SHP Cryoablation

AUTH: SHP Surgical 82 v7 (AC)

MCG Health
Ambulatory Care
26th Edition

Link to Codes

Coverage

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See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.

Application to Products

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Policy is applicable to all products.

Authorization Requirements

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Pre-certification by the Plan is required.

Description of Item or Service

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

Exceptions and Limitations

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- There is insufficient scientific evidence to support the medical necessity of cryoablation as it is not shown to improve health outcomes upon technology review for any of the following:
  - 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
- There is insufficient scientific evidence to support the medical necessity of this procedure for uses other than those listed in the clinical indications for procedure section.

Clinical Indications for Procedure

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- 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
- Neuroendocrine tumors of the liver that are unresectable
- Non small cell lung cancer that is considered inoperable
- 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 **NOT COVERED** for **ANY** of the following:
  - 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

Document History

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- Revised Dates:
  - 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 Information

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- CPT/HCPCS codes covered if policy criteria is met:
  - CPT 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
  - CPT 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)
  - CPT 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
  - CPT 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)
  - CPT 47371 - Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical
  - CPT 47381 - Ablation, open, of 1 or more liver tumor(s); cryosurgical
  - CPT 47383 - Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
  - CPT 50593 - Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy
  - CPT 55873 - Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring
- CPT/HCPCS codes considered not medically necessary per this Policy:
  - CPT 0440T - Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
  - CPT 0441T - Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
  - CPT 0442T - Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)
  - CPT 0581T - Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral
  - CPT 30117 - Excision or destruction (eg, laser), intranasal lesion; internal approach
  - CPT 30999 - Unlisted procedure, nose (Surgery or other procedure for the nose)
  - CPT 31299 - Unlisted procedure, accessory sinuses
  - CPT 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

References

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References used include but are not limited to the following:

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

(2022). Retrieved Nov 17, 2022, from Hayes, Inc: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522cryoablation%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%2522:%255

(2022, Aug 18). Retrieved Nov 18, 2022, from MCG: https://careweb.careguidelines.com/ed26/index.html

(2022). Retrieved Nov 08, 2022, from National Comprehensive Cancer Network: https://www.nccn.org/guidelines/guidelines-with-evidence-blocks

(2022). Retrieved Nov 21, 2022, from Department of Medical Assistance Services: https://vamedicaid.dmas.virginia.gov/global-search?keys=Cryoablation

Appropriate Use Criteria: Interventional Pain Management. (2022, Nov 06). Retrieved Nov 18, 2022, from AIM Specialty Health: https://guidelines.aimspecialtyhealth.com/interventional-pain-management-11-06-22-for-commercial-medicare-non-anthem-medicaid/?highlight=%22Cryoablation%22

Chin, Y., & Lynn, N. (2022, Jun 28). Systematic Review of Focal and Salvage Cryotherapy for Prostate Cancer. Retrieved Nov 21, 2022, from PubMed: https://pubmed.ncbi.nlm.nih.gov/35911314/

Clinically Localized Prostate Cancer: AUA/ASTRO Guideline 2022. (2022). Retrieved Nov 21, 2022, from American Urological Association: https://www.auanet.org/guidelines-and-quality/guidelines/clinically-localized-prostate-cancer-aua/astro-guideline-2022

Hines, A., & Goldberg, S. (2021, Nov 03). Radiofrequency ablation and cryoablation for renal cell carcinoma. Retrieved Nov 18, 2022, from UpToDate: https://www.uptodate.com/contents/radiofrequency-ablation-and-cryoablation-for-renal-cell-carcinoma?search=Cryoablation&source=search_result&selectedTitle=5~150&usage_type=default&display_rank=5#H7

NCD: Cryosurgery of Prostate (230.9). (2001, Jul 01). Retrieved Nov 18, 2022, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=123&ncdver=1&keyword=cryo&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

Pisters, L., & Spiess, P. (2022, Aug 31). Cryotherapy and other ablative techniques for the initial treatment of prostate cancer. Retrieved Nov 18, 2022, from UpToDate: https://www.uptodate.com/contents/cryotherapy-and-other-ablative-techniques-for-the-initial-treatment-of-prostate-cancer?search=Cryoablation&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#H85227821

Prohaska, J., & Jan, A. (2022, Jun 25). Cryotherapy. Retrieved Nov 21, 2022, from PubMed: https://www.ncbi.nlm.nih.gov/books/NBK482319/

The Arctic Front Advance and Arctic Front Advance Pro and The Freezor MAX Cardiac Cryoablation Catheters – P100010/S110. (2021, Jul 27). Retrieved Nov 21, 2022, from Food and Drug Administration: https://www.fda.gov/medical-devices/recently-approved-devices/arctic-front-advance-and-arctic-front-advance-pro-and-freezor-max-cardiac-cryoablation-catheters

Comparative Effectiveness Review of Cryoablation For Primary Treatment Of Localized Prostate Cancer. (2021, Sep 13). Retrieved Dec 05, 2021, from Hayes, Inc.: https://evidence.hayesinc.com/report/dir.cryoablationprostate215

Comparative Effectiveness Review Of Cryoablation For Salvage Treatment Of Recurrent Prostate Cancer Following Radiotherapy. (2021, Sep 14). Retrieved Dec 05, 2021, from Hayes, Inc.: https://evidence.hayesinc.com/report/dir.cryosalvage4050

Endometrial Ablation. (2021, Mar 26). Retrieved Dec 05, 2021, from DynaMed: https://www.dynamedex.com/procedure/endometrial-ablation#CRYOABLATION

Hines, A., & Goldberg, S. (2021, Nov 03). Radiofrequency ablation and cryoablation for renal cell carcinoma. Retrieved Dec 05, 2021, from UpToDate: https://www.uptodate.com/contents/radiofrequency-ablation-and-cryoablation-for-renal-cell-carcinoma?search=Cryoablation&source=search_result&selectedTitle=1~88&usage_type=default&display_rank=1#H7

Kurup, A., & Callstrom, M. (2021, Apr 28). Image-guided ablation of skeletal metastases. Retrieved Dec 05, 2021, from UpToDate: https://www.uptodate.com/contents/image-guided-ablation-of-skeletal-metastases?search=Cryoablation&source=search_result&selectedTitle=3~88&usage_type=default&display_rank=3#H747522

Pierorazio, P., & Campbell, S. (2021, May 21). Diagnostic approach, differential diagnosis, and management of a small renal mass. Retrieved Dec 05, 2021, from UpToDate: https://www.uptodate.com/contents/diagnostic-approach-differential-diagnosis-and-management-of-a-small-renal-mass?search=Cryoablation&source=search_result&selectedTitle=9~88&usage_type=default&display_rank=9#H723729118

Codes

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CPT® : 0440T, 0441T, 0442T, 0581T, 20983, 30117, 30999, 31299, 31641, 32994, 43229, 47371, 47381, 47383, 50593, 55873, 67229

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