

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

Surgical Services

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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 therapy¹ 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]

- 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.

¹Per 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.

- 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 function²) 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

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; radiofrequency
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.

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

- 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.

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

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.



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 Ablation/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.

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