

# Radiofrequency Tumor Ablation



INDEPENDENT CARE HEALTH PLAN

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## Medicare Advantage Medical Coverage Policy

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#### Disclaimer

The Coverage Summaries are reviewed by the iCare Medicare Utilization Management Committee. Policies in this document may be modified by a member's coverage document. Clinical policy is not intended to preempt 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. 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. Clinical technology is constantly evolving, and we reserve the right to review and update this policy periodically. References to CPT® codes or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee of claims payment. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise, without permission from iCare.

## Related Medicare Advantage Medical/Pharmacy Coverage Policies

None

## Related Documents

There are no NCDs and/or LCDs for radiofrequency tumor ablation.

## Description

Radiofrequency (RF) tumor ablation is a procedure in which a needle electrode is inserted via image guidance into a tumor (lesion) and electrical energy generates heat to destroy cancer cells. The current moves from the tip of the electrode into the surrounding tissue. The movement of ions results in frictional

heating of the tissue and as the temperature becomes elevated beyond 60 degrees Celsius, cells around the electrode undergo necrosis (begin to die).

RF tumor ablation can be performed laparoscopically, percutaneously or intraoperatively; however, it is typically used for those individuals whose tumors are inoperable or for those who cannot undergo a surgical procedure due to age, presence of comorbidities or overall poor general health.

## Coverage Determination

*iCare follows the CMS requirements that only allows coverage and payment for services that are reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member except as specifically allowed by Medicare.*

*In interpreting or supplementing the criteria above and in order to determine medical necessity consistently, iCare may consider the criteria contained in the following:*

**RF tumor ablation** will be considered medically reasonable and necessary when the following requirements are met:

- Differentiated thyroid cancer for the following indications<sup>18</sup>:
  - Distant metastatic disease not amenable to radioactive iodine (RAI); **OR**
  - Persistent/recurrent, nonmetastatic disease; **OR**
- Malignant painful bone tumors in an individual who has failed or cannot tolerate conventional treatments, such as medication or radiation therapy<sup>33,61</sup>; **OR**
- Metastatic and nonmetastatic (primary) lung cancer in an individual who is not a candidate for surgical intervention<sup>46,60</sup>; **OR**
- Nonmetastatic renal cancer in an individual who is not a candidate for surgical intervention<sup>45,54</sup>; **OR**
- Osteoid osteoma in an individual who remains symptomatic despite treatment with nonsteroidal anti-inflammatory drugs (NSAIDs)<sup>33,50,61</sup>; **OR**
- Soft tissue sarcoma for the following indications<sup>44,49</sup>:
  - Gastrointestinal stromal tumors with limited progressive disease (defined as appearance of no new lesion or increase in tumor size); **OR**
  - Synchronous [stage IV soft tissue sarcoma](#) with either of the following:
    - Palliation of symptomatic disseminated metastases; **OR**

- Single organ and limited tumor bulk that are amenable to local therapies; **OR**
- Unresectable, metastatic hepatic tumors whose primary site is from colorectal cancer or neuroendocrine cancer<sup>6,45</sup>; **OR**
- Unresectable primary malignant hepatic tumors less than or equal to 3 cm without nodal or extrahepatic metastases<sup>6,45</sup>

*The use of the criteria in this Medicare Advantage Medical Coverage Policy provides clinical benefits highly likely to outweigh any clinical harms. Services that do not meet the criteria above are not medically necessary and thus do not provide a clinical benefit. Medically unnecessary services carry risks of adverse outcomes and may interfere with the pursuit of other treatments which have demonstrated efficacy.*

## Coverage Limitations

[US Government Publishing Office. Electronic code of federal regulations: part 411 – 42 CFR § 411.15 - Particular services excluded from coverage](#)

The following services will not be considered medically reasonable and necessary:

- Metastatic hepatic tumors whose primary site is any other than colon/neuroendocrine/rectum
- Prostate cancer
- Spinal tumors/spinal metastases

A review of the current medical literature shows that there is no evidence to determine that this service is standard medical treatment for these indications. There is an absence of randomized, blinded clinical studies examining benefit and long-term clinical outcomes establishing the value of this service in clinical management for these indications.

The following services will not be considered medically reasonable and necessary:

- Breast tumors

A review of the current medical literature shows that the evidence is insufficient to determine that these services are standard medical treatments. There remains an absence of randomized, blinded clinical studies examining benefit and long-term clinical outcomes establishing the value of these services in clinical management.

## Summary of Evidence

### ***Breast Tumors***

At this time, there are no FDA approved percutaneous or transcutaneous ablative treatments for breast cancer. Techniques being under evaluation at this time includes ablation by focused ultrasound, laser, cryotherapy, microwave and radiofrequency.<sup>16</sup>

## Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	
19499	Unlisted procedure, breast	
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	
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, including imaging guidance when performed, unilateral; radiofrequency	
38999	Unlisted procedure, hemic or lymphatic system	
43499	Unlisted procedure, esophagus	
43659	Unlisted laparoscopy procedure, stomach	
43999	Unlisted procedure, stomach	
44799	Unlisted procedure, small intestine	
45399	Unlisted procedure, colon	
45499	Unlisted laparoscopy procedure, rectum	
45999	Unlisted procedure, rectum	
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	
47579	Unlisted laparoscopy procedure, biliary tract	
49999	Unlisted procedure, abdomen, peritoneum and omentum	
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	
60699	Unlisted procedure, endocrine system	

76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	
<b>CPT® Category III Code(s)</b>	<b>Description</b>	<b>Comments</b>
No code(s) identified		
<b>HCPCS Code(s)</b>	<b>Description</b>	<b>Comments</b>
No code(s) identified		

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## Appendix

### Appendix A

#### Soft Tissue Sarcoma Stages<sup>7</sup>

IA	Cancer is 5 cm (2 inches) or smaller; it has not spread to nearby lymph nodes or to distant sites. Considered grade 1 cancer.
IB	Cancer is larger than 5 cm; it has not spread to nearby lymph nodes or to distant sites. Considