HEALTHHELP®

A WNS COMPANY

Ablation: Cryoablation • Microwave • Radiofrequency • Surgical • Ultrasound • Waterjet

Surgical Services

SURG-SABL-BCBSSC

Last Review Date: 06/27/2024

Previous Review Date: 06/16/2023

Guideline Initiated: 06/30/2019

HEALTHHELP®

A WNS COMPANY

Table of Contents

BlueCross and BlueShield of South Carolina

IMPORTANT
To locate the appropriate updated Clinical Policies for BlueCross and BlueShield of South Carolina, please go to: https://www.southcarolinablues.com/web/public/brands/sc/providers/policies-and-authorizations/medical-policies/

TIP
A National Coverage Determination (NCD) or Local Coverage Determination (LCD) may be necessary to review for Medicare participants. Please go to: https://www.cms.gov/medicare-coverage-database/search.aspx for the latest coverage determination information.

Internal Use Only

11231 11235 11233 11238 11241 11234 11240 11474 11224 11229 11225 11226 11274 11269 11267 11268 11264 11263 11236 11237 11239 11242 11228 11646 11275 11262 11265 11266 11270

Cryoablation

NCD 230.9
See also, **NCD 230.9**: Cryosurgery of Prostate at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Biliary Tract Cancer Guideline

Cryoablation for the treatment of biliary tract cancer: [19] [2]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Bone Cancer Guideline

Cryoablation for the treatment of bone cancer: [21] [5] [4]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Kidney Cancer Guideline

Cryoablation for the treatment of kidney cancer is considered medically appropriate when the documentation demonstrates **ALL** of the following: [7]

- Diagnosis of clinical stage T1 renal lesions [20]
- Tumor size is 3 cm or less. [9]
- **NOT** a candidate for a nephrectomy [9]

Liver Cancer Guideline

Cryoablation for the treatment of liver cancer is considered medically appropriate when the documentation demonstrates **ALL** of the following: [19]

- Diagnosis of liver cancer [3]
- Tumor is unresectable. [3]
- Tumor size is 3 cm or less. [3]

Prostate Cancer Guideline

Cryoablation for the treatment of prostate cancer is considered medically appropriate when the documentation demonstrates local therapy[1] and **ALL** of the following: [17] [22] [23]

- Recurrence after completion of radiation therapy [25]
- **NO** metastatic disease [25]

Prostate Non-Cancer Guideline

Cryoablation for the treatment of prostate non-cancer: [10] [26]

[1]Per National Comprehensive Cancer Network (NCCN), Cryotherapy or other local therapies are not recommended as routine primary therapy for localized prostate cancer due to lack of long term data comparing these treatments to radiation or radical prostatectomy. At this time, the panel recommends only cryosurgery and high-intensity focused ultrasound (HIFU; category 2B) as local therapy options for RT recurrence in absence of metastatic disease.

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Procedure Codes

Table 1. Cryoablation Associated Procedure Codes

CODE	DESCRIPTION
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
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical
47381	Ablation, open, of one 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
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

Cryoablation Summary of Changes

Cryoablation guideline had the following version changes from 2023 to 2024:

- Citations updated, evidence review completed.
- Kidney Cancer mass less than 3 cm changed to tumor size 3 cm or less per current research.
- Prostate cancer removed localized and locally advanced therapy and updated with local therapy per current research.

Microwave Ablation

Prostate Cancer Guideline

Microwave ablation for the treatment of prostate cancer: [22] [17] [25]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Procedure Codes

Table 1. Microwave Ablation Associated Procedure Codes

CODE	DESCRIPTION
53850	Transurethral destruction of the prostate tissue; by microwave thermotherapy

Microwave Ablation Summary of Changes

Microwave ablation guideline had the following version changes from 2023 to 2024:

- Citations updated, evidence review completed.

