Medical Policy:
Cryosurgical Radiofrequency Ablation for Renal Tumors (Commercial)

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<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
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<td>MG.MM.SU.45C12</td>
<td>06/14/2019</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 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

| Cryoablation | Also known as cryosurgery or cryotherapy, cryoablation is a technique of ablating cells using liquid nitrogen or argon gas that is circulated through a hollow probe placed in direct contact with the tumor. An ice crystal formation around the probe tip freezes nearby cells, which destroys them. The ablated tissue is then absorbed by the body. |
| Radiofrequency ablation (RFA) | A technique of heating cells using a small needle electrode placed directly into a tumor. High frequency radio waves heat the tumor and cause local necrosis. The dead cells become scar tissue and eventually shrink. |
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Guideline
Members with small undefined renal lesions (≤ 4 cm in diameter) that are suspected to be malignant, or with malignant potential, are eligible for coverage of either cryoablation or RFA by any modality (eg laparoscopically or percutaneously) when either of the following criteria is met:

1. Medically or surgically inoperable tumor(s).
2. Poor candidacy for standard treatments (i.e., nephrectomy).

Limitations/Exclusions
Neither cryoablation nor RFA is considered medically necessary for members able to undergo surgical resection.

Coding Criteria:
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy.

| Applicable CPT and Diagnosis Codes |

References


Specialty-matched clinical peer review.

Revision history

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<td>12/2019</td>
<td>• Reformatted and reorganized policy, transferred content to new template</td>
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