

Medical Policy:

Cryosurgery for Liver Tumors

POLICY NUMBER	LAST REVIEW
MG.MM.SU.13bc12	November 12, 2021

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The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as “EmblemHealth”), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. 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. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth 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). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program 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 EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. 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. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definitions

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 \leq 10 cm
2. No uncontrolled extrahepatic malignancies
3. Liver volume replacement by tumor $<$ 40%

Limitations and Exclusions

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

Procedure Codes

47371	Laparoscopy, surgical, ablation of one or more liver tumor(s); cryosurgical
47381	Ablation, open, of one or more liver tumor(s); cryosurgical
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation

ICD-10 Diagnoses

C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C18.0	Malignant neoplasm of cecum
C18.1	Malignant neoplasm of appendix
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure
C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C18.9	Malignant neoplasm of colon, unspecified
C22.0	Liver cell carcinoma
C22.2	Hepatoblastoma
C22.3	Angiosarcoma of liver
C22.4	Other sarcomas of liver
C22.7	Other specified carcinomas of liver
C22.8	Malignant neoplasm of liver, primary, unspecified as to type
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct

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Revision History

Oct. 19, 2020	ConnectiCare adopts the clinical criteria of its parent corporation EmblemHealth Removed primary treatment as a covered indication
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