MASSACHUSETTS

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Medical Policy

Laser Interstitial Thermal Therapy

Table of Contents

Policy Number: 948

BCBSA Reference Number: 7.01.170 (For Plan internal use only)
NCD/LCD: N/A

Related Policies

Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy #716
Vagus Nerve Stimulation #474

Policy

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

Laser interstitial thermal therapy (LITT) is considered **INVESTIGATIONAL** for all neurological indications, including but not limited to individuals with primary or metastatic brain tumors, radiation necrosis, and drug-resistant epilepsy.

Laser interstitial thermal therapy (LITT) is considered **INVESTIGATIONAL** for the treatment of psychiatric disorders, including but not limited to depression, treatment resistant depression or obsessive-compulsive disorder.

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)	This is **not** a covered service.
Commercial PPO and Indemnity	This is **not** a covered service.
Medicare HMO Blue℠	This is **not** a covered service.
Medicare PPO Blue℠	This is **not** a covered service.

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.

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 following CPT codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)

Description

Laser Interstitial Thermal Therapy

Laser interstitial thermal therapy (LITT) involves the introduction of a laser fiber probe to deliver thermal energy for the targeted ablation of diseased tissue. Thermal destruction of tissue is mediated via DNA damage, necrosis, protein denaturation, membrane dissolution, vessel sclerosis, and coagulative necrosis.[1] The goal of therapy is selective thermal injury through the maintenance of a sharp thermal border, as monitored via the parallel use of real-time magnetic resonance (MR) thermography and controlled with the use of actively cooled applicators.[2] In neurological applications, LITT involves the creation of a transcranial burr hole for the placement of the laser probe at the target brain tissue. Probe position, ablation time, and intensity are controlled under magnetic resonance imaging (MRI) guidance.

The majority of neurological LITT indications described in the literature involve the ablation of primary and metastatic brain tumors, epileptogenic foci, and radiation necrosis in surgically inaccessible or eloquent brain areas.[2] LITT may offer a minimally invasive treatment option for patients with a high risk of morbidity with traditional surgical approaches. The most common complications following LITT are transient and permanent weakness, cerebral edema, hemorrhage, seizures, and hyponatremia.[3] Delayed neurological deficits due to brain edema are temporary and typically resolve after corticosteroid therapy. Contraindications to MRI are also applicable to the administration of LITT.

Summary

Description

Laser interstitial thermal therapy (LITT) involves the introduction of a laser fiber probe to deliver thermal energy for the targeted ablation of diseased tissue. The goal of therapy is selective thermal injury through the maintenance of a sharp thermal border, as monitored via the parallel use of real-time magnetic resonance (MR) thermography and controlled with the use of actively cooled applicators. In neurological applications, LITT involves the creation of a transcranial burr hole for the placement of the laser probe at the target brain tissue. Probe position, ablation time, and intensity are controlled under magnetic resonance imaging (MRI) guidance. LITT has been proposed as a less invasive treatment option for patients with neurological conditions compared to surgery. Two LITT systems, Visualase and NeuroBlate®, have received marketing clearance from the U.S. Food and Drug Administration (FDA).

Summary of Evidence

For individuals who have primary or metastatic brain tumors who receive magnetic resonance (MR)-guided laser interstitial thermal therapy (LITT), the evidence includes systematic reviews and meta-analyses and several nonrandomized comparative and single-arm studies. Relevant outcomes are overall survival (OS), disease-specific survival, symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Overall survival estimates have ranged from 9.0 to 14.4 months in new or recurrent glioblastoma. Among patients with metastatic tumors receiving LITT following prior stereotactic radiosurgery (SRS), OS rates have ranged between 72% to 76% at 6 months and 63% to 65% at 12 months. In a more heterogenous population of patients with primary and metastatic brain tumors who received LITT, 12-month OS rates were slightly lower in patients with brain metastases (56.3%) and high-grade glioma (43.0%) than other analyses. Systematic reviews comparing LITT to open craniotomy with resection or SRS suggest a reduced incidence of adverse events with LITT; however, neurological deficits attributable to LITT-induced thermal damage have been observed despite concurrent magnetic resonance imaging (MRI) guidance. Studies are limited by predominantly retrospective designs, small sample sizes, and population heterogeneity, with study subjects varying by performance status, lesion volume and location, extent of prior therapies, and extent of ablation. Prospective comparative studies in well-defined and -controlled patient populations are lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have symptomatic cranial radiation necrosis who receive MR-guided LITT, the evidence includes meta-analyses, nonrandomized comparative studies, and a single-arm study. Relevant outcomes are OS, disease-specific survival, symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Studies have reported improved local control and survival outcomes in patients with radiation necrosis compared to those with brain metastases. One study comparing LITT to bevacizumab suggested that LITT treatment may be more successful among patients before radiation necrosis lesions become symptomatic. One study comparing LITT to craniotomy and one study comparing LITT to medical management did not report significant survival differences between groups. Studies are limited by retrospective designs, small sample sizes, population heterogeneity, and unclear relevance, as symptomatic status and steroid-related morbidity were not consistently reported. Prospective comparative studies in well-defined and -controlled patient populations are lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have drug-resistant epilepsy who receive MR-guided LITT, the evidence includes systematic reviews and meta-analyses, nonrandomized comparative studies, and single-arm studies. Relevant outcomes are disease-specific survival, symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Meta-analyses have reported seizure freedom rates ranging from 50% to 61% but are limited by heterogeneous study populations and follow-up durations. Studies comparing LITT to open resection have reported comparable outcomes in patients with pediatric insular epilepsy and adult temporal lobe epilepsy (TLE). In one meta-analysis comparing LITT to radiofrequency ablation (RFA) and conventional surgery, superior outcomes were noted with conventional surgery among patients with TLE. A subsequent meta-analysis concluded that while there is no evidence to suggest that LITT is less effective than open surgical resection in the short term, long-term data are lacking. Total quality of life scores reported in the ongoing LAANTERN registry increased by 72.4%, but this change was not considered statistically significant. Prospective comparative studies in well-defined and -controlled patient populations are required to assess a net health outcome and to identify patients most likely to benefit from LITT. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

While LITT has been evaluated mostly for neurological conditions, there have been some studies evaluating improved patient outcomes for individuals with psychiatric conditions such as depression, treatment resistant depression and obsessive-compulsive disorder. One small retrospective review and one small nonrandomized study evaluated the safety and effectiveness of LITT in reducing symptoms of mood disorder and obsessive-compulsive disorder. Larger randomized clinical trials and comparative data are needed. The evidence is insufficient to determine that this technology results in an improvement in the net health outcomes.

Policy History

Date	Action
9/2025	Investigational statement clarified. 9/1/2025.
2/2025	Annual policy review. Policy updated with literature review through October 14, 2024; references added. Policy statements unchanged.
1/2024	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
2/2023	Annual policy review. Minor editorial refinements to policy statement; intent unchanged.
5/2022	New medical policy describing investigational indications for laser interstitial thermal therapy for all neurological indications, including but not limited to primary and metastatic brain tumors, radiation necrosis, and drug-resistant epilepsy. Effective 5/1/2022.

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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