



MASSACHUSETTS

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Medical Policy Whole Gland Cryoablation of the Prostate

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Policy Number: 149

BCBSA Reference Number: 7.01.79 (For Plan internal use only)

Related Policies

- Charged-Particle (Proton or Helium Ion) Radiotherapy for Neoplastic Conditions, #[437](#)
- Focal Treatments for Prostate Cancer, #[733](#)
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- Brachytherapy for Clinically Localized Prostate Cancer Using Permanently Implanted Seeds, #[175](#)
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Policy

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

Whole gland cryosurgical ablation may be considered **MEDICALLY NECESSARY** as treatment of clinically localized (organ-confined) prostate cancer when performed:

- As initial treatment or
- As salvage treatment of disease that recurs following radiotherapy.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is not required .
Commercial PPO and Indemnity	Prior authorization is not required .

CPT Codes / HCPCS Codes / ICD Codes

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.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above **medical necessity criteria MUST** be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT codes above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
C61	Malignant neoplasm of prostate
D07.5	Carcinoma in situ of prostate

Description

Prostate Cancer

Prostate cancer is the most commonly diagnosed cancer in men and the second leading cause of cancer death among men in the U. S., with an estimated 268,490 new cases and 34,500 deaths in 2022. ¹The diagnosis and grading of prostate cancer are performed by taking a biopsy of the prostate gland.

Treatment

Whole gland (also known as total) cryoablation is one of several methods used to treat clinically localized prostate cancer and may be considered an alternative to radical prostatectomy or external-beam radiotherapy (EBRT). Additionally, whole gland cryoablation may be used for salvage of nonmetastatic relapse following initial therapy for clinically localized disease. Using percutaneously inserted cryoprobes, the glandular tissue is rapidly frozen and thawed to cause tissue necrosis. Cryosurgical ablation is less invasive than radical prostatectomy and recovery time may be shorter. External-beam radiotherapy requires multiple treatments, whereas cryoablation usually requires a single treatment.

Summary

Description

Cryoablation, also known as cryotherapy or cryosurgery, is a procedure that attacks cancer cells using extremely cold gas. This technique can be used to treat prostate cancer by percutaneously inserting thin, needle-like cryoprobes into the prostate gland and then sending very cold gas down the cryoprobes to rapidly freeze and thaw the tissue, causing necrosis. This review evaluates evidence on the use of total (whole gland, definitive therapy) cryoablation. Subtotal (focal) cryoablation and alternative procedures are considered in medical policy #[733](#).

Summary of Evidence

For individuals who are considering initial treatment for localized prostate cancer who receive whole gland cryoablation, the evidence includes systematic reviews, 2 randomized controlled trials, and many comparative and noncomparative observational studies. Relevant outcomes are overall survival (OS),

disease-specific survival, symptoms, functional outcomes, quality of life (QOL), and treatment-related morbidity. High-quality data comparing cryoablation with external-beam radiotherapy (EBRT), radical prostatectomy, or active surveillance are lacking, but available data have suggested similar OS and disease-specific survival rates compared with radical prostatectomy and EBRT. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have salvage treatment for a recurrence of localized prostate cancer following radiotherapy who receive whole gland cryoablation, the evidence primarily includes case series and a few retrospective studies comparing salvage cryoablation with salvage prostatectomy or brachytherapy. Relevant outcomes are OS, disease-specific survival, symptoms, functional outcomes, QOL, and treatment-related morbidity. High-quality data comparing salvage cryoablation with salvage prostatectomy or brachytherapy are lacking, though limited evidence suggests that salvage cryotherapy may be associated with better survival outcomes than prostatectomy. Men with recurrent localized prostate cancer have limited treatment options and prostatectomy can be difficult in tissue that has been irradiated. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
10/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
10/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
10/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
2/2018	Clarified coding information.
9/2017	Annual policy review. New references added.
11/2016	Annual policy review. New references added.
10/2015	Annual policy review. Information on focal therapy was removed from policy and the policy statement on focal therapy was deleted; "whole gland" was added to medically necessary policy statement and to the title of the policy. Effective 10/1/2015.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
6/2013	Annual policy review. New references added.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
9/2011	Reviewed - Medical Policy Group – Urology, Obstetrics and Gynecology. No changes to policy statements.
7/2011	Reviewed - Medical Policy Group – Hematology and Oncology. No changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
6/2010	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
12/1/2009	National Policy review. Revision to policy statement.
6/2009	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
6/2008	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
6/2007	Reviewed - Medical Policy Group - Urology. No changes to policy statements.
6/2007	National Policy review. Revision to policy statement.

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](#)

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