Medical Policy: Cryosurgery for Liver Tumors (Commercial)

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<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
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<td>MG.MM.SU.13bC10v3</td>
<td>10/11/2019</td>
<td>MPC (Medical Policy Committee)</td>
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**IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:**

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

**Definitions**

| Cryosurgery | Cryosurgery (also known as cryosurgical ablation) is a means for the surgical destruction of a liver tumor using a process of freeze-thaw cycles that kill tumors through physiochemical change and obliteration of small blood vessels. This method is often used in addition to surgical resection. |

**Guideline**

Members with primary hepatocellular or metastatic tumors (i.e. colorectal, neuroendocrine [NET]) that are not amenable to surgical resection alone are eligible for coverage of cryosurgery when all of the following clinical criteria are met:

1. Greatest tumor dimension ≤ 10 cm.
2. No uncontrolled extrahepatic malignancies.
3. Liver volume replacement by tumor < 40%.
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**Exclusions and Limitations:**
The cryosurgical device used must be FDA-approved for the indications present. In the case of carcinomas metastatic to the liver, the following qualifying conditions for coverage must be met:

1. The primary extrahepatic cancer site must be effectively controlled.
2. The metastatic lesions must be limited to the liver and not present in other organs.
3. The patient must have ≤ 5 metastatic sites.
4. Lesions should be ≤ 10 cm.

**Applicable Coding**
*To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy*

**References**


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Specialty-matched clinical peer review.


Revison history

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<tr>
<td>03/09/2020</td>
<td>Reformatted and reorganized policy, transferred content to new CCI template. ConnectiCare has adopted the clinical criteria for its parent company, EmblemHealth</td>
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