

## Clinical Policy: Catheter Ablation for Supraventricular Tachyarrhythmia

Reference Number: WA.CP.MP.525

Date of Last Review: 01/23

Effective Date: 02/01/23

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

This policy describes the medical necessity guidelines for catheter ablation for supraventricular tachyarrhythmia, including atrial flutter and atrial fibrillation.

### Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that for catheter ablation for supraventricular tachyarrhythmia is considered **medically necessary** per *InterQual* guidelines.
- II. *InterQual* guidelines meet or exceed the HTA requirement that catheter ablation for supraventricular tachyarrhythmia is covered for the following conditions:
  - A. Re-entrant tachycardias (e.g., Wolff-Parkinson-White Syndrome, Atrioventricular re-entrant tachycardia, atrioventricular nodal re-entrant tachycardia)
  - B. Symptomatic atrial flutter
  - C. Symptomatic atrial fibrillation where drug therapy is either not tolerated or ineffective.
- III. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that for catheter ablation for supraventricular tachyarrhythmia is **not medically necessary** for other, non-reentrant supraventricular tachycardias.

### Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
93653	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmias with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; 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.
93654	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmias with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed , and left ventricular pacing and recording, when performed
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.
93656	Comprehensive electrophysiological evaluation including transeptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation.
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.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	10/19	10/19
Annual review. References updated.	03/20	04/20
Annual review. References updated.	02/21	03/21
Annual review. References updated.	02/22	02/22
Annual review. References updated. Removed CPT 93650	12/22	01/23

**References**

1. Hashimoto, R., Raich, A., Junge, M. Skelly, A. Spectrum Research. *Catheter ablation procedures for supraventricular tachyarrhythmia including atrial flutter and atrial fibrillation*. Washington Health Technology Assessment. April 15, 2013.
2. Washington State Health Care Authority. *Physician-related Services/Health Care Billing Guide*. <https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20230101.pdf> Revision effective January 1, 2023.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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