, or as modifiers of the arrhythmia so that drug therapy becomes more effective. Ablative approaches focus on the interruption of the electrical pathways that contribute to AF through modifying the arrhythmia triggers and/or the myocardial substrate that maintains the aberrant rhythm. The maze procedure, an open surgical procedure often combined with other cardiac surgeries (e.g., valve repair), is an ablative treatment that involves sequential atriotomy incisions designed to create electrical barriers that prevent the maintenance of AF. Because of the highly invasive nature of this procedure, it is currently mainly reserved for patients undergoing open-heart surgery for other reasons (e.g., valve repair, coronary artery bypass grafting).

Catheter Ablation for Atrial Fibrillation

Radiofrequency ablation (RFA) using a percutaneous catheter-based approach is widely used to treat a variety of supraventricular arrhythmias, in which intracardiac mapping identifies a discrete arrhythmogenic focus that is the target of ablation. The situation is more complex for AF because there may be no single arrhythmogenic focus. Atrial fibrillation most frequently arises from an abnormal focus at or near the junction of the pulmonary veins and the left atrium, thus

leading to the feasibility of more focused, percutaneous ablation techniques. Strategies that have emerged for focal ablation within the pulmonary veins originally involved segmental ostial ablation guided by pulmonary vein potential (electrical approach) but currently more typically involve circumferential pulmonary vein ablation (anatomic approach). Circumferential pulmonary vein ablation using radiofrequency energy is the most common approach at present.

Research into specific ablation and pulmonary vein isolation techniques is ongoing.

The use of current radiofrequency catheters for AF has a steep learning curve because they require extensive guiding to multiple ablation points. The procedure can also be done using cryoablation technology. One of the potential advantages of cryoablation is that cryoablation catheters have a circular or shaped endpoint, permitting a "one-shot" ablation.

Pulsed field ablation (PFA) employs a series of brief electrical pulses to desiccate tissue without significantly heating the tissue and is believed to be more selective for myocardial tissue than other ablative techniques. Two PFA devices were recently approved in the US.

Repeat Procedures

Repeat procedures following initial RFA are commonly performed if AF recurs or if atrial flutter develops post-procedure. The need for repeat procedures may, in part, depend on the clinical characteristics of the individual (e.g., age, persistent vs paroxysmal AF, atrial dilatation), and the type of ablation initially performed. Repeat procedures are generally more limited in scope than the initial procedure. Additional clinical factors associated with the need for a second procedure include the length of AF, permanent AF, left atrial size, and left ventricular ejection fraction.

Summary of Evidence

For individuals who have symptomatic paroxysmal or persistent atrial fibrillation (AF) who have failed antiarrhythmic drugs who receive radiofrequency ablation (RFA) or cryoablation, the evidence includes multiple randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are overall survival (OS), symptoms, morbid events, and quality of life. The RCTs comparing RFA with antiarrhythmic medications have reported that freedom from AF is more likely after ablation than after medications. Results of long-term follow-up (5 to 6 years) after ablation have demonstrated that late recurrences continue in patients who are free of AF at 1 year. However, most patients who are AF-free at 1 year remain AF-free at 4 to 6 years. Radio frequency ablation and cryoablation differ in their adverse event profiles. For example,

