blue of california

Medical Policy

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors	
Type: Medical Necessity and Investigational / Experimental	**Policy Specific Section:** Surgery
Original Policy Date: December 7, 2006	**Effective Date:** April 4, 2014

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California / Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Description

Radiofrequency ablation (RFA) is used to treat various tumors, including inoperable tumors or to treat patients ineligible for surgery due to age, presence of comorbidities, or poor general health. Radiofrequency ablation is accomplished through the creation of an electrical circuit. A needle

electrode is inserted into the tumor and grounding pads are placed on the patient's skin. Radiofrequency energy is discharged from the tip of the electrode resulting in ionic agitation and frictional heat. Tumor destruction occurs from coagulation necrosis and cell death within the tumor. Radiofrequency ablation can be performed as an open surgical procedure, laparoscopically, or percutaneously with ultrasound or computed tomography guidance.

Note: For information regarding RFA for liver tumors see Blue Shield of California Medical Policy: Locoregional Treatment of Primary and Metastatic Hepatic Tumors.

Policy

Radiofrequency ablation may be considered **medically necessary** for treatment of **any** of the following indications:

- Pain palliation in patients with osteolytic bone metastases who have failed or are poor candidates for standard treatments such as radiation or opioids
- Osteoid osteomas that cannot be managed successfully with medical treatment
- Localized renal cell carcinoma that is no more than 4 cm in size when **either** of the following criteria are met:
    - Preservation of kidney function in patients with significantly impaired renal function (i.e., the patient has one kidney or renal insufficiency defined by a glomerular filtration rate [GFR] of less than 60 mL/min per m^2) when standard surgical approach (i.e., resection of renal tissue) is likely to substantially worsen existing kidney function
    - Patient is not considered a surgical candidate
- An isolated peripheral non-small-cell lung cancer lesion that is no more than 3 cm in size when **both** of the following criteria are met:
    - Surgical resection or radiation treatment with curative intent is considered appropriate based on stage of disease, however, medical comorbidity renders the individual unfit for those interventions
    - Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart
- Malignant nonpulmonary tumor(s) metastatic to the lung that are no more than 3 cm in size when **all** of the following criteria are met:
    - There is no evidence of extrapulmonary metastases
    - Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart
    - **One** of the following:
        - In order to preserve lung function when surgical resection or radiation treatment is likely to substantially worsen pulmonary status
        - Patient is not considered a surgical candidate

An Independent Member of the Blue Shield Association

- There are no more than 3 tumors per lung to be ablated
- Tumors should be amenable to complete ablation
- If a repeat ablation procedure, 12 months should have elapsed since the prior ablation

Radiofrequency ablation is considered **investigational** as a technique for ablation of:

- Breast tumors
- Lung cancer not meeting the criteria above
- Renal cell cancer not meeting the criteria above
- Osteoid osteomas that can be managed with medical treatment
- Painful bony metastases as initial treatment
- All other tumors outside the liver including, but not limited to, the head and neck, thyroid, adrenal gland, ovary, and pelvic/abdominal metastases of unspecified origin

Policy Guideline

Coding

Osteoid osteoma and other primary or metastatic tumors:

- **20982**: Ablation, bone tumor(s) (e.g., osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance

Pulmonary tumors:

- **32998**: Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral

Renal tumors:

- **50592**: Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency

CPT code 76940 might be used to describe the ultrasound guidance for radiofrequency ablation for both intra- and extrahepatic targets.

- **76940**: Ultrasound guidance for, and monitoring of, parenchymal tissue ablation

There are no specific CPT codes for the other indications mentioned in this policy.

Internal Information

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htm

An Independent Member of the Blue Shield Association

Documentation Required for Clinical Review
• History and physical and/or consultation notes including: o Reason for procedure o Prior treatment(s) and response(s) o Size and location of tumor o Reason patient is not a surgical candidate o Glomerular filtration rate (GFR) for renal cell cancer patients Post Service • Operative report(s) or procedure report(s)

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

Click here to view the appendix for this policy

An Independent Member of the Blue Shield Association