Radiofrequency Ablation

Bone Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of bone cancer is considered medically appropriate when the documentation demonstrates **ALL** of the following: [5]

I. Bone cancer is known. [4]

II. Physical ability and clinical status of **ANY** of the following:

  A. Eastern Cooperative Oncology Group (ECOG) Performance Status grade of 2 or less

  B. Karnofsky Performance Status (KPS) grade of 70 or more

III. RFA is being used as an alternative to surgery. [27]

IV. Treatment is to preserve function and/or prevent pathological fracture in a weight bearing bone. [16]

Liver Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of liver cancer is considered medically appropriate when the documentation demonstrates **ANY** of the following: [13] [3]

I. Hepatocellular carcinoma (HCC) is known and **ALL** of the following:

  A. Physical ability and clinical status of **ANY** of the following:

    A. Eastern Cooperative Oncology Group (ECOG) Performance Status grade of 2 or less

    B. Karnofsky Performance Status (KPS) grade of 70 or more

  B. Use is **ANY** of the following:

1. Radiofrequency is **NOT** being used for bridging and the largest lesion is 3 cm or smaller.
2. Radiofrequency is being used for bridging.

C. **NOT** a surgical candidate.

II. **NO** diagnosis of hepatocellular carcinoma and **ALL** of the following:

A. Colorectal cancer is known.

B. Metastases of colorectal cancer is isolated to the liver.

C. Number of metastatic lesions are 3 or fewer.

D. Size of largest lesion is 3 cm or smaller.

E. Site of treatment is **NOT** in close proximity (1 cm or closer) to one or more major vascular structures.

Prostate Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of prostate cancer: [22] [17] [25]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Benign Prostatic Hypertrophy (BPH) Guideline

Radiofrequency ablation (RFA) for the treatment of benign prostatic hypertrophy (BPH) is considered medically appropriate when the documentation demonstrates **ALL** of the following: (***NOTE:** *Radiofrequency ablation (RFA) for the treatment of benign prostatic hypertrophy (BPH) using transurethral needle ablation (TUNA) is **NOT** recommended)*. [8] [14]

I. International prostate symptom score (IPSS) score is 8 or higher.

II. Lower urinary tract symptoms (LUTS) are diagnosed, secondary to BPH, that interferes with activities of daily living (ADLs), including **ANY** of the following:

A. Bladder emptying has a decreased sensation.

B. Hematuria

C. Nocturia

D. Urinary frequency, urgency, incontinence or straining has increased.

E. Urinary stream is intermittent and the force has decreased.

III. Prostate volume is 30 to 80 cc.

IV. Treatment consists of water vapor thermal therapy (REZŪM™).

V. Medical therapy did **NOT** alleviate LUTS (eg, lifestyle, non-procedural treatments, pharmacologic).

Renal Cysts Guideline

Radiofrequency ablation (RFA) for the treatment of renal cysts: [11] [24]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Renal Cell Carcinoma (RCC)/Kidney Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of renal cell cancer (RCC) is considered medically appropriate when the documentation demonstrates **ANY** of the following: [9] [20] [1]

I. Initial treatment and **ALL** of the following:
   A. Diagnosis of clinical stage pT1a renal lesion
   B. Physical ability and clinical status of **ANY** of the following:
      A. Eastern Cooperative Oncology Group (ECOG) Performance Status grade of 2 or less
      B. Karnofsky Performance Status (KPS) grade of 70 or more
   C. Tumor is 3 cm or less.
   D. **NOT** a surgical candidate (eg, solitary kidney, morbid obesity, advanced age, decreased renal function[2]) or surgery refusal

II. Recurrence of RCC and **ALL** of the following:
   A. Previous partial nephrectomy or enucleation.
   B. Physical ability and clinical status of **ANY** of the following:
      A. Eastern Cooperative Oncology Group (ECOG) Performance Status grade of 2 or less
      B. Karnofsky Performance Status (KPS) grade of 70 or more

[2]Renal insufficiency is defined by a glomerular filtration rate (GFR) of less than or equal to 60 mL/min/m2.

Procedure Codes

Table 1. Radiofrequency Ablation Associated Procedure Codes

CODE	DESCRIPTION
20982	Ablation therapy for reduction or eradication of 1 or more bone tumor(s) (e.g., metastasis) including adjacent soft tissue when involved by tumor excision, percutaneous, including imaging guidance when performed; radio-frequency
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency
53852	Transurethral destruction of the prostate tissue; by radiofrequency thermotherapy
53854	Transurethral destruction of the prostate tissue; by radiofrequency generated water vapor thermotherapy

Radiofrequency Ablation Summary of Changes

Radiofrequency ablation guideline had the following version changes from 2023 to 2024:

- Citations updated, evidence review completed.
- Renal cell carcinoma
  - Removed "surgical candidate" and added "**NOT** a surgical candidate" per current research.
  - Removed "RCC tumor measures more than 3 cm and is associated with intractable hematuria" per current research.
  - Added "diagnosis of clinical stage pT1a renal lesion" per current research.
  - Removed "tumors are confined to the kidney with 1 site of metastasis" per current research.
  - Removed "tumors are centrally located near the hilum or collection system" per current research.
  - Updated "Ablation is for treatment of localized recurrence of RCC in individual with a previous nephrectomy" to "Previous partial nephrectomy or enucleation" per current research.

