

Medical Policy:

Cryosurgical Ablation for Prostate Cancer

POLICY NUMBER	LAST REVIEW
MG.MM.SU.53cC	October 14, 2022

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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 (aka cryotherapy or cryoablation) 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 and 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).

Procedure Codes

55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
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ICD-10 Diagnoses

C61	Malignant neoplasm of prostate
D07.5	Carcinoma in situ of prostate

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Revision History

Oct. 8, 2021	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 < 8 ng/mL
Nov. 11, 2019	Removed Gleason Score prerequisite
Sept. 13, 2019	Connecticare adopts the clinical criteria of its parent corporation EmblemHealth Removed primary treatment as a covered indication