

Cryoablation, Surgical 82

Table of Content

[Description & Definitions](#)
[Criteria](#)
[Document History](#)
[Coding](#)
[Special Notes](#)
[References](#)
[Keywords](#)

[Effective Date](#) 2/2008
[Next Review Date](#) 1/2026
[Coverage Policy](#) Surgical 82
[Version](#) 9

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details.*.

Description & Definitions:

Cryoablation uses hollow needles (cryoprobes) that are thermally cooled to apply extreme cold to an area and ablate the tissue.

Criteria:

Cryoablation is considered medically necessary for individuals for **1 or more** of the following:

- Atrial fibrillation
- Barrett's esophagus with **All** of the following:
 - Residual or recurrent dysplasia are present
 - Documented failure of medical management with high dose proton pump inhibitors
- Basal cell carcinoma, low risk
- Colorectal cancer with **All** of the following:
 - Metastases to liver
 - Open resection is not appropriate
- Endobronchial obstruction, malignant
- Hepatocellular cancer or liver metastases from colorectal cancer or functioning neuroendocrine tumors with **1 or more** of the following:
 - For initial treatment **All** of the following:
 - Individual is a poor candidate for surgical resection or unwilling to undergo surgical resection
 - Individual has the presence of three lesions or less as documented by Magnetic Resonance Imaging (MRI) or Computerized Tomography (CT) scan
 - Individual's lesions measure no more than five centimeters in diameter each
 - Individual has no evidence of extra-hepatic disease
 - All foci of individual's disease are amenable to ablative therapy
 - For repeat treatment **All** of the following:
 - At least six months must have elapsed since the prior surgical resection or ablation
- Early stage esophageal cancer.
- Neuroendocrine tumors of the liver that are unresectable
- Non small cell lung cancer that is considered inoperable (32994)

- Prostate cancer and **1 or more of the following**:
 - Primary treatment of clinically localized prostate cancer stage T1-T2
 - Primary treatment of Prostate cancer stage T3 and lymph nodes involvement is not detected on imaging studies
 - Salvage cryosurgery for recurrent Prostate cancer with localized diagnosis following failed trial of radiation as primary treatment and **1 or more** of the following;
 - Prostate specific antigen (PSA)<8ng/ml
 - Gleason score <9
 - disease stage T2b or below
- Renal cell carcinoma and **ALL of the following**:
 - Stage I (T1a)
 - Confirmed by biopsy
 - Single tumor <3 cm
 - No metastasis
- Soft tissue sarcomas with **1 or more of the following**:
 - Single organ and limited tumor bulk that are amenable to local therapy
 - As palliative modality for disseminated metastases in both primary and recurrent disease
- Squamous cell carcinoma in situ (Bowen disease) where surgery or radiation are contraindicated

Cryoablation is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Back pain (acute or chronic) including but not limited to that attributed to facet or SI etiologies
- Bone and soft tissue carcinomas
- Breast carcinoma
- Clarifix for sinuses/rhinitis
- Cryoneurolysis nerve block
- Endometrial Cancer
- Extra-abdominal desmoid tumors
- Fibroadenoma
- Hepatic metastases from non-colonic primary cancers
- Hip pain
- Idiopathic ventricular tachycardia (VT)
- Intercostal nerves
- Knee pain
- Leiomyosarcoma
- Lipoma
- Neuromas
- Pancreatic cancer
- Percutaneous cryoablation of bone tumors
- Plantar fasciitis or plantar fibroma
- Post-infarction VT
- Retinopathy of prematurity

Document History:

Revised Dates:

- 2025: January – Procedure coding updated to align with service authorization changes. Additional items added to not medically necessary section.
- 2024: January
- 2022: January, March, September
- 2020: January, December
- 2019: November
- 2015: April, May
- 2014: April
- 2013: April

- 2012: April, November
- 2011: February
- 2010: March
- 2009: February

Reviewed Dates:

- 2023: January
- 2019: March
- 2018: April
- 2016: December
- 2010: February
- 2008: July

Effective Date:

- February 2008

Coding:

Medically necessary with criteria:

Coding	Description
31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical
47381	Ablation, open, of 1 or more liver tumor(s); cryosurgical
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

Considered Not Medically Necessary:

Coding	Description
67229	Treatment of extensive or progressive retinopathy, 1 or more sessions, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve

0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral
30117	Excision or destruction (eg, laser), intranasal lesion; internal approach
30999	Unlisted procedure, nose (Surgery or other procedure for the nose)
31299	Unlisted procedure, accessory sinuses