Surgical Ablation

Kidney Cancer Guideline

Surgical ablation for the treatment of kidney cancer: [9] [20]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Procedure Codes

Table 1. Surgical Ablation Associated Procedure Codes

CODE	DESCRIPTION
50541	Laparoscopy, surgical; ablation of renal cysts
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed

Surgical Ablation Summary of Changes

Surgical Ablation guideline from 2023 to 2024 had the following changes:

- Citations updated, evidence review completed.

High Intensity Focused Ultrasound (HIFU) Ablation

Prostate Cancer Guideline

Ultrasound (HIFU) ablation for the treatment of prostate cancer is considered medically appropriate when the documentation demonstrates **ALL** of the following:

- **NO** metastatic disease [25] [22] [18]
- Recurrence after completion of radiation therapy. [25]

Procedure Codes

Table 1. Ultrasound (HIFU) Associated Procedure Codes

CODE	DESCRIPTION
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance

Ultrasound (HIFU) Summary of Changes

Ultrasound (HIFU) guideline from 2023 to 2024 had the following changes:

- Added the following criteria:
  - **NO** metastatic disease

- Recurrence after completion of radiation therapy.

Water Jet Ablation

Prostate Cancer Guideline

Water jet ablation for the treatment of prostate cancer: [22] [17] [25]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Benign Prostatic Hypertrophy (BPH) Guideline

Water jet ablation for the treatment of benign prostatic hypertrophy (BPH)[3]: [15] [25] [22] [6]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

Local Coverage Determinations (LCDs) Associated With Water Jet Ablation

LCD 38367
See also, **LCD 38367**: Fluid Jet System Treatment for LUTS/BPH at www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38367&ver=24&bc=0 *if applicable to individual's healthplan membership*.

LCD 38378
See also, **LCD 38378**: Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH) at www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38378&ver=16&bc=0 *if applicable to individual's healthplan membership*.

[3]Per the American Urological Association, robotic waterjet treatment is evidence level: Grade C.

LCD L38549
See also, **LCD L38549**: Transurethral Waterjet Ablation of the Prostate at www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38549&ver=12&bc=0 *if applicable to individual's healthplan membership*.

LCD 38682
See also, **LCD 38682**:Transurethral Waterjet Ablation of the Prostate at www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38682 *if applicable to individual's healthplan membership*.

LCD 38705
See also, **LCD 38705**: Transurethral Waterjet Ablation of the Prostate at www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38705 *if applicable to individual's healthplan membership*.

LCD L38707
See also, **LCD L38707**: Transurethral Waterjet Ablation of the Prostate at www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38707 *if applicable to individual's healthplan membership*.

LCD 38712
See also, **LCD 38712**: Transurethral Waterjet Ablation of the Prostate at www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38712 *if applicable to individual's healthplan membership*.

LCD 38726
See also, **LCD 38726**: Transurethral Waterjet Ablation of the Prostate at www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=38726 *if applicable to individual's healthplan membership*.

Procedure Codes

Table 1. Water Jet Ablation Associated Procedure Codes

CODE	DESCRIPTION
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)

Water Jet Ablation Summary of Changes

Water Jet Ablation clinical guidelines had the following version changes from 2023 to 2024:

- Added benign prostatic hypertrophy indication.
- Citations updated, evidence review completed.

