Ablation of Miscellaneous Solid Tumors

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Approved By:	Highmark Health Options – Market Leadership
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Application:	All participating hospitals and providers
Page Number(s):	1 of 9

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 radiofrequency ablation of miscellaneous solid tumors, excluding liver 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 (DHCP) and Diamond State Health Plan Plus members.

Radiofrequency Ablation (RFA) – Heat is projected into a tumor by a high-frequency, alternating current that flows from electrodes. The cells killed by RFA are gradually replaced by fibrosis and scar tissue. RFA can be performed percutaneously, laparoscopically, or as an open procedure.

Cryosurgical Ablation – Also called cryosurgery, cryotherapy, or cryodestruction, is the use of extreme cold to destroy cancer cells while preserving the surrounding healthy tissue.

PROCEDURES

A prior authorization is required.

OSTEOLYTIC BONE PAIN

RFA may be considered medically necessary to palliate pain in individuals with osteolytic bone metastases who have failed or are poor candidates for standard treatments such as radiation or opioids.

RFA as initial treatment for painful bony metastases is considered experimental/investigational, and therefore, noncovered. The evidence is insufficient to determine the impact of technology on health outcomes.

OSTEOID OSTEOMAS

RFA may be considered medically necessary to treat osteoid osteomas that cannot be managed successfully with medical treatment.

RFA for osteoid osteomas that can be managed with medical treatment is considered experimental/investigational, and therefore, non-covered. The evidence is insufficient to determine the impact of technology on health outcomes.

ISOLATED PERIPHERAL NON-SMALL CELL LUNG CANCER

RFA may be considered medically necessary to treat an isolated peripheral non-small-cell lung cancer lesion that is no more than three (3) cm in size when ALL the following criteria are met:

- Surgical resection or radiation treatment with curative intent is considered appropriate based on stage of disease, however, medical comorbidity renders the individual unfit for those interventions; **and**
- Tumor is located at least one (1) cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery, and the heart.

RFA for any other isolated peripheral non-small cell lung cancer is considered experimental/investigational, and is therefore, non-covered due to the evidence is insufficient to determine the impact of the technology on health outcomes.

MALIGNANT NONPULMONARY TUMOR(S) METASTATIC TO THE LUNG

RFA may be considered medically necessary to treat malignant nonpulmonary tumor(s) metastatic to the lung that are no more than three (3) cm in size when the following criteria are met:

- To preserve lung function when surgical resection or radiation treatment is likely to worsen pulmonary status, or the individual is not considered a surgical candidate; and
- There is no evidence of extrapulmonary metastases; and
- The tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery, and the heart; and
- No more than three (3) tumors per lung should be ablated; and
- Tumors should be amenable to complete ablation; and
- Twelve (12) months should elapse before a repeat ablation is considered.

RFA for any other malignant non-pulmonary tumors metastatic to the lung is considered experimental/investigational, and is therefore, noncovered due to the evidence is insufficient to determine the impact of the technology on health outcomes.

RENAL CELL CARCINOMA

RFA 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/m^2; 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 for renal cell carcinoma not meeting the criteria as indicated in this policy is considered not medically necessary.

RFA as a technique for ablation for ANY of the following is considered experimental/investigational, and therefore, noncovered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

- Breast tumors; or
- Lung cancer not meeting the criteria above; or
- Osteoid osteomas that can be managed with medical treatment; or
- Painful bony metastases as initial treatment; or
- All other tumors outside the liver including, but not limited to:
  - The head and neck; or
  - Thyroid; or
  - Ovary; or
  - Pelvic/abdominal metastases of unspecified origin.

RENAL CELL CARCINOMA CRYOSURGICAL ABLATION

Cryosurgical ablation may be considered medically necessary to treat localized 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:
  - 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 for renal cell carcinoma not meeting the criteria as indicated in this policy is considered not medically necessary.

LUNG CANCER CRYOSURGICAL ABLATION

Cryosurgical ablation may be considered medically necessary to treat lung cancer when **EITHER** of the following criteria is met:

- The individual has early-stage non-small-cell lung cancer and is a poor surgical candidate; **or**
- The individual requires palliation for a central airway obstructing lesion.

Cryosurgical ablation for lung cancer not meeting the criteria as indicated in this policy is considered experimental/investigational, and is therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

OSTEOLYTIC BONE PAIN CRYOSURGICAL ABLATION

Cryosurgical ablation may be considered medically necessary to palliate pain in individuals with osteolytic bone metastases who have failed or are poor candidates for standard treatments such as radiation or opioids.

Cryosurgical ablation for osteolytic bone pain not meeting the criteria as indicated in this policy is considered experimental/investigational, and is therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature

Cryosurgical ablation as a technique for ablation for ANY of the following is considered experimental/investigational, and therefore, noncovered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

- Benign or malignant tumors of the breast; or
- Pancreas.

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/OUTPATIENT

Experimental/Investigational (E/I) services are not covered regardless of place of service.

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in exceptional circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting

CODING REQUIREMENTS

CPT code	Description
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency.
32998	Ablation therapy for reduction or eradication of one of more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral.
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed.
50592	Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency.
50250	Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed.
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy.
31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser therapy, cryotherapy).

32994	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation.
20983	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., Metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation.
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma.

COVERED DIAGNOSIS CODES FOR PROCEDURES CODE 20982 AND 20983

Codes						
C40.00	C40.01	C40.02	C40.10	C40.11	C40.12	C40.20
C40.21	C40.22	C40.30	C40.31	C40.32	C41.0	C41.1
C41.2	C41.3	C41.4	C41.9	C76.3	C79.51	C79.52
C7B.03	D16.00	D16.01	D16.02	D16.10	D16.11	D16.12
D16.20	D16.21	D16.22	D16.30	D16.31	D16.32	D16.4
D16.5	D16.6	D16.7	D16.8	D16.9		

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES 32994, AND 32998

Codes						
C34.00	C34.01	C34.02	C34.10	C34.11	C34.12	C34.2
C34.30	C34.31	C34.32	C34.80	C34.81	C34.82	C34.90
C34.91	C34.92	C78.00	C78.01	C78.02		

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES 50250, 50542, 50592, AND 50593

Codes						
C64.1	C64.2	C64.9	C65.1	C65.2	C65.9	C79.00
C79.01	C79.02	D49.511	D49.512	D49.519		

POLICY SOURCES

National Comprehensive Cancer Network (NCCN) – 2022

The NCCN guidelines (v.2.2020) for renal cancer indicate that "[t]hermal ablation (e.g., cryosurgery, radiofrequency ablation) is an option for the management of patients with clinical stage T1 renal lesions. Thermal ablation is an option for masses <3 cm, but it may also be an option for larger masses in select patients. Ablation in masses >3 cm is associated with higher rates of local recurrence/persistence and complications."

REIMBURSEMENT

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

Reference

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POLICY UPDATE HISTORY

12/21/2021	Approved in Medical Policy Committee
01/2022	Approved in QI/UM
12/28/2022	Annual review; approved in Medical Policy Committee
01/03/2023	Approved in QI/UM