

Cryoablation



Medical Coverage Policy

Effective Date: 12/08/2021

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Change Summary: Updated Description, Coverage Determination, Coverage Limitations, References, Appendix

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Disclaimer

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over clinical policy and must be considered first in determining eligibility for coverage. Coverage may also differ for our Medicare and/or Medicaid members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Medical Review Policies (LMRP) and/or Local Coverage Determinations. Refer to the [CMS website](#). The member's health plan benefits in effect on the date services are rendered must be used. Clinical policy is not intended to preempt 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. 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. Clinical technology is constantly evolving, and we reserve the right to review and update this policy periodically. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise, without permission from Humana.

Description

Cryoablation (also known as cryotherapy or cryosurgery) involves the internal or external use of liquid nitrogen or argon gas at extreme cold temperatures to destroy diseased tissue. For external uses, the liquid nitrogen is applied directly with a cotton swab or spray device. For internal purposes, either argon gas or liquid nitrogen is circulated through a cryoprobe that has been situated next to diseased tissue via image guidance, such as ultrasound, magnetic resonance imaging (MRI) or computed tomography (CT), which reportedly ensures less damage to nearby healthy tissue. Ice crystals form around the probe, which freezes the cells. Once the cells thaw, the body absorbs them. Cryoablation may be used to treat several types of cancer including, but may not be limited to, cervical, kidney, liver and prostate. Cryoablation has also been used in precancerous conditions to avoid the development of cancer (eg, cervical intraepithelial neoplasia [CIN]).

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Cryoablation may be utilized for the treatment of cutaneous (superficial) basal cell carcinoma (BCC) and squamous cell carcinoma in situ (Bowen disease) in which surgery is contraindicated. Choice of treatment depends on factors such as anatomic location, risk factors for tumor recurrence, age and health status of the individual. Cryoablation may purportedly be utilized for the treatment of cutaneous melanoma; however, data appears to be insufficient to support its use for this indication. **(Refer to Coverage Limitations section)**

Other areas being studied for the use of cryoablation include, but may not be limited to, Barrett's esophagus, bone tumors, breast cancer, breast fibroadenomas, esophageal cancer, pulmonary tumors, non-small cell lung cancer (NSCLC) as well as thyroid cancer. **(Refer to Coverage Limitations section)**

Cryotherapy is proposed for the use of ocular conditions such as retinal detachment. This treatment is designed to create scar tissue, which will seal the tear or help the retina reattach to the underlying tissue to keep it in the correct position.

Cryotherapy is also being investigated for the treatment of uveal melanoma, retinopathy (eg, diabetic retinopathy) or conjunctival lesions. **(Refer to Coverage Limitations section)**

Cryoablation is also being investigated for the treatment of chronic rhinitis. The treatment is designed to destroy unwanted tissue and to purportedly interrupt nerve signals in the nose to reduce rhinitis symptoms (eg, ClariFix). **(Refer to Coverage Limitations section)**

Cryoablation has also been utilized for noncancerous conditions such as atrial fibrillation, benign prostatic hyperplasia, benign skin lesions, chronic nerve pain, chronic spinal pain, plantar fasciitis, uterine fibroids as well as varicose veins.

For information regarding **cryoablation for the treatment of atrial fibrillation (AF)**, please refer to [Cardiac Electrophysiological Studies and Cardiac Catheter Ablation](#) Medical Coverage Policy.

For information regarding **cryoablation for benign prostatic hyperplasia**, please refer to [Benign Prostatic Hyperplasia \(BPH\) Treatments](#) Medical Coverage Policy

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For information regarding **cryoablation for the treatment of benign skin conditions**, please refer to [Actinic Keratoses Treatments](#) Medical Coverage Policy and [Benign Skin Lesion Treatments](#) Medical Coverage Policy.

For information regarding **cryoablation for chronic nerve and spinal pain**, please refer to [Neuroablative Techniques for Chronic Pain](#) Medical Coverage Policy.

For information regarding **cryoablation for the treatment of plantar fasciitis**, please refer to [Plantar Fasciitis Treatments](#) Medical Coverage Policy

For information regarding **cryoablation for the treatment of uterine fibroids**, please refer to [Uterine Fibroid Surgical Treatments](#) Medical Coverage Policy.

For information regarding **cryoablation for the treatment of varicose veins**, please refer to [Varicose Vein Treatments](#) Medical Coverage Policy)

Coverage Determination

Humana members may be eligible under the Plan for **cryoablation** for the following indications:

- Cervical intraepithelial neoplasia ([CIN](#)) [grade](#) 1, 2 or 3; **OR**
- Endometrial cryoablation for premenopausal women with menorrhagia (excessive bleeding) not related to uterine fibroids and whom childbearing is complete and are refractory to medical treatment; **OR**
- Localized, cutaneous (superficial) BCC in which surgery or radiation therapy is contraindicated;⁵⁷ **OR**
- Localized, cutaneous (superficial) squamous cell carcinoma in situ (Bowen disease) in which surgery is contraindicated;⁶⁷ **OR**
- Malignant inoperable endobronchial obstruction in symptomatic individuals; **OR**
- Prostate cancer as a primary therapy alternative to surgery or irradiation in individuals with localized disease (eg, [TNM stage](#) T1-T3) **OR** as salvage therapy for recurrent cancer following failure of radiation therapy; **OR**

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- Renal cell cancer in individuals who are not candidates for partial nephrectomy, radical nephrectomy or radiofrequency ablation (RFA); **OR**
- Retinal detachment; **OR**
- Retinopathy of prematurity; **OR**
- Soft tissue sarcoma of the extremities or the trunk in symptomatic individuals with disseminated metastases; **OR**
- Unresectable malignant primary or metastatic liver tumors

Note: The criteria for **cryoablation of the prostate** are not consistent with the Medicare National Coverage Policy and therefore may not be applicable to Medicare members. Refer to the [CMS website](#) for additional information.