Ablation Definitions

Cryoablation is a procedure that uses extremely cold gas to freeze and destroy abnormal cells or diseased tissue. Also called cryotherapy and cryosurgery.
Enucleation is the removal of an organ or tumor in such a way that it comes out clean and whole.
Local therapy is treatment that is directed to a specific organ or limited area of the body.
Microwave Ablation: A minimally-invasive treatment for cancer. Microwave ablation (MWA) uses ultrasound, computed tomography (CT), or magnetic resonance imaging (MRI) to guide placement of a needle-like probe into a tumor. MWA uses microwaves to heat and destroy the tumor.
Pathological fracture is a bone fracture which occurs without adequate trauma and is caused by a preexistent pathological bone lesion.
Radiofrequency Ablation: A minimally invasive procedure that uses electrical energy and heat to destroy cancer cells. Radiofrequency ablation (RFA) uses image guidance to place a needle through the skin into a tumor. In RFA, high-frequency electrical currents are passed through an electrode in the needle, creating a small region of heat. The heat destroys the cancer cells.
Surgical Ablation: Surgical removal of tissue. For the kidney specifically, surgical ablation is usually performed as a minimally invasive laparoscopic procedure. Under general anesthesia,

small incisions are made and the kidney is exposed. A needle is then placed into the tumor under direct vision.

Ultrasound Albation/High Intensity Focused Ultrasound: A non-invasive therapy that uses focused ultrasound waves to thermally ablate a portion of tissue. Also referred to as high intensity focused ultrasound (HIFU).

Waterjet Ablation: A heat-free system that uses a high-speed solution of saline and a real-time transrectal ultrasound (electromagnetically controlled) to destroy prostatic tissue.

References

[1] Bazzocchi, M. V., Bertolotti, L., . . . Ziglioli, F. (2023). Radiofrequency Ablation, Cryoablation, and Microwave Ablation for the Treatment of Small Renal Masses: Efficacy and Complications. *Diagnostics, 13*(3), 388.

[2] Benson, A.B., D'Angelica, M.I., . . . Yopp, A. (2023). Biliary Tract Cancers Version 3.2023. *National Comprehensive Cancer Network*. Retrieved: January 2024. https://www.nccn.org/professionals/physician_gls/pdf/btc.pdf

[3] Benson, A.B., D'Angelica, M.I., . . . Yopp, A. (2023). Hepatocellular Carcinoma Version 2.2023. *National Comprehensive Cancer Network*. Retrieved: May 2024. https://www.nccn.org/professionals/physician_gls/pdf/hcc.pdf

[4] Bierman, J.S., Hirbe, A., . . . Wustrack, R.L. (2024). Bone Cancer Version 2.2024. *National Comprehensive Cancer Network*. Retrieved: March 2024. https://www.nccn.org/professionals/physician_gls/pdf/bone.pdf

[5] Costelloe, C.M., Lin, P.P., . . . Madewell, J.E. (2021). Bone Metastases: Mechanisms of the Metastatic Process, Imaging and Therapy. *Seminars in Ultrasound, CT and MRI, 42*(2), 164-183.

[6] Cornu, J.N., Gacci.M., . . . Moris, L. (2023). EAU Guidelines on Non-Neurogenic Male Lower Urinary Tract Symptoms (LUTS), incl. Benign Prostatic Obstruction (BPO). *European Association of Urology*. Retrieved: March 2024. https://uroweb.org/guidelines/management-of-non-neurogenic-male-luts

[7] De Marini, P., Cazzato, R.L., . . . Gangi, A. (2021). Safety and oncologic efficacy of percutaneous MRI-guided cryoablation of intraparenchymal renal cancers. *Diagnostic and Interventional Imaging, 102*(9), 531-538.

[8] Elterman, D., Aube-Peterkin, M., . . . Bhojani, N. (2022). UPDATE – Canadian Urological Association guideline: Male lower urinary tract symptoms/ benign prostatic hyperplasia. *Canadian Urological Association Journal, 16*(8), 245-256.

[9] Escudier, B., Porta, C., . . . Horwich, A. (2019). Renal cell carcinoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Annals of Oncology, 30*, 706-720.

[10] Ferri, F.F. (2023). Benign Prostatic Hyperplasia. F.F. Ferri (Ed.). *Ferri's Clinical Advisor 2023*, (pp. 259-261.e1). Philadelphia, PA: Elsevier, Inc.

[11] Finelli, A., Ismalia, N., . . . Russo, P. (2017). 2017 Management of Small Renal Masses: American Society of Clinical Oncology Clinical Practice Guideline. *Journal of Clinical Oncology, 35*(6), 668-680.