cryoablation is associated with higher rates of phrenic nerve paralysis but may permit a shorter procedure time. Given current data, it would be reasonable to consider both RFA and cryoablation effective for catheter ablation of AF foci or pulmonary vein isolation, provided there is a discussion about the risks and benefits of each. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have symptomatic AF and congestive heart failure who have failed rate control and antiarrhythmic drugs who receive RFA or cryoablation, the evidence includes RCTs and systematic reviews. Relevant outcomes are OS, symptoms, morbid events, and quality of life. Findings from the RCTs have been supported by other comparative studies, which have reported improvements in AF. It is reasonable to consider both RFA and cryoablation effective for catheter ablation of AF foci or pulmonary vein isolation, provided that there is a discussion about the risks and benefits of each. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have recurrent symptomatic paroxysmal AF who receive RFA or cryoablation as an initial rhythm-control strategy, the evidence includes RCTs, nonrandomized studies, and systematic reviews. Relevant outcomes are OS, symptoms, morbid events, and quality of life. One RCT with adequate follow-up compared pulmonary vein isolation by catheter ablation (using either cryoablation or RFA) to medical therapy. Catheter ablation was not superior to medical therapy for major cardiovascular outcomes, but secondary outcomes including AF recurrence favored catheter ablation. Quality of life measures reported in this RCT favored catheter ablation. Two other RCTs with low risk of bias compared RFA for pulmonary vein isolation with antiarrhythmic medications. One RCT demonstrated reduced rates of AF recurrence, while the other reported reduced cumulative overall AF burden. Additionally, three RCTs comparing cryoablation to antiarrhythmic drug therapy as first-line therapy demonstrated improved outcomes for atrial arrhythmia recurrence up to one year. In a meta-analysis of six RCTs, catheter ablation as first-line therapy significantly reduced the risk of recurrence of atrial arrhythmia and the rate of hospitalizations compared to antiarrhythmic drug therapy. In another meta-analysis of the same RCTs, treatment ranking based on the surface under the cumulative ranking curve ranked RFA as most likely to be the best treatment for reducing the overall rates of AF recurrence, symptomatic recurrence, and hospitalizations, whereas cryoablation was most likely to reduce serious adverse events. Together, these results suggest that, when a rhythm-control strategy is desired, catheter ablation using RFA or cryoablation is a reasonable alternative to antiarrhythmic drug therapy. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have symptomatic paroxysmal or persistent AF who have failed antiarrhythmic drugs who receive pulsed field ablation, the evidence includes RCTs. Relevant

outcomes are overall survival (OS), symptoms, morbid events, and quality of life. One noninferiority RCT compared PFA with thermal ablation techniques in patients with paroxysmal AF. PFA was found to be noninferior for the primary composite outcome of initial procedural failure, documented atrial tachyarrhythmia after a 3-month blanking period, antiarrhythmic drug use, cardioversion, or repeat ablation. The incidence of serious adverse events was similar between groups. The publication provided minimal reporting of thermal ablation technique. One noninferiority RCT compared dual energy PFA and RFA to RFA in patients with persistent AF. Dual energy PFA and RFA were found to be noninferior to RFA for the primary effectiveness and safety outcomes. Both RCTs included primarily White participants. Numerous nonrandomized trials have been conducted and found high success rates with acceptable safety. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome. (See **Clinical Input** below).

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in **Table 1**.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT05159492	Ground-Breaking Electroporation-based Intervention for PAROXysmal Atrial Fibrillation Treatment (BEAT PAROX-AF)	292 (Actual)	Feb 2025
NCT05971693	Safety and Effectiveness Evaluation of the OMNYPULSE Catheter With the TRUPULSE Generator for Treatment of Paroxysmal Atrial Fibrillation (PAF)	160	Apr 2025
NCT06039722	Prospective, Multicenter, Single-arm Clinical Trial Evaluating the Safety and Efficacy of the Pulse Field Ablation System in Combination With the Pulse Field Ablation Catheter for the Treatment of Paroxysmal Atrial Fibrillation	166	Aug 2024

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT05717725	Pulsed-field Ablation Versus Sham Ablation to Treat Atrial Fibrillation	60	Dec 2024
NCT04942171	EMOTIon and COgNitive Function After Atrial FibrillationCatheter Ablation vs. Medical Therapy; Randomized Clinical Trial (EMOTICON Trial)	320	Feb 2026
NCT02150902	Augmented Wide Area Circumferential Catheter Ablation for Reduction of Atrial Fibrillation Recurrence (AWARE)	411	Sep 2025
NCT04037397	First Line Radiofrequency Ablation Versus Antiarrhythmic Drugs for Persistent Atrial Fibrillation Treatment (RAAFT-3)	25 (Actual)	Oct 2024
NCT05534581	Single Shot Pulmonary Vein Isolation: Comparison of Cryoballoon vs. Pulsed Field Ablation in Patients With Symptomatic Paroxysmal Atrial Fibrillation - A Multi-Center Non-Inferiority Design Clinical Trial (The SINGLE SHOT CHAMPION Trial)	210	Jan 2027
Unpublished			
NCT02106663	Evaluating the Efficacy of Circumferential Pulmonary Vein Ablation (CPVA) Versus Segmental Pulmonary Vein Isolation (SPVI) in Paroxysmal Atrial Fibrillation	97	Dec 2021

NCT: national clinical trial.