Coverage Limitations

Humana members may **NOT** be eligible under the Plan for **cryoablation** for any indications other than those listed above including, but may not be limited to:

- Barrett's esophagus; **OR**
- Bone tumors (primary or metastatic); **OR**
- Breast cancer; **OR**
- Breast fibroadenomas; **OR**
- Chronic rhinitis (eg, ClariFix); **OR**
- Conjunctival lesions; **OR**
- Cutaneous melanoma; **OR**
- Diabetic retinopathy; **OR**

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- Esophageal cancer; **OR**
- Morton's neuromas; **OR**
- Pancreatic cancer; **OR**
- Peripheral neuropathy; **OR**
- Plantar fibromas; **OR**
- Pulmonary tumors (eg, NSCLC); **OR**
- Thyroid cancer; **OR**
- Uveal melanoma

These are considered experimental/investigational as they are not identified as widely used and generally accepted for any other proposed uses as reported in nationally recognized peer-reviewed medical literature published in the English language.

Background

Additional information about **cancer, menorrhagia, retinopathy of prematurity or skin lesions** may be found from the following websites:

- [American Academy of Dermatology](#)
- [American Academy of Pediatrics](#)
- [American Cancer Society](#)
- [American College of Obstetricians and Gynecologists](#)
- [National Library of Medicine](#)

Medical Alternatives

Alternatives to **cryoablation** include, but may not be limited to, the following:

- Prescription drug therapy
- Radiation
- Surgery

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Physician consultation is advised to make an informed decision based on an individual's health needs.

Provider Claims Codes Any CPT, HCPCS or ICD codes listed on this medical coverage policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
17260	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less	
17261	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	
17262	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	
17263	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm	
17264	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm	
17266	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter over 4.0 cm	
17270	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	

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17271	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	
17272	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	
17273	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm	
17274	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm	
17276	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm	
17280	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	
17281	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	
17282	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	
17283	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm	
17284	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm	

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17286	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm	
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Not Covered
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Not Covered
31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Not Covered
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Not Covered if used to report any treatment outlined in Coverage Limitations section
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Not Covered if used to report any treatment outlined in Coverage Limitations section
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	
47381	Ablation, open, of 1 or more liver tumor(s); cryosurgical	
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	
50541	Laparoscopy, surgical; ablation of renal cysts	

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50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	Not Covered if used to report any treatment outlined in Coverage Limitations section
57511	Cautery of cervix; cryocautery, initial or repeat	
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed	
67113	Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens	
67229	Treatment of extensive or progressive retinopathy, 1 or more sessions, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy	
CPT® Category III Code(s)	Description	Comments
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	Not Covered
HCPCS Code(s)	Description	Comments
C2618	Probe/needle, cryoablation	Not Covered if used to report any procedure outlined in Coverage Limitations section

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C9771	Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s), unilateral or bilateral	Not Covered
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Cryoablation

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Appendix A

CIN Grades

CIN 1	Abnormal cells are found on the surface of the cervix.
CIN 2	Moderately abnormal cells are found on the surface of the cervix.
CIN 3	Severely abnormal cells are found on the surface of the cervix.

Appendix B

TNM Staging System for Prostate Cancer⁶⁵

Primary tumor (T)	
Clinical T (cT)	
T category	T criteria
TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
T1	Clinically inapparent tumor that is not palpable
T1a	Tumor incidental histologic finding in 5% or less of tissue resected
T1b	Tumor incidental histologic finding in more than 5% of tissue resected
T1c	Tumor identified by needle biopsy found in one or both sides, but not palpable
T2	Tumor is palpable and confined within prostate
T2a	Tumor involves one-half of one side or less
T2b	Tumor involves more than one-half of one side but not both sides
T2c	Tumor involves both sides
T3	Extraprostatic tumor that is not fixed or does not invade adjacent structures
T3a	Extraprostatic extension (unilateral or bilateral)
T3b	Tumor invades seminal vesicle(s)
T4	Tumor is fixed or invades adjacent structures other than seminal vesicles such as external sphincter, rectum, bladder, levator muscles, and/or pelvic wall.
Pathological T (pT)	
T category	T criteria
T2	Organ confined
T3	Extraprostatic extension
T3a	Extraprostatic extension (unilateral or bilateral) or microscopic invasion of bladder neck

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T3b	Tumor invades seminal vesicle(s)
T4	Tumor is fixed or invades adjacent structures other than seminal vesicles such as external sphincter, rectum, bladder, levator muscles, and/or pelvic wall