Sentara Health Plans

Medicaid

Cryoablation, Surgical 82

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Effective Date	2/2008
Next Review Date	1/2026
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

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 o**f 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

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.

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 Medicaid products.
- Authorization requirements: Pre-certification by the Plan is required.
- Special Notes:
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. 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.
    - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.
    - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

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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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