Medical Policy

Cryoablation of the Prostate

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Policy Number: 149
BCBSA Reference Number: 7.01.79

Related Policies
- Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy, #277
- Brachytherapy for Clinically Localized Prostate Cancer Using Permanently Implanted Seeds, #175
- High Dose Rate Temporary Prostate Brachytherapy, #353
- Intensity-Modulated Radiation Therapy (IMRT) of the Prostate, #090

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Cryosurgical ablation of the prostate as treatment of clinically localized (organ-confined) prostate cancer may be considered MEDICALLY NECESSARY when performed:
- As initial treatment, or
- As salvage treatment of disease that recurs following radiation therapy.

Cryosurgical ablation of the prostate for other indications is INVESTIGATIONAL.

Subtotal prostate cryoablation in the treatment of prostate cancer is INVESTIGATIONAL.

Medicare Members: Managed Care HMO BlueSM and Medicare PPO BlueSM

BCBSMA covers cryosurgical ablation of the prostate for the following indications for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD:
- For primary treatment of patients with clinically localized prostate cancer, Stages T1-T3.
- As salvage therapy for patients with localized disease who have failed a trial of radiation therapy as primary treatment and meet one of the following requirements:
  - Stage T2 B or below,
  - Gleason score less than 9, or
  - PSA less than 8 ng/mL.

Cryosurgery as salvage is only covered for Medicare HMO Blue and Medicare PPO Blue members after the failure of a trial of radiation therapy, under the conditions noted above.

BCBSMA does not cover cryosurgery as salvage therapy for Medicare HMO Blue and Medicare PPO Blue members after failure of other therapies as the primary treatment in accordance with CMS NCD.
National Coverage Determination (NCD) for Cryosurgery of Prostate (230.9)

Prior Authorization Information
Commercial Members: Managed Care (HMO and POS)
Prior authorization is NOT required.

Commercial Members: PPO, and Indemnity
Prior authorization is NOT required.

Medicare Members: HMO Blue\textsuperscript{SM}
Prior authorization is NOT required.

Medicare Members: PPO Blue\textsuperscript{SM}
Prior authorization is NOT required.

CPT Codes / HCPCS Codes / ICD-9 Codes
The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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</thead>
<tbody>
<tr>
<td>55873</td>
<td>Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)</td>
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</table>

ICD-9 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>185</td>
<td>Malignant neoplasm of prostate</td>
</tr>
<tr>
<td>233.4</td>
<td>Carcinoma in situ of prostate</td>
</tr>
</tbody>
</table>

ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C61</td>
<td>Malignant neoplasm of prostate</td>
</tr>
<tr>
<td>D07.5</td>
<td>Carcinoma in situ of prostate</td>
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</tbody>
</table>

Description
Cryoablation is one of several methods available to treat clinically localized prostate cancer, and may be considered an alternative to radical prostatectomy or radiation therapy. Cryosurgical ablation is less invasive than surgery and recovery time may be shorter. Typically only one treatment is required for cryoablation.

Subtotal prostate cryoablation is also being evaluated as a form of more localized therapy (referred to by some as “male lumpectomy”) for small localized prostate cancers.
Summary
The available evidence for use of cryotherapy in the treatment of clinically localized (organ-confined) prostate cancer when performed as initial treatment or as salvage treatment of disease that recurs following radiation therapy is sufficient to demonstrate improvement in net health outcome. This conclusion is based on the extensive data from cohort studies and clinical input including an indirect chain of evidence and the recognition that the data for this long-used technique is similar to data for a number of accepted techniques. While the data for treatment of recurrence after radiation therapy are limited, these patients have few options; one option with recurrence is prostatectomy, which can be difficult in tissue that has been irradiated. For patients with recurrence after radiation therapy who elect further treatment, based on the limited data available, cryosurgical treatment does appear to produce anti-tumor activity.

Given the lack of long-term follow-up data, including a lack of comparative studies, subtotal prostate cryoablation is considered investigational.

Per national coverage determination, CMS indicates cryotherapy is medically necessary and appropriate as primary treatment for clinically localized prostate cancer in stages T1-T-3. Salvage cryotherapy is only medically necessary and appropriate in localized disease when radiation therapy has failed as primary treatment, and the patient meets 1 of 3 criteria: stage T2B or below, Gleason score less than 9 or PSA less than 8ng/mL. Salvage cryotherapy after failure of other therapies is not covered.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
</tr>
<tr>
<td>6/2013</td>
<td>New references from BCBSA National medical policy.</td>
</tr>
<tr>
<td>12/1/2009</td>
<td>National Policy review.</td>
</tr>
<tr>
<td>6/2007</td>
<td>National Policy review.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines
References