Clinical Input Received from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2025 Input

Clinical input was sought to help determine whether the use of pulsed field ablation for individuals with symptomatic paroxysmal or persistent atrial fibrillation who have failed antiarrhythmic drugs would provide a clinically meaningful improvement in net health outcome and represents generally accepted medical practice in selected patients. In response to requests, clinical input was received from 3 respondents, including 2 specialty society-level responses. For individuals with symptomatic paroxysmal or persistent atrial fibrillation who have failed antiarrhythmic drugs, there was consensus that this use provides a clinically meaningful improvement in net health outcomes and indicates this use is consistent with generally accepted medical practice.

2015 Input

In response to requests, input was received from three physician specialty societies (Six reviewers) and four academic medical centers while this policy was under review in 2015. Input focused on the use of ablation as an initial procedure for symptomatic paroxysmal and persistent atrial fibrillation (AF) and the use of cryoablation for AF. There was consensus supporting the use of radiofrequency ablation (RFA) as an initial treatment for symptomatic paroxysmal AF, and the use of cryoablation as an alternative to RFA as a treatment for AF. For the use of RFA as initial treatment for symptomatic persistent AF, support from clinical input was more mixed.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or the National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Heart Association

In 2021, the American Heart Association published a scientific statement regarding the management of atrial fibrillation in patients with heart failure.[84] The statement included the following:

"In patients with AF and heart failure with reduced ejection fraction (HFrEF) who already have an indication for a cardiac resynchronization therapy defibrillator (CRT-D) device such as left bundle-branch block (LBBB) and in whom AF remains poorly controlled despite maximum efforts at restoration and maintenance of sinus rhythm or pharmacological rate control, atrioventricular node (AVN) ablation should be considered for rate control and promotion of adequate biventricular pacing

- In patients with AF and HFrEF who have a narrow QRS but in whom AF remains poorly controlled despite maximum efforts at restoration and maintenance of sinus rhythm or pharmacological rate control, a strategy of AV node ablation with cardiac resynchronization therapy (CRT) implantation is reasonable, and
- In patients with AF and HFrEF, surgical AF ablation is reasonable in those patients undergoing concomitant cardiac surgery"

American College of Cardiology et al

In 2023, the American College of Cardiology, American Heart Association, American College of Clinical Pharmacy, and Heart Rhythm Society (ACC/AHA/ACCP/HRS) updated guidelines for the management of patients with AF.[83] The recommendations specific to catheter ablation are summarized in **Table 2**. In addition, the guidelines recommend, "PVI [pulmonary vein isolation] is recommended as the primary lesion set for all patients unless a different specific trigger is identified." However, no particular ablation method is recommended.

Table 2. Guidelines for Rate and Rhythm in Management of Atrial Fibrillation

Recommendation	COR	LOE
"In patients with symptomatic AF in whom antiarrhythmic drugs have been ineffective, contraindicated, not tolerated or not preferred, and continued rhythm control is desired, catheter ablation is useful to improve symptoms."	1	A

Recommendation	COR	LOE
"In selected patients (generally younger with few comorbidities) with symptomatic paroxysmal AF in whom rhythm control is desired, catheter ablation is useful as first-line therapy to improve symptoms and reduce progression to persistent AF."	1	A
"In patients with symptomatic or clinically significant AFL, catheter ablation is useful for improving symptoms."	1	A
"In patients who are undergoing ablation for AF, ablation of additional clinically significant supraventricular arrhythmias can be useful to reduce the likelihood of future arrhythmia."	2a	B-NR
"In patients (other than younger with few comorbidities) with symptomatic paroxysmal or persistent AF who are being managed with a rhythm-control strategy, catheter ablation as first-line therapy can be useful to improve symptoms."	2a	B-R
"In selected patients with asymptomatic or minimally symptomatic AF, catheter ablation may be useful for reducing progression of AF and its associated complications."	2b	B-NR

AF: atrial fibrillation; AFL: atrial flutter; COR: class of recommendation; LOE: level of evidence.

a Where 1 is a strong recommendation, 2a is moderate, and 2b is a weak recommendation.

b Where Level A is evidence from more than 1 RCT/meta-analyses of RCTs, Level B-R is moderate quality evidence from 1 or more RCTs, and Level B-NR is moderate quality evidence from 1 or more well-designed nonrandomized studies.

