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2025 Ablation: Cryoablation • Microwave • Radiofrequency • Surgical • Ultrasound • Waterjet

Surgical Services

SURG-SABL-HH

Last Review Date: 08/21/2025
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Guideline Initiated: 06/30/2019

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Preamble: Pediatric Surgical Oncology

HealthHelp's clinical guidelines for the Surgical Oncology program, are intended to apply to both adults and pediatrics (21 years of age or younger), unless otherwise specified within the criteria.

Clinical Judgment

These medical policies are designed to provide clinical guidance and do not supplant a provider's independent professional judgment. Physicians retain full and independent authority to determine appropriate care based on each patient's individual clinical circumstances. Although services may be subject to documentation requirements, medical necessity review, or coverage limitations, nothing in this policy is intended to restrict or interfere with a physician's independent medical judgment.

Cryoablation

Cryoablation Related National Coverage Determination (NCD)/ Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's health plan membership.

Type/ID Number	Title
NCD 230.9	Cryosurgery of Prostate

Bone Cancer Guideline

Cryoablation for the treatment of bone cancer:

1. 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.

References: [16] [4] [3]

Kidney Cancer Guideline

Cryoablation for the treatment of kidney cancer in an adult is considered medically appropriate when the documentation demonstrates **ALL** of the following:

- Biopsy proven diagnosis of clinical stage T1 renal cell carcinoma **OR** biopsy to be performed at the time of ablation.

- Tumor size is 3 cm or less.
- **NOT** a surgical candidate (eg, solitary kidney, morbid obesity, advanced age, decreased renal function) or surgery refusal.[1]

References: [6] [18] [15]

Cryoablation for the treatment of kidney cancer in the pediatric population:

1. 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.

References: [15]

Liver Cancer Guideline

Cryoablation for the treatment of liver cancer in an adult is considered medically appropriate when the documentation demonstrates **ALL** of the following:

- Diagnosis of liver cancer (primary or metastatic)
- Tumor is unresectable.
- Tumor size is 3 cm or less.

References: [2]

Cryoablation for the treatment of liver cancer in the pediatric population:

1. 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.

References: [2]

Prostate Cancer Guideline

Cryoablation for the treatment of prostate cancer in an adult is considered medically appropriate when the documentation demonstrates local therapy and **ALL** of the following: [2]

- Recurrence after completion of radiation therapy
- **NO** metastatic disease

References: [17] [19] [23]

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

[2]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.

Cryoablation for the treatment of prostate cancer in the pediatric population:

1. 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.

References: [23]

Prostate Non-Cancer Guideline

Cryoablation for the treatment of prostate non-cancer:

1. 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.

References: [21] [8]

Cryoablation 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 in 2025:

- Added pediatric indications
- Citations updated per the evidence.
- Indications removed for biliary tract cancer as current research does not support cryoablation

Microwave Ablation

Prostate Cancer Guideline

Microwave ablation for the treatment of prostate cancer:

1. 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.

References: [17] [23]

Microwave Ablation 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 in 2025:

- Added pediatric preamble.
- Citations updated per the evidence.

Radiofrequency Ablation

Bone Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of bone cancer in an adult is considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Bone cancer is known.
2. 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
3. RFA is being used as an alternative to surgery.
4. Treatment is to preserve function and/or prevent pathological fracture in a weight bearing bone.

References: [4] [22] [13] [3]

Radiofrequency ablation (RFA) for the treatment of bone cancer in the pediatric population:

1. 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.

