

Medical Policy:

Cryosurgical Ablation for Prostate Cancer

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

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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

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)
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ICD-10 Diagnoses

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

References

- Bahn D, et al. Focal cryotherapy for clinically unilateral, low-intermediate risk prostate cancer in 73 men with a median follow-up of 3.7 years. *Eur Urol* 2012 Jul;62(1):55-63.
- BlueCross BlueShield Association (BCBS), Technology Evaluation Center. Cryoablation for the primary treatment of clinically localized prostate cancer. TEC Assessment Program. Chicago IL: BCBSA; 2001;16(6).
- BlueCross BlueShield Association Technology Evaluation Center (TEC). Cryoablation for the primary treatment of clinically localized prostate cancer. 2001 Sep;16(6).
- Cheetham P, et al. Long term cancer-specific and overall survival for men followed more than 10 years after primary and salvage cryoablation of the prostate. *J Endourol* 2010 Ju;24(7):1123-9.
- Chou R, et al. Treatments for localized prostate cancer: systematic review to update the 2002 U.S. Preventive Services Task Force Recommendation . Rockville (MD) 2011.
- Dhar N, et al. Primary full-gland prostate cryoablation in older men (> age of 75 years): results from 860 patients traced with the COLD Registry. *BJU Int* 2011 Aug;108(4):508-12.
- Donnelly BJ, et al. A randomized trial of external beam radiotherapy versus cryoablation in patients with localized prostate cancer. *Cancer* 2010;116:323–30.
- Durand M, et al. Focal cryoablation: a treatment option for unilateral low-risk prostate cancer. *BJU Int* 2014 Jan;113(1):56-64.
- Li YH, et al. Salvage focal prostate cryoablation for locally recurrent prostate cancer after radiotherapy: initial results from the cryo on-line data registry. *Prostate* 2015 Jan;75(1):1-7.
- Malcolm JB, et al. Quality of life after open or robotic prostatectomy cryoablation or brachytherapy for localized prostate cancer. *J Urol* 2010 May;183:1822-9.
- Mouraviev V, et al. Cryoablation for locally recurrent prostate cancer following primary radiotherapy. *Eur Urol* 2012;61:1204-11.
- National Comprehensive Cancer Network. Prostate Cancer Guidelines. V1.2022. https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed October 15, 2021.
- National Institute for Health and Clinical Excellence (NICE). Cryotherapy as a primary treatment for prostate cancer. *Interventional Procedure Guidance* 145. London, UK: NICE; November 2005.
- National Institute for Health and Clinical Excellence (NICE). Cryotherapy for recurrent prostate cancer. *Interventional Procedure Guidance* No. 119. London, UK: NICE; May 2005.
- Parekh A, et al. Cancer control and complications of salvage local therapy after failure of radiotherapy for prostate cancer: a systematic review. *Semin Radiat Oncol* 2013 Jul;23(3):222-34.
- Punnen S, et al. Management of biochemical recurrence after primary treatment of prostate cancer: a systematic review of the literature. *Eur Urol* 2013 Dec;64(6):905-15.
- Shelley M, et al. Cryotherapy for localised prostate cancer. *Cochrane Database Syst Rev* 2007;(3):CD005010. Ullal AV, et al. A report on major complications and biochemical recurrence after primary and salvage cryosurgery for prostate cancer in patients with prior resection of benign prostatic hyperplasia: a single-center experience. *Urology* 2013 Sep;82(3):648-52.
- Ward JF, et al. Cryoablation for locally advanced clinical stage T3 prostate cancer: a report from the Cryo-On-Line Database (COLD) Registry. *BJU Int* 2014 May;113(5):714-8.

Xiong T, et al. Comparative efficacy and safety of treatments for localized prostate cancer: an application of network meta-analysis. *BMJ Open* 2014;4:e004285.

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