Medical Policy:

Cryosurgical Ablation for Prostate Cancer

POLICY NUMBER	LAST REVIEW
MG.MM.SU.53c	October 8, 2021

Definitions

Cryosurgery (aka cryotherapy or cryoablation) is a minimally invasive therapy performed with ultrasound guidance that destroys prostate tumor tissue through local freezing. The modality involves either complete or focal ablation (subtotal cryoablation) only targeting diseased tissue while leaving normal tissue intact.

Guideline

Cryosurgery is considered medically necessary as salvage therapy for prostate cancer recurrence after treatment with radiation when disease is localized to one lobe of the prostate.

Limitations and Exclusions

Salvage therapy is not considered medically necessary when radiation was not utilized as a primary therapy.

Cryosurgery as a primary treatment modality is not considered medically necessary because it is not supported by the National Comprehensive Cancer Network® (NCCN).

Procedure Codes

55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

ICD-10 Diagnoses

C61	Malignant neoplasm of prostate
D07.5	Carcinoma in situ of prostate

References

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Revision History

Oct. 8, 2021	Updated positive coverage statement to communicate cryotherapy applicability to one lobe, post-radiation, and removed test parameter prerequisites of stage T2b or below, and PSA of < 8 ng/mL
Nov. 11, 2019	Removed Gleason Score prerequisite
Sept. 13, 2019	Connecticare adopts the clinical criteria of its parent corporation EmblemHealth Removed primary treatment as a covered indication