References: [3]

Liver Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of liver cancer in an adult is considered medically appropriate when the documentation demonstrates **ANY** of the following:

1. Hepatocellular carcinoma (HCC) is known and **ALL** of the following:
    a. **ANY** of the following:
        i. **NOT** a surgical candidate (eg, unresectable disease)
        ii. Declines surgery
        iii. RFA is being used as a bridge therapy to other curative treatment
    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. Single tumor 5 cm or less **OR** multiple tumors (up to 3 tumors) each 3 cm or less in size
    d. **NO** extrahepatic disease
2. **NO** diagnosis of hepatocellular carcinoma and **ALL** of the following:
    a. Colorectal cancer **OR** neuroendocrine tumor is known.
    b. Metastases of colorectal cancer **OR** neuroendocrine tumor is isolated to the liver.
    c. Single tumor 5 cm or less **OR** multiple tumors (up to 3 tumors) each 3 cm or less in size.
    d. Site of treatment is **NOT** in close proximity (1 cm or closer) to one or more major vascular structures.

References: [24] [2]

Radiofrequency ablation (RFA) for the treatment of liver cancer in the pediatric population:

1. 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.

References: [2]

Prostate Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of prostate cancer:

1. 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.

References: [17] [23]

Benign Prostatic Hypertrophy (BPH) Guideline

Radiofrequency ablation (RFA) for the treatment of benign prostatic hypertrophy (BPH) in an adult 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)*.

1. International prostate symptom score (IPSS) score is 8 or higher.
2. 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.
3. Medical therapy did **NOT** alleviate LUTS (eg, lifestyle, non-procedural treatments, pharmacologic).
4. Prostate volume is 30 to 80 cc.
5. Treatment consists of water vapor thermal therapy (REZŪM™).

References: [7] [11]

Radiofrequency ablation (RFA) for the treatment of benign prostatic hypertrophy (BPH) in the pediatric population:

1. 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.

References: [7] [11]

Renal Cysts Guideline

Radiofrequency ablation (RFA) for the treatment of renal cysts:

1. 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.

References: [20] [9]

Renal Cell Carcinoma (RCC)/Kidney Cancer Guideline

Radiofrequency ablation (RFA) for the treatment of renal cell cancer (RCC) in an adult is considered medically appropriate when the documentation demonstrates **ANY** of the following:

1. Initial treatment and **ALL** of the following:
    a. Biopsy proven diagnosis of clinical stage pT1 renal cell carcinoma **OR** biopsy to be performed at the time of ablation.
    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 size is 3 cm or less.
    d. **NOT** a surgical candidate (eg, solitary kidney, morbid obesity, advanced age, decreased renal function) or surgery refusal.[3]
2. Recurrence of RCC 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. Previous partial nephrectomy or enucleation.

References: [1] [18] [15]
Radiofrequency ablation (RFA) for the treatment of renal cell cancer (RCC) in the pediatric population:

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

1. 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.

References: [15]

Radiofrequency Ablation Procedure Codes

Table 1. Radiofrequency Ablation Associated Procedure Codes

CODE	DESCRIPTION
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance
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 in 2025:

- Added pediatric indications.
- Citations updated, evidence review completed.

Surgical Ablation

Kidney Cancer Guideline

Surgical ablation for the treatment of kidney cancer:

1. 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.

References: [18] [15]

Surgical Ablation 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 had the following changes in 2025:

- Added pediatric preamble.
- Citations updated per the evidence.

High Intensity Focused Ultrasound (HIFU) Ablation

Prostate Cancer Guideline

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

- **NO** metastatic disease
- Recurrence after completion of radiation therapy.

References: [17] [14] [23]
Ultrasound (HIFU) ablation for the treatment of prostate cancer in the pediatric population:

1. 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.

References: [23]

Ultrasound (HIFU) Ablation 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 had the following changes in 2025:

- Added pediatric indication.
- Citations updated per the evidence.

Water Jet Ablation

Water Jet Ablation Related National Coverage Determination (NCD)/Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's health plan membership.

Type/ID Number	Title
LCD 38367	Fluid Jet System Treatment for LUTS/BPH
LCD 38378	Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH)
LCD 38549	Transurethral Waterjet Ablation of the Prostate
LCD 38682	Transurethral Waterjet Ablation of the Prostate
LCD 38705	Transurethral Waterjet Ablation of the Prostate
LCD 38707	Transurethral Waterjet Ablation of the Prostate
LCD 38712	Transurethral Waterjet Ablation of the Prostate
LCD 38726	Transurethral Waterjet Ablation of the Prostate

Prostate Cancer Guideline

Water jet ablation for the treatment of prostate cancer:

1. 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.

