

## Medical Policy:

### Cryosurgical and Radiofrequency Ablation for Renal Tumors

| POLICY NUMBER  | LAST REVIEW  |
|----------------|--------------|
| MG.MM.SU.45C15 | July 8, 2022 |

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The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as “EmblemHealth”), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

## Definitions

|                               |   |
|-------------------------------|---|
| Cryoablation                  | Also known as cryosurgery or cryotherapy, cryoablation is a technique of ablating cells using liquid nitrogen or argon gas that is circulated through a hollow probe placed in direct contact with the tumor. An ice crystal formation around the probe tip freezes nearby cells, which destroys them. The ablated tissue is then absorbed by the body. |
| Radiofrequency ablation (RFA) | A technique of heating cells using a small needle electrode placed directly into a tumor. High frequency radio waves heat the tumor and cause local necrosis. The dead cells become scar tissue and eventually shrink.  |

## Guideline

Members with small undefined renal lesions ( $\leq 4$  cm in diameter) that are suspected to be malignant, or with malignant potential, are eligible for coverage of either cryoablation or RFA by any modality (eg laparoscopically or percutaneously) when either of the following criteria is met:

1. Medically or surgically inoperable tumor(s).
2. Poor candidacy for standard treatments (i.e., nephrectomy).

## Limitations and Exclusions

Neither cryoablation nor RFA is considered medically necessary for members able to undergo surgical resection.

## Procedure Codes

|       |   |
|-------|---|
| 50250 | Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed |
| 50542 | Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring when performed       |
| 50592 | Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency  |
| 50593 | Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy   |

## ICD-10 Diagnoses

|        |   |
|--------|---|
| C64.1  | Malignant neoplasm of right kidney, except renal pelvis       |
| C64.2  | Malignant neoplasm of left kidney, except renal pelvis        |
| C64.9  | Malignant neoplasm of unspecified kidney, except renal pelvis |
| C65.1  | Malignant neoplasm of right renal pelvis                      |
| C65.2  | Malignant neoplasm of left renal pelvis                       |
| C65.9  | Malignant neoplasm of unspecified renal pelvis                |
| D41.00 | Neoplasm of uncertain behavior of unspecified kidney          |
| D41.01 | Neoplasm of uncertain behavior of right kidney                |
| D41.02 | Neoplasm of uncertain behavior of left kidney                 |
| D41.10 | Neoplasm of uncertain behavior of unspecified renal pelvis    |
| D41.11 | Neoplasm of uncertain behavior of right renal pelvis          |
| D41.12 | Neoplasm of uncertain behavior of left renal pelvis           |

## References

National Cancer Institute. Renal Cell Cancer Treatment PDQ® Health Professional Version. March 2021. <http://www.cancer.gov/cancertopics/pdq/treatment/renalcell/healthprofessional>. Accessed July 13, 2022.

National Institute for Clinical Excellence. Laparoscopic cryotherapy for renal cancer. July 14, 2021. <http://guidance.nice.org.uk/IPG405>. Accessed July 13, 2022.

National Institute for Clinical Excellence. Percutaneous cryotherapy for renal tumors. July 2011. <http://guidance.nice.org.uk/IPG402>. Accessed July 13, 2022.

National Institute for Clinical Excellence. Percutaneous Radiofrequency Ablation of Renal Cancer. July 2010. <http://guidance.nice.org.uk/IPG353>. Accessed July 13, 2022.

Specialty-matched clinical peer review.

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## Revision History

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|---------------|--|
| Jun. 14, 2019 | ConnectiCare adopts clinical criteria of its parent corporation EmblemHealth |
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