Medical Policy
Radiofrequency Ablation of Primary or Metastatic Liver Tumors

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

Policy Number: 286
BCBSA Reference Number: 7.01.91
NCD/LCD: NA

Related Policies
• Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors, #259
• Radioembolization for Primary and Metastatic Tumors of the Liver, #292
• Cryosurgical Ablation of Primary or Metastatic Liver Tumors, #633
• Transcatheter Arterial Chemoembolization (TACE) to Treat Primary or Metastatic Liver Malignancies, #634

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

Radiofrequency ablation of primary, inoperable (eg, due to location of lesion[s] and/or comorbid conditions) hepatocellular carcinoma may be considered MEDICALLY NECESSARY under the following conditions:

• As a primary treatment of hepatocellular carcinoma meeting the Milan criteria (a single tumor of ≤5 cm or up to 3 nodules <3 cm).
• As a bridge to transplant, where the intent is to prevent further tumor growth and to maintain a patient’s candidacy for liver transplant.

Radiofrequency ablation as a primary treatment of inoperable hepatic metastases may be considered MEDICALLY NECESSARY under the following conditions:
• Metastases are of colorectal origin and meet the Milan criteria (a single tumor of ≤5 cm or up to 3 nodules <3 cm).
• Metastases are of neuroendocrine in origin and systemic therapy has failed to control symptoms.

Radiofrequency ablation of primary, inoperable, hepatocellular carcinoma is considered INVESTIGATIONAL under the following conditions:
• When there are more than 3 nodules or when not all sites of tumor foci can be adequately treated.
• When used to downstage (downsize) hepatocellular carcinoma in patients being considered for liver transplant.
Radiofrequency ablation of primary, operable hepatocellular carcinoma is INVESTIGATIONAL.

Radiofrequency ablation for hepatic metastasis is considered INVESTIGATIONAL for:

- Hepatic metastases from colorectal cancer or neuroendocrine tumors that do not meet the criteria above; and
- For hepatic metastases from other types of cancer except colorectal cancer or neuroendocrine tumors.

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

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, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47370</td>
<td>Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency</td>
</tr>
<tr>
<td>47380</td>
<td>Ablation, open, of one or more liver tumor(s); radiofrequency</td>
</tr>
<tr>
<td>47382</td>
<td>Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency</td>
</tr>
</tbody>
</table>

**Description**

**Hepatic and Neuroendocrine Tumors**

Hepatic tumors can arise as primary liver cancer (hepatocellular cancer) or by metastasis to the liver from other tissues. Local therapy for hepatic metastasis may be indicated when there is no extrahepatic disease, which rarely occurs for patients with primary cancers other than colorectal carcinoma or certain neuroendocrine malignancies.

Neuroendocrine tumors are tumors of cells that possess secretory granules and originate from the neuroectoderm. Neuroendocrine cells have roles both in the endocrine system and in the nervous system. They produce and secrete a variety of regulatory hormones, or neuropeptides, which include neurotransmitters and growth factors. Overproduction of the specific neuropeptides produced by the
cancerous cells causes various symptoms, depending on the hormone produced. They are rare, with an incidence of 2 to 4 per 100000 per year.

**Treatment**
Treatment of liver metastases is undertaken to prolong survival and to reduce endocrine-related symptoms and hepatic mass-related symptoms.

At present, surgical resection with adequate margins or liver transplantation constitutes the only treatments available with demonstrated curative potential for hepatic tumors. However, most hepatic tumors are unresectable at diagnosis, due either to their anatomic location, size, number of lesions, or underlying liver reserve. Patients may also have comorbid conditions and do not qualify for surgical resection.

Alternative therapies available include liver transplantation, systemic therapies, or ablation procedures (radiofrequency ablation [RFA], cryoablation, microwave ablation, percutaneous ethanol or acetic acid injection). Choice of therapy depends on the severity of the underlying liver disease, size, and distribution of tumors, vascular supply, and patient overall health.

**Radiofrequency Ablation**
RFA is a procedure in which a needle electrode is inserted into a tumor either percutaneously, through a laparoscope, or through an open incision. The electrode is heated by a high-frequency, alternating current, which destroys tissue in a 3 to 5 cm sphere of the electrode. RFA has been investigated as a treatment for unresectable hepatic tumors, both as a primary intervention and as a bridge to a liver transplant. In the latter setting, RFA is being tested to determine whether it can reduce the incidence of tumor progression in patients awaiting transplantation and thus maintain patients' candidacy for liver ablation, transhepatic arterial chemoembolization, microwave coagulation, percutaneous ethanol injection, and radioembolization (yttrium-90 microspheres).

Note that RFA of extrahepatic tumors is addressed policy # 259

**Summary**
Radiofrequency ablation (RFA) is a procedure in which a probe is inserted into the center of a tumor and heated locally by a high-frequency, alternating current that flows from electrodes. The local heat treats the tissue adjacent to the probe, resulting in a 3 to 5 cm sphere of dead tissue. The cells killed by RFA are not removed but are gradually replaced by fibrosis and scar tissue. If there is a local recurrence, it occurs at the edge of the treated tissue and, in some cases, is retreated. RFA may be performed percutaneously, laparoscopically, or as an open procedure.

