Cryosurgical Ablation and Radiofrequency Ablation of Renal Tumors

Policy ID:	HHO-DE-MP-1054
Approved By:	Highmark Health Options – Market Leadership
Provider Notice Date:	
Original Effective Date:	N/A
Annual Approval Date:	09/2022
Last Revision Date:	09/20/2021
Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 4

Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary cryosurgical ablation and radiofrequency ablation of renal tumors.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus members.

Cryosurgical ablation of the kidney (also called cryosurgery, cryotherapy, or cryodestruction) – The use of extreme cold to destroy cancer cells while preserving the surrounding healthy tissue.

Radiofrequency ablation (RFA) – A type of treatment for malignant renal tumors. This technique uses heat to destroy cancerous cells.

PROCEDURES

Cryosurgical Ablation

Cryosurgical ablation may be considered medically necessary to treat localized renal cell carcinoma that is no more than 4 cm in size when EITHER of the following criteria is met:

- Preservation of kidney function is necessary:
  - Individual has 1 (one) kidney; or
  - Renal insufficiency defined by a glomerular filtration rate of less than 60 mL/min/m^2; and
  - Standard surgical approach (i.e., resection of renal tissue) is likely to worsen existing kidney function substantially; or
- The individual is not considered a surgical candidate.

Cryosurgical ablation is considered not medically necessary for renal cell carcinoma that does not meet the above criteria.

Radiofrequency Ablation

Radiofrequency ablation of renal cell carcinoma may be considered medically necessary to treat localized small renal cell carcinoma that is no more than four (4) cm in size when EITHER of the following criteria is met:

- Preservation of kidney function is necessary:
  - The individual has one (1) kidney; or
  - Renal insufficiency defined by a glomerular filtration rate of less than 60 ml/min/m2; and
  - Standard surgical approach (i.e., resection of renal tissue) is likely to substantially worsen existing kidney function; or
- The individual is not considered a surgical candidate.

Radiofrequency ablation is considered not medically necessary for renal cell carcinoma that does not meet the above criteria.

Post-payment Audit Statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

Place of Service

Inpatient

CODING REQUIREMENTS

CPT codes	Description
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed.
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed.
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy.
50592	Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency.

Covered Diagnosis Codes for Procedure Codes 50250, 50542, 50592, 50593

Code	Description
C64.1	Malignant neoplasm of right kidney, except renal pelvis.
C64.2	Malignant neoplasm of left kidney, except renal pelvis.
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis.
C65.1	Malignant neoplasm of right renal pelvis.
C65.2	Malignant neoplasm of left renal pelvis.
C65.9	Malignant neoplasm of unspecified renal pelvis.
D49.511	Neoplasm of unspecified behavior of right kidney.
D49.512	Neoplasm of unspecified behavior of left kidney.
D49.519	Neoplasm of unspecified behavior of unspecified kidney.

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Health Options contract.

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POLICY UPDATE HISTORY

<Date>	<Event>