

Cryoablation, Surgical 82

Table of Content
Purpose
Description & Definitions
Criteria
Coding
Document History
References
Special Notes
Keywords

<u>Effective Date</u>	2/2008
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<u>Coverage Policy</u>	Surgical 82
<u>Version</u>	8

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

Purpose:

This policy addresses the medical necessity of surgery for Cryoablation.

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
- 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
- Neuroendocrine tumors of the liver that are unresectable
- Non-small cell lung cancer that is considered inoperable
- 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
- Esophageal cancer
- Extra-abdominal desmoid tumors
- Fibroadenoma
- Hepatic metastases from non-colonic primary cancers
- Idiopathic ventricular tachycardia (VT)
- Leiomyosarcoma
- Lipoma
- Neuromas
- Pancreatic cancer
- Percutaneous cryoablation of bone tumors
- Plantar fasciitis or plantar fibroma
- Post-infarction VT
- Retinopathy of prematurity

Coding:

Medically necessary with criteria:

Coding	Description
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation
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.

Document History:

Revised Dates:

- 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

References:

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

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Special Notes: *

This medical policy expresses Sentara Health Plan's determination of medical necessity of services, and they are based upon a review of currently available clinical information. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

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.

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