**Primary, Operable Hepatocellular Carcinoma**
For individuals who have primary, operable HCC who receive RFA, the evidence includes randomized controlled trials (RCTs), meta-analyses of these RCTs, database analyses, and observational studies. The relevant outcomes are overall survival (OS), disease-specific survival, change in disease status, and morbid events. Results from these studies have suggested that RFA alone or RFA plus transhepatic arterial chemoembolization may be as effective as a resection for small resectable HCC tumors, although the exact size cutoff has not been established. Some studies found that OS was similar in patients receiving RFA or resection when tumor size was 3 cm or less; however, OS was significantly longer in patients undergoing resection if the tumor size was between 3.1 cm and 5 cm. Further study in a multicenter RCT would permit greater certainty whether RFA, with or without transhepatic arterial chemoembolization, is as effective as surgical resection in treating HCC tumors 3 cm or smaller. The evidence is insufficient to determine the effects of the technology RFA on health outcomes.

**Inoperable HCC**
For individuals who have inoperable HCC who receive RFA, the evidence includes randomized trials and several systematic reviews and meta-analyses. The relevant outcomes are OS, disease-specific survival, change in disease status, and morbid events. When resection is not an option, nonsurgical options include RFA, percutaneous ethanol injection, transarterial chemoembolization, cryoablation, microwave ablation, and systemic therapy. Meta-analyses comparing these nonsurgical options have shown improved survival
outcomes with RFA alone or combined with other treatments (eg, with percutaneous ethanol injection or systemic therapy) compared with other nonsurgical treatments alone. Response rates have demonstrated that, in patients with small foci of HCC (≤3 lesions), RFA appears to be better than percutaneous ethanol injection in achieving complete ablation and preventing local recurrence. Three-year survival rates of 80% have been reported. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Inoperable HCC Awaiting Liver Transplant**
For individuals who have inoperable HCC awaiting liver transplant who receive RFA, the evidence includes small case series. The relevant outcomes are OS, disease-specific survival, and change in disease status. A number of approaches are used in this patient population, including RFA and other locoregional therapies, particularly transarterial chemoembolization. Locoregional therapy has reduced the dropout rate of patients with HCC awaiting a liver transplant. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Inoperable Hepatic Metastases of Colorectal Origin**
For individuals who have inoperable hepatic metastases of colorectal origin who receive RFA, the evidence includes an RCT, systematic reviews and meta-analyses, prospective cohort series, and retrospective case series. The relevant outcomes are OS, disease-specific survival, symptoms, change in disease status, morbid events, quality of life (QOL), and treatment-related morbidity. There are no RCTs comparing RFA with alternative treatments for patients who have unresectable colorectal liver metastases. However, an RCT assessing RFA plus chemotherapy found improved survival at eight years compared with chemotherapy alone. In addition, prospective studies have demonstrated that OS following RFA is at least equivalent to and likely better than for currently accepted systemic chemotherapy in well-matched patients with unresectable hepatic metastatic colorectal cancer who do not have extrahepatic disease. Results from a number of uncontrolled case series also have suggested RFA of hepatic colorectal cancer metastases produces long-term survival that is at a minimum equivalent to but likely superior to historical outcomes achieved with systemic chemotherapy. Evidence from a comparative study has indicated RFA has fewer deleterious effects on QOL than chemotherapy and that RFA patients recover the QOL significantly faster than chemotherapy recipients. It should be noted that patients treated with RFA in different series might have had better prognoses than those who had chemotherapy, suggesting patient selection bias might at least partially explain the better outcomes observed following RFA. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Inoperable Hepatic Metastases of Neuroendocrine Origin**
For individuals who have inoperable hepatic metastases of neuroendocrine origin who receive RFA, the evidence includes case series and a systematic review of case series. The relevant outcomes are OS, disease-specific survival, symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Most reports of RFA treatment for neuroendocrine liver metastases have assessed small numbers of patients or subsets of patients in reports of multiple ablative methods or very small subsets of larger case series of patients with various diagnoses. The available evidence has indicated that durable tumor and symptom control of neuroendocrine liver metastases can be achieved using RFA in individuals whose symptoms are not controlled by systemic therapy or who are ineligible for resection. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Hepatic Metastases Not of Colorectal or Neuroendocrine Origin**
For individuals who have hepatic metastases, not of colorectal or neuroendocrine origin who receive RFA, the evidence includes small nonrandomized comparative studies and small case series. The relevant outcomes are OS, disease-specific survival, symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Similar to primary HCC, resection appears to have the most favorable outcomes. For patients who are ineligible for resection, RFA may provide a survival benefit. However, the evidence is limited by study designs with a high-risk of bias and small sample sizes. The evidence is insufficient to determine the effects of the technology RFA on health outcomes.

**Policy History**
<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2018</td>
<td>BCBSA National medical policy review. Policy statements reformatted and edited for clarity and specificity, including the distinction between operable and non-operable tumors and the Milan criteria. The intent of the statements is unchanged. A statement has been added that RFA for operable HCC is considered investigational. Clarified coding information.</td>
</tr>
<tr>
<td>10/2016</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>11/2015</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>11/2013</td>
<td>Removed ICD-9 diagnosis code 155.2 as it does not meet the intent of the policy.</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**