[12] Ghavimi, S., Apfel, T., . . . Pyrsopoulos, T. (2020). Management and Treatment of Hepatocellular Carcinoma with Immunotherapy: A Review of Current and Future Options. *The Journal of Clinical and Translational Hepatology, 8*(2), 168-176.

[13] Izzo, F., Granata, V., . . . Curley, S.A. (2019). Radiofrequency Ablation and Microwave Ablation in Liver Tumors: An Update. *The Oncologist, 24*(3), 123-145.

[14] Lerner, L.B., McVary, K.T., . . . Wilt, T.J. (2021). Management of Lower Urinary Tract Symptoms Attributed to Benign Prostatic Hyperplasia: AUA GUIDELINE PART I Initial Work-up and Medical Management. *The Journal of Urology, 206*, 806-817.

[15] Lerner, L.B., Barry, M.B.,... McVary, K,T. (2023). Management of Lower Urinary Tract Symptoms Attributed to Benign Prostatic Hyperplasia: AUA Guideline. *Amerian Urological Association*. Retrieved: March 2024. https://www.auanet.org/guidelines-and-quality/guidelines/benign-prostatic-hyperplasia-(bph)-guideline

[16] Li, C., Wu, Q., . . . Huang, Z. (2022). State-of-the-art of minimally invasive treatments of bone metastases. *Journal of Bone Oncology, 34*, Article 100425.

[17] Lodeizen, O., de Bruin, M., . . . de la Rosette, J. (2019). Ablation energies for focal treatment of prostate cancer. *World Journal of Urology, 37*(3), 409-418.

[18] Lopez, W., Nguyen, N., . . . Chow, M.S. (2021). Ultrasound Therapy, Chemotherapy and Their Combination for Prostate Cancer. *Technology in Cancer Research & Treatment, 20*, 1-11.

[19] Ma, J., Wang, F., . . . Yang, J. (2019). Percutaneous cryoablation for the treatment of liver cancer at special sites: an assessment of efficacy and safety. *Quantitative Imaging in Medicine and Surgery, 9*(2), 1948–1957.

[20] Motzer, R.J., Jonasch, E., . . . Zibelman, M. (2024). Kidney Cancer Version 3.2024. *National Comprehensive Cancer Network*. Retrieved: March 2024. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf

[21] National Cancer Institute., ... (2021). Cryosurgery to Treat Cancer. *National Cancer Institute*. Retrieved: May 2024. https://www.cancer.gov/about-cancer/treatment/types/surgery/cryosurgery

[22] Parker, C., Castro, E., . . . Gillessen, S. (2020). Prostate cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Annals of Oncology, 31*(9), 1119-1134.

[23] Ramalingam, V., Degerstedt, S., . . . Ahmed, M. (2022). Abstract No. 154 Safety and Efficacy of CT-Guided Cryoablation for Recurrent Prostate Cancer. *Journal of Vascular and Interventional Radiology, 34*(3), S72-S72.

[24] Richard, P.O., Violette, P.D., . . . Finelli, A. (2023). CUA guideline on the management of cystic renal lesions. *Canadian Urological Association Journal, 17*(6), E162-E174.
[25] Schaeffer, E.M., Srinivas, S., . . . Wong, J.K. (2024). Prostate Cancer Version 3.2024. *National Comprehensive Cancer Network*. Retrieved: March 2024. https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf
[26] Sciacqua, L.V., Vanzulli, A., . . . Carrafiello, G. (2023). Minimally Invasive Treatment in Benign Prostatic Hyperplasia (BPH). *Technology in Cancer Research & Treatment, 22*, 1-12.
[27] Souza, F., Aguilera, A., . . . Subhawong, T.K. (2021). Diagnostic and Interventional Radiology Considerations in Metastatic Bone Disease. *Operative Techniques in Orthopaedics, 31*(3), Article 100893.
[28] Stewart, C,. Warner, S., . . . Fong, Y. (2018). Cytoreduction for Colorectal Metastases: Liver, Lung, Peritoneum, Lymph Nodes, Bone, Brain. When Does it Palliate, Prolong Survival, and Potentially Cure? *Current Problems in Surgery, 55*(9), 330-379.

Disclaimer & Legal Notice

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions

and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

Registered Trademarks (®/™) and Copyright (©)