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products: Policy is applicable to Sentara Health Plan Commercial products.
- Authorization requirements: Pre-certification by the Plan is required.
- Special Notes:
 - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
 - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2024, Mar 14). Retrieved Jan 13, 2025, from MCG 28th Edition:
<https://careweb.careguidelines.com/ed28/index.html>

(2025). Retrieved Jan 14, 2025, from Centers for Medicare and Medicaid Services:
<https://www.cms.gov/medicare-coverage-database/search->

results.aspx?keyword=Cryotherapy&keywordType=starts&areald=all&docType=NCA,CAL,NCD,MEDCAC,TA,MC D,6,3,5,1,F,P&contractOption=all

(2025). Retrieved Jan 14, 2025, from Hayes - a symplr company:

<https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522cryoablation%2522,%2522title%2522:n ull,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size %2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%2522:%255>

(2025). Retrieved Jan 14, 2025, from Virginia Department of Medical Assistance Services:

<https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library#gsc.tab=0&gsc.q=cryoablation&gsc.sort=>

21 CFR 878.4350. (2025). Retrieved Jan 14, 2025, from Code of Federal Regulations:

<https://www.ecfr.gov/current/title-21/chapter-I/subchapter-H/part-878/subpart-E/section-878.4350>

Cryo Nerve Block Therapy. (2025). Retrieved Jan 14, 2025, from ArtiCure: <https://www.atricure.com/healthcare-professionals/therapies/cryo-nerve-block>

Cryotherapy, HIFU, and Other Ablative Treatments for Prostate Cancer. (2024, Dec 10). Retrieved Jan 14, 2025, from American Cancer Society: <https://www.cancer.org/cancer/types/prostate-cancer/treating/cryosurgery.html>

Dupuy, D. (2023, Nov 06). Image-guided ablation of lung tumors. Retrieved Jan 13, 2025, from UpToDate:

https://www.uptodate.com/contents/image-guided-ablation-of-lung-tumors?search=Cryoablation&source=search_result&selectedTitle=2%7E81&usage_type=default&display_rank=2#H62602141

Hines, A., & Goldberg, S. (2024, Sep 03). Radiofrequency ablation, cryoablation, and other ablative techniques for renal cell carcinoma. Retrieved Jan 13, 2025, from UpToDate: https://www.uptodate.com/contents/radiofrequency-ablation-cryoablation-and-other-ablative-techniques-for-renal-cell-carcinoma?search=Cryoablation&source=search_result&selectedTitle=1%7E81&usage_type=default&display_rank=1#H14

Kurup, A., & Callstrom, M. (2023, Jan 05). Image-guided ablation of skeletal metastases. Retrieved Jan 13, 2025, from UpToDate: https://www.uptodate.com/contents/image-guided-ablation-of-skeletal-metastases?search=Cryoablation&source=search_result&selectedTitle=4%7E81&usage_type=default&display_rank=4#H747576

Law, L., Rayi, A., Hendrix, J., & Derian, A. (2024, Feb 14). Cryoanalgesia. Retrieved Jan 14, 2025, from PubMed: <https://www.ncbi.nlm.nih.gov/books/NBK482123/>

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) with NCCN Evidence Blocks™. (2025).

Retrieved Jan 14, 2025, from National Comprehensive Cancer Network:

<https://www.nccn.org/guidelines/guidelines-with-evidence-blocks>

NCD: Cryosurgery of Prostate (230.9). (2001, Jul 01). Retrieved Jan 13, 2025, from Centers for Medicare and Medicaid Services: <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=123&ncdver=1&>

Percutaneous image-guided cryoablation of peripheral neuroma for chronic pain. (2023, Jan 04). Retrieved Jan 14, 2025, from National Institute for Health and Care Excellence: <https://www.nice.org.uk/guidance/ipg747>

Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy). (2024, Nov 01). Retrieved Jan 14, 2025, from Carelon Medical Benefits Management: <https://guidelines.carelonmedicalbenefitsmanagement.com/upper-gastrointestinal-endoscopy-esophagogastroduodenoscopy-2024-11-01/>

Keywords:

Cryoablation, cryotherapy, Cervical intraepithelial neoplasia, shp surgical 82, Atrial fibrillation, Barrett's esophagus, Basal cell carcinoma, Colorectal cancer, Endobronchial obstruction, Hepatocellular cancer, liver metastases, colorectal cancer, functioning neuroendocrine tumors, Neuroendocrine tumors, Non small cell lung cancer, Prostate cancer, stage A prostate cancer, stage B prostate cancer, stage C prostate cancer, Renal cell carcinoma, Soft tissue sarcomas, Squamous cell carcinoma in situ, Bowen disease