Medical Policy: Cryosurgical Ablation for Prostate Cancer (Commercial)

**POLICY NUMBER** | Last Review Date | APPROVED BY
--- | --- | ---
MG.MM.SU.53c | 10/8/2021 | MPC (Medical Policy Committee)

**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 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 (aka cryotherapy or cryoaablontion) | Cryosurgery is a minimally invasive therapy performed with ultrasound guidance that destroys prostate tumor tissue through local freezing. The modality involves either complete or focal ablation (subtotal cryoablation) only targeting diseased tissue while leaving normal tissue intact. |

**Guideline**

Cryosurgery is considered medically necessary as salvage therapy for prostate cancer recurrence after treatment with radiation when disease is localized to one lobe of the prostate.

**Limitations/Exclusions**

Salvage therapy is not considered medically necessary when radiation was not utilized as a primary therapy.

Cryosurgery as a primary treatment modality is not considered medically necessary because it is not supported by the National Comprehensive Cancer Network® (NCCN).

**Applicable Procedure Codes**

| 55873 | Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring) |
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Applicable ICD-10 Diagnosis Codes

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<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
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<tbody>
<tr>
<td>C61</td>
<td>Malignant neoplasm of prostate</td>
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<tr>
<td>D07.5</td>
<td>Carcinoma in situ of prostate</td>
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References


BlueCross BlueShield Association (BCBS), Technology Evaluation Center. Cryoablation for the primary treatment of clinically localized prostate cancer. TEC Assessment Program. Chicago IL: BCBSA; 2001;16(6).

BlueCross BlueShield Association Technology Evaluation Center (TEC). Cryoablation for the primary treatment of clinically localized prostate cancer. 2001 Sep;16(6).


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Revision history

<table>
<thead>
<tr>
<th>DATE</th>
<th>REVISION</th>
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<tbody>
<tr>
<td>10/8/2021</td>
<td>• Updated positive coverage statement to communicate cryotherapy applicability to one lobe, post-radiation, and removed test parameter prerequisites of stage T2b or below, and PSA of &lt; 8 ng/mL</td>
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<tr>
<td>11/11/2019</td>
<td>• Removed Gleason Score prerequisite</td>
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| 09/13/2019 | • Connecticare has adopted the clinical criteria of its parent corporation, EmblemHealth  
|            | • Reformatted and reorganized policy, transferred content to new template  
|            | • Removed primary treatment as a covered indication                        |