



MASSACHUSETTS

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## Medical Policy

### Whole Gland Cryoablation of the Prostate

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#### Policy Number: 149

BCBSA Reference Number: 7.01.79

NCD/LCD: National Coverage Determination (NCD) for Cryosurgery of Prostate (230.9)

#### Related Policies

- Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy, [#277](#)
- Brachytherapy for Clinically Localized Prostate Cancer Using Permanently Implanted Seeds, [#175](#)
- High Dose Rate Temporary Prostate Brachytherapy, [#353](#)
- Intensity-Modulated Radiation Therapy (IMRT) of the Prostate, [#090](#)

#### Policy

##### Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Whole gland cryosurgical ablation may be considered **MEDICALLY NECESSARY** as treatment of clinically localized (organ-confined) prostate cancer when performed:

- As initial treatment or
- As salvage treatment of disease that recurs following radiotherapy.

##### Medicare Members: Managed Care HMO Blue<sup>SM</sup> and Medicare PPO Blue<sup>SM</sup>

BCBSMA covers cryosurgical ablation of the prostate for the following indications for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD:

- For primary treatment of patients with clinically localized prostate cancer, Stages T1-T3.
- As salvage therapy for patients with localized disease who have failed a trial of radiation therapy as primary treatment and meet one of the following requirements:
  - Stage T2 B or below,
  - Gleason score less than 9, or
  - PSA less than 8 ng/mL.

Cryosurgery as salvage is only covered for Medicare HMO Blue and Medicare PPO Blue members after the failure of a trial of radiation therapy, under the conditions noted above.

BCBSMA does not cover cryosurgery as salvage therapy for Medicare HMO Blue and Medicare PPO Blue members after failure of other therapies as the primary treatment in accordance with CMS NCD.

**National Coverage Determination (NCD) for Cryosurgery of Prostate (230.9)**

<https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=123&ncdver=1&bc=AgAAgAAAAAAA&>

**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.  
 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.

	<b>Outpatient</b>
<b>Commercial Managed Care (HMO and POS)</b>	No
<b>Commercial PPO and Indemnity</b>	No
<b>Medicare HMO Blue<sup>SM</sup></b>	No
<b>Medicare PPO Blue<sup>SM</sup></b>	No

**CPT Codes / HCPCS Codes / ICD Codes**

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. *A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.*

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

*The following codes are included below for informational purposes only; this is not an all-inclusive list.*

The above medical necessity criteria **MUST** be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

**CPT Codes**

<b>CPT codes:</b>	<b>Code Description</b>
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT codes above if medical necessity criteria are met:

**ICD-10 Diagnosis Codes**

<b>ICD-10-CM Diagnosis codes:</b>	<b>Code Description</b>
C61	Malignant neoplasm of prostate
D07.5	Carcinoma in situ of prostate

**Description**

Whole gland (also known as total) cryoablation is one of several methods available to treat clinically localized prostate cancer and may be considered an alternative to radical prostatectomy or EBRT. It also may be used for salvage of nonmetastatic relapse following initial therapy for clinically localized disease. Using percutaneously inserted cryoprobes, the glandular tissue is rapidly frozen and thawed such that tissue necrosis follows. Cryosurgical ablation is less invasive than radical prostatectomy and recovery

time may be shorter. EBRT requires multiple treatments, whereas only one treatment is usually required for total cryoablation.

## Summary

Cryoablation, also known as cryotherapy or cryosurgery, of prostate cancer is a technique in which cryoprobes are inserted percutaneously into the prostate gland to rapidly freeze and thaw tissue causing necrosis. This policy reviews evidence on the use of total (whole gland, definitive therapy) cryoablation compared with external beam radiotherapy (EBRT), radical prostatectomy or other alternative definitive treatments for patients with organ-confined (localized) prostate cancer. Subtotal (focal) cryoablation and alternatives to this procedure, are considered in a separate MPRM policy.

The available evidence for use of total cryotherapy in the treatment of clinically localized (organ-confined) prostate cancer when performed as initial treatment or as salvage treatment of disease that recurs following radiotherapy is sufficient to demonstrate improvement in net health outcome. This conclusion is based on the extensive data from cohort studies and clinical input including an indirect chain of evidence and the recognition that the data for this long-used technique are similar to data for a number of accepted techniques, such as radical prostatectomy and EBRT.

While the evidence for outcomes of treatment for recurrence after EBRT are limited, such patients have few options; one option with recurrence is prostatectomy, which can be difficult in tissue that has been irradiated. However, for patients with recurrence after radiotherapy who elect further treatment, based on the limited evidence available, cryosurgical treatment does appear to produce antitumor activity.

## Policy History

Date	Action
2/2018	Clarified coding information.
9/2017	New references added from BCBSA National medical policy.
11/2016	New references added from BCBSA National medical policy.
10/2015	BCBSA National medical policy review. Information on focal therapy was removed from policy and the policy statement on focal therapy was deleted; "whole gland" was added to medically necessary policy statement and to the title of the policy. Effective 10/1/2015.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
6/2013	New references from BCBSA National medical policy.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
9/2011	Reviewed - Medical Policy Group – Urology, Obstetrics and Gynecology. No changes to policy statements.
7/2011	Reviewed - Medical Policy Group – Hematology and Oncology. No changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
6/2010	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
12/1/2009	National Policy review. Revision to policy statement.
6/2009	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
6/2008	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
6/2007	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
6/2007	National Policy review.

## 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

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