Medical Policy
Whole Gland Cryoablation of the Prostate

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

Policy Number: 149
BCBSA Reference Number: 7.01.79
NCD/LCD: National Coverage Determination (NCD) for Cryosurgery of Prostate (230.9)

Related Policies
- Charged-Particle (Proton or Helium Ion) Radiotherapy for Neoplastic Conditions, #437
- Focal Treatments for Prostate Cancer, #733
- 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 BlueSM and Medicare PPO BlueSM

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.

Medical necessity criteria and coding guidance can be found through the link below.

**National Coverage Determinations (NCDs)**

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

**Note:** To review the specific NCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

**Prior Authorization Information**

**Inpatient**
- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

**Outpatient**
- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55873</td>
<td>Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C61</td>
<td>Malignant neoplasm of prostate</td>
</tr>
</tbody>
</table>
Description
Prostate Cancer
Prostate cancer is the most commonly diagnosed cancer and the third leading cause of cancer deaths among men in the U.S., with an estimated 161360 new cases and 26730 deaths in 2017.\(^1\) The diagnosis and grading of prostate cancer are performed by taking a biopsy of the prostate gland.

Treatment
Whole gland (also known as total) cryoablation is one of several methods used to treat clinically localized prostate cancer and may be considered an alternative to radical prostatectomy or external-beam radiotherapy. Additionally, whole gland cryoablation 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 to cause tissue necrosis. Cryosurgical ablation is less invasive than radical prostatectomy and recovery time may be shorter. External-beam radiotherapy requires multiple treatments, whereas cryoablation usually requires a single treatment.

Summary
Cryoablation, also known as cryotherapy or cryosurgery, is a procedure that attacks cancer cells using extremely cold gas. This technique can be used to treat prostate cancer by percutaneously inserting thin, needle-like cryoprobes into the prostate gland and then sending very cold gas down the cryoprobes to rapidly freeze and thaw the tissue, causing necrosis. This review evaluates evidence on the use of total (whole gland, definitive therapy) cryoablation. Subtotal (focal) cryoablation and alternative procedures are considered in medical policy \#733.

For individuals who are considering initial treatment for localized prostate cancer who receive whole gland cryoablation, the evidence includes several systematic reviews, two randomized controlled trials, and many comparative and noncomparative observational studies. The relevant outcomes are overall survival, disease-specific survival, symptoms, functional outcomes, quality of life, and treatment-related morbidity. High-quality data comparing cryoablation with external-beam radiotherapy, radical prostatectomy, or active surveillance are lacking, but available data have suggested similar overall survival and disease-specific survival rates compared with radical prostatectomy and external-beam radiotherapy. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have salvage treatment for a recurrence of localized prostate cancer following radiotherapy who receive whole gland cryoablation, the evidence includes primarily noncomparative case series and a few retrospective studies comparing salvage cryoablation with salvage prostatectomy. The relevant outcomes are overall survival, disease-specific survival, symptoms, functional outcomes, quality of life, and treatment-related morbidity. High-quality data comparing cryoablation with prostatectomy was mixed, and evidence comparing cryotherapy with brachytherapy is lacking. Men in this group have few options and prostatectomy can be difficult in tissue that has been irradiated. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/2018</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>9/2017</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>11/2016</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>10/2015</td>
<td>BCBSA National medical policy review.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
</tr>
<tr>
<td>6/2013</td>
<td>New references from BCBSA National medical policy.</td>
</tr>
<tr>
<td>12/1/2009</td>
<td>National Policy review. Revision to policy statement.</td>
</tr>
<tr>
<td>6/2007</td>
<td>National Policy review. Revision to policy statement.</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


