Medical Policy
Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors

Table of Contents
- Policy: Commercial
- Policy: Medicare
- Authorization Information
- Coding Information
- Description
- Policy History
- Information Pertaining to All Policies
- References

Policy Number: 260
BCBSA Reference Number: 7.01.92
NCD/LCD: NA

Related Policies
- Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors, #259
- Cryosurgical Ablation of Primary or Metastatic Liver Tumors, #633
- Radiofrequency Ablation of Primary or Metastatic Liver Tumors, #286

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Cryosurgical ablation to treat localized renal cell carcinoma that is no more than 4 cm in size may be MEDICALLY NECESSARY when either of the following criteria is met:

- Preservation of kidney function is necessary (i.e., the patient has one kidney or renal insufficiency defined by a glomerular filtration rate [GFR] of less than 60 mL/min per m²) and standard surgical approach (i.e., resection of renal tissue) is likely to substantially worsen kidney function, or
- Patient is not considered a surgical candidate.

Cryosurgical ablation as a treatment of benign or malignant tumors of the breast, cancer of the pancreas, other solid tumors outside the liver and prostate, or renal cell carcinomas in patients who are surgical candidates is INVESTIGATIONAL.

Prior Authorization Information
Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.
Outpatient

| Commercial Managed Care (HMO and POS) | No |
| Commercial PPO and Indemnity | No |
| Medicare HMO BlueSM | No |
| Medicare PPO BlueSM | No |

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50250</td>
<td>Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed</td>
</tr>
<tr>
<td>50542</td>
<td>Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed</td>
</tr>
<tr>
<td>50593</td>
<td>Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy</td>
</tr>
<tr>
<td>76940</td>
<td>Ultrasound guidance for, and monitoring of, parenchymal tissue ablation</td>
</tr>
<tr>
<td>77013</td>
<td>Computed tomography guidance for, and monitoring of, parenchymal tissue ablation</td>
</tr>
<tr>
<td>77022</td>
<td>Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation</td>
</tr>
</tbody>
</table>

ICD-9 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>189.0</td>
<td>Malignant neoplasm of kidney, except pelvis</td>
</tr>
</tbody>
</table>

ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10 diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C64.1</td>
<td>Malignant neoplasm of right kidney, except renal pelvis</td>
</tr>
<tr>
<td>C64.2</td>
<td>Malignant neoplasm of left kidney, except renal pelvis</td>
</tr>
<tr>
<td>C64.9</td>
<td>Malignant neoplasm of unspecified kidney, except renal pelvis</td>
</tr>
</tbody>
</table>

Description

Cryosurgical ablation (also known as cryosurgery) involves freezing of target tissues, most often by inserting into the tumor a probe through which coolant is circulated. Cryosurgery may be performed as an open surgical technique or as a closed procedure under laparoscopic or ultrasound guidance.

The hypothesized advantages of cryosurgery include improved local control, preservation of normal organ tissue, decreased morbidity, and decreased length of hospitalization. Potential complications of cryosurgery include those caused by hypothermic damage to normal tissue adjacent to the tumor, structural damage along the probe track, and secondary tumors, if cancerous cells are seeded during probe removal.
Renal Cell Carcinoma
Localized renal cell carcinoma (RCC) is treated by radical nephrectomy or nephron-sparing surgery. Prognosis drops precipitously if the tumor extends outside the kidney capsule, since chemotherapy is relatively ineffective against metastatic RCC.

Breast Tumors
Early stage primary breast cancers are treated surgically. Adjuvant radiation therapy decreases local recurrences, particularly for those who select lumpectomy. Adjuvant hormonal therapy and/or chemotherapy are added, depending on presence and number of involved nodes, hormone receptor status, and other factors. Treatment of metastatic disease includes surgery to remove the primary lesion and combination chemotherapy.

Fibroadenomas are common, benign tumors of the breast that can either present as a palpable mass or a mammographic abnormality. These benign tumors are frequently surgically excised to rule out malignancy.

Pancreatic Cancer
Surgical resection of tumors contained entirely within the pancreas is currently the only potentially curative treatment. Patients with more advanced local disease or metastatic disease may undergo chemotherapy with radiation following resection. This is rarely curative, but rather seeks to retard tumor growth or palliate symptoms.

Examples of cryoablation devices for miscellaneous solid tumors include the Cryocare Surgical System by Endocare, the CryoGen Cryosurgical System by Cryosurgical, Inc. and the Visica System by Sanarus Medical. All cryoablation devices are considered investigational regardless of the commercial name, the manufacturer or FDA approval status except when used for the medically necessary indications that are consistent with the policy statement.

Summary
The literature on the use of cryosurgical ablation of tumors addressed in this policy consists primarily of reports of single-center case series; however, evidence is accumulating that cryoablation provides short-term tumor control and perhaps survival benefit for carefully selected patients with small renal cell carcinomas. Based on the scientific data (large numbers of patients treated with follow-up) and the clinical input received, cryoablation of small (4 cm or less) renal cancers may be considered medically necessary in those patients who are not surgical candidates due to comorbid conditions or who have baseline renal insufficiency such that standard surgical procedures would impair their kidney function.

The current evidence on cryoablation for all other indications consists largely of non-comparative, case series and is insufficient to permit conclusions concerning the effect of cryoablation on health outcomes. Therefore, cryoablation is considered investigational for all other indications. Comparative studies with larger numbers of subjects and longer follow-up are needed.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/2016</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>8/2015</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>9/2014</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
</tr>
<tr>
<td>10/2013</td>
<td>New references from BCBSA National medical policy.</td>
</tr>
</tbody>
</table>
Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References