January 26, 2026

Carelon Health
12900 Park Plaza Dr. Ste 150
Cerritos, CA 90703
(Sent via email)

Re: CPT Code 93657

Dear Dr. Thomas Power,

On behalf of the Heart Rhythm Society (HRS) and the American College of Cardiology (ACC), we are writing to express significant concern regarding the proposed policy that would categorically restrict coverage for CPT code 93657 for any left atrial ablation beyond pulmonary vein isolation (PVI) in patients with atrial fibrillation (AF). We believe this policy will compromise treatment for our patients. While PVI is universally recognized as the foundational element of AF ablation, atrial fibrillation is a complex arrhythmia that often involves atrial substrate well beyond the pulmonary veins. A blanket prohibition fails to reflect contemporary electrophysiology practice, recent evidence, or the underlying pathophysiology of this disease.

We acknowledge that prior randomized trials such as STAR AF II[1] and CAPLA[2] did not demonstrate clear benefit when empiric linear lesions or posterior-wall isolation were added to PVI. However, these findings must be interpreted in context. Both studies suffered from well-documented limitations, most importantly the inability to create durable lesion sets. Bidirectional block across linear lesions was rarely confirmed, posterior-wall isolation was frequently incomplete, and the mapping and ablation technologies available at the time lacked the precision needed for consistent lesion durability. These trials demonstrated that *incomplete* adjunctive ablation adds no value; they do not demonstrate that well-executed, durable adjunctive ablation is ineffective.

Contemporary evidence tells a different story. Recent randomized and prospective studies consistently show improved outcomes when durable lesions are achieved. Clinical programs

incorporating optimized linear ablation combined with vein-of-Marshall ethanol infusion have reported significantly higher freedom from atrial arrhythmias compared with PVI alone, reflecting improved rates of durable conduction block (VENUS trial)[3]. This evidence has been reproduced with the PROMPT-AF[4] trial and the MARSHALL-PLAN[5] data. Thus three randomized trials now show that when durable linear block is obtained in extra-pulmonary vein lesion sets, outcomes unequivocally improve.

Advances in energy sources have further changed the landscape. Pulsed-field ablation (PFA), a non-thermal modality capable of producing consistent and transmural lesions with a markedly improved safety profile near the esophagus, has made posterior-wall ablation both safer and more effective. Recent PFA studies in persistent AF, including the ADVANTAGE-AF[6] study, incorporated PVI plus posterior-wall ablation and reported favorable procedural safety and encouraging reductions in arrhythmia recurrence. Persistent AF patients had a striking 85% symptomatic arrhythmia free event rate post ablation at 12 months. These results highlight that the limitations seen in prior radiofrequency-based posterior-wall trials do not apply to contemporary PFA-based lesion sets.

AF is not a homogeneous, PV-trigger–only disease. It frequently involves posterior-wall drivers, low-voltage substrate, non-PV triggers, and macroreentrant circuits such as perimitral flutter. For many patients, PVI alone is insufficient to restore durable sinus rhythm, and adjunctive ablation is required to address the non-PV substrate responsible for maintaining arrhythmia. Modern mapping, imaging, and ablation technologies allow clinicians to identify and treat this substrate with precision and durability that were not possible during the era of prior trials.

Contemporary randomized clinical evidence, including the SPHERE Per-AF (Sphere-9)[7] study, demonstrate that effective treatment of persistent AF frequently involves lesion sets beyond pulmonary vein isolation. In SPHERE Per-AF, persistent AF patients underwent PVI plus additional linear lesions as clinically indicated, and those treated with the investigational Sphere-9 system achieved higher arrhythmia-free survival at 12 months compared to those patients treated with conventional RF ablation (73.8% vs. 65.8%). These data underscore both the routine clinical incorporation of extra-PV lesion sets in persistent AF and the capacity of modern ablation platforms to deliver these lesions safely and with durability. A coverage policy that prohibits adjunctive ablation disregards this evidence and does not align with contemporary practice patterns or outcomes data.

For these reasons, a unilateral policy restricting adjunctive ablation beyond PVI is not clinically appropriate and does not reflect current science. A more evidence-aligned policy would permit adjunctive ablation when clinically justified, such as when non-PV substrate is identified, when atypical flutters are induced, when the operator employs techniques with demonstrated durability (including vein-of-Marshall ethanol infusion, optimized linear ablation, or PFA-enabled posterior-wall ablation), or when durable lesion endpoints are documented.

We understand that the proposed policy is likely a reaction to the increase in linear ablation add-on to PVI that has occurred with the advent of PFA. The safety profile of the technology has lowered the threshold for posterior wall isolation. Thus we think that identification of a clear

procedural rationale for additional ablation as outlined above rather than complete restriction would be meaningful. It should be noted that CPT code 93657 was recently revalued by Medicare in 2022. Medicare acknowledged that additional linear ablation lines require more time beyond the stand alone PVI procedure, thus the add-on code was retained. In addition, if there is no coverage for additional ablation then we fear that patients will require a higher rate of repeat procedures due to recurrence of atrial fibrillation or atrial tachycardia, which will only increase cost. There may also be increased hospitalizations and stroke-related treatments which will further increase burden and costs. Finally, while it is the opinion of this committee that PFA is leading to a reduction in the number of patients who need repeat ablation, we need more time to accumulate studies to understand the efficacy of PFA on rates of redo procedures. More data is needed to guide the appropriate ablation strategy with PFA.

In summary, while PVI remains the cornerstone of AF ablation, durable adjunctive ablation beyond PVI is often necessary and is supported by contemporary data. The proposed policy fails to account for these advancements and would prevent clinicians from providing evidence-based, patient-specific care for persistent AF. We respectfully urge reconsideration of the proposed restriction and recommend a policy that reflects modern technology, contemporary trial evidence, and established clinical practice.

HRS and ACC would like to have a formal dialogue to further discuss our concerns and reach consensus in the best interest of patient care. Please contact Lisa Miller at LMiller@hrsonline.org or Kristin Christensen at kchristensen@acc.org to schedule a meeting at your earliest convenience. Thank you for your consideration of this request.

Sincerely,

Mina K. Chung, M.D., FHRS
President, Heart Rhythm Society

Christopher M. Kramer, FACC
President, American College of Cardiology

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