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

In February 2009, the NaviStar ThermoCool Irrigated Deflectable Diagnostic/Ablation Catheter and EZ Steer ThermoCool NAV Catheter (Biosense Webster) received expanded approval by the US Food and Drug Administration (FDA) through the premarket approval process for RFA to treat drug-refractory recurrent symptomatic paroxysmal AF. FDA product code: OAD.

Devices using laser or cryoablation techniques for substrate ablation have been approved by the FDA through the premarket approval process for AF (FDA product code: OAE). They include:

- Arctic Front Cardiac CryoAblation Catheter and CryoConsole (Medtronic) in 2010.
- TactiCath Quartz Catheter and TactiSysQuartz Equipment (St. Jude Medical) in 2014.

- HeartLight Endoscopic Ablation System (Cardiofocus) in 2016.
- The Freezor Xtra Catheter (Medtronic) in 2016.

Pulsed field ablation (non-thermal energy) devices have also been approved by the FDA for catheter ablation of atrial fibrillation FARAPULSE (Boston Scientific) is approved for paroxysmal AF in drug-resistant patients. PulseSelect (Medtronic) is approved for both paroxysmal and persistent AF. Sphere-9 Catheter and Affera Ablation System (Medtronic) are capable of delivering either radiofrequency energy or pulsed field energy and approved for drug refractory, recurrent, symptomatic persistent atrial fibrillation (episode duration less than 1 year). (FDA product code: QZI).

Also, numerous catheter ablation systems have been approved by the FDA for other ablation therapy for arrhythmias such as supraventricular tachycardia, atrial flutter, and ventricular tachycardia. FDA product code: LPB.

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History

Date	Comments
09/14/04	New policy 2.02.19 Catheter Ablation of the Pulmonary Veins as Treatment for Atrial Fibrillation. Add to Medicine / Cardiology Section.
07/12/05	Replace Policy - Policy updated with literature review; references added; no change to policy statement.
05/26/06	Update Scope and Disclaimer - No other changes.
08/08/06	Replace Policy - Policy changed to PR policy and renamed "Pulmonary Vein Ablation in the Treatment of Atrial Fibrillation, replacing BC.2.02.19; policy statement revised to list pulmonary vein ablation as medically necessary.
02/26/07	Update Codes - No other changes.
08/14/07	Replace Policy - Policy updated with literature review; references added. No change to policy statement.
08/12/08	Replace Policy - Policy updated with literature search, no change to the policy statement. References added.
06/09/09	NEW BC - Replaces PR.2.02.502, converted to BC status.
03/09/10	Replace Policy - Policy updated with literature search. Policy statement added for repeat procedures may be medically necessary in specific situations. Policy Guidelines updated to reflect this update. References added.
10/12/10	Replace Policy - Policy updated with literature review through July 2010; policy statement regarding radiofrequency ablation unchanged; new statement regarding cryoablation as investigational added. References 19-30 added. The term "radiofrequency" has been removed from the policy title and the policy has been renamed.
06/13/11	Policy 2.02.19 Catheter Ablation of the Pulmonary Veins as Treatment for Atrial Fibrillation archived, approved June 13, 2011. Policy updated with review of clinical input. Policy statements edited for clarification, but no change in intent of policy statements. Information about repeat procedures from 08/13/09 review reinserted into policy. ICD-10 codes added to policy.
04/01/25	New policy 2.02.516 Catheter Ablation as Treatment for Atrial Fibrillation, approved March 11, 2025, effective for dates of service on or after July 3, 2025, following 90-day provider notification. Policy updated with literature review through March 16, 2023; references added. Transcatheter radiofrequency ablation (RFA) or cryoablation to treat atrial fibrillation may be considered medically necessary when criteria are met. Added CPT codes 93655, 93656 and 93657 to match criteria.
06/01/25	Interim Review, approved May 13, 2025. Policy updated with literature review through December 9, 2024; references added. Pulsed field ablation added to medically necessary statements.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.