References: [17] [23]

Benign Prostatic Hypertrophy (BPH) Guideline

Water jet ablation for the treatment of benign prostatic hypertrophy (BPH)[4]:

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

1. 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.

References: [5] [12]

Water Jet Ablation Procedure Codes

Table 1. Water Jet Ablation Associated Procedure Codes

CODE	DESCRIPTION
52597	Transurethral robotic-assisted waterjet resection of prostate, including intraoperative planning, ultrasound guidance, control of postoperative bleeding, complete, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy, when performed.

Water Jet Ablation Summary of Changes

Water Jet Ablation clinical guidelines had the following version changes in 2025:

- Added pediatric preamble.
- Citations updated per the evidence.

Ablation Definitions

Bridge therapy refers to a temporary treatment used to manage a condition while awaiting a more permanent or less harmful therapy to take effect. It's essentially a "bridge" between two stages of treatment, helping patients maintain stability or manage symptoms until the more definitive treatment becomes available.

Cryoablation is a medical procedure that uses extreme cold to destroy abnormal or diseased tissue. It's a minimally invasive technique that involves freezing the targeted tissue, causing it to die and be eventually absorbed by the body. This process is used to treat a variety of conditions, including some cancers and precancerous conditions.

Kidney enucleation (tumor enucleation) is a nephron-sparing surgical technique used to treat renal cell carcinoma (RCC) by removing only the tumor along its natural capsule, sparing maximal healthy parenchyma. It is particularly beneficial for small renal masses, solitary kidneys, or hereditary renal syndromes. It offers similar oncologic safety to partial nephrectomy with fewer positive margins.

Local therapy refers to treatments that focus on a specific area of the body, like a tumor or a localized area of disease. It aims to eliminate or control cancer in that specific location, often with the goal of preventing local recurrence. Examples of local therapies include surgery, radiation therapy, and some types of ablation techniques (e.g., cryoablation, microwave ablation).

Microwave ablation (MWA) is a minimally invasive procedure used to treat tumors by heating and destroying cancerous tissue. It involves using a needle-like probe to deliver microwave energy, which generates heat and kills the tumor cells. The procedure is typically guided by imaging techniques like ultrasound or CT scans to ensure precise placement of the probe.

Pathological fracture is a break in a bone that occurs due to disease weakening the bone, rather than from a significant injury. Essentially, the bone is already compromised by an underlying condition, making it susceptible to breaking under normal stress or even with minimal trauma.

Radiofrequency ablation (RFA) is a minimally invasive medical procedure that uses heat generated by radio waves to destroy abnormal tissue. It's commonly used to treat pain, certain cancers, and heart rhythm disorders by selectively targeting and ablating, or destroying, the targeted tissue.

Surgical ablation refers to 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 (HIFU) is a non-invasive medical treatment that uses focused ultrasound waves to heat and destroy targeted tissue, such as tumors or fibroids, while minimizing damage to surrounding healthy tissue. It is a type of ablation, meaning it destroys tissue, and is often used as a treatment for prostate cancer, uterine fibroids, and other conditions.

Waterjet ablation, also known as Aquablation, is a minimally invasive surgical procedure that uses a robotically guided, high-pressure water jet to remove excess prostate tissue in men with benign prostatic hyperplasia (BPH). It's a heat-free method that combines ultrasound imaging and robotics for precise targeting of tissue and aims to relieve lower urinary tract symptoms.

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Disclaimer section

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.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.
CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.

In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

For Internal Use Only:

11248 11249 11253 11282 11325 11328 11333 11349 11350 11351 11352 11354 11355 11356 11358 11359 11360 11361 11362 11365 11366 11367 11368 11369 11370 11374 11375 11394 11395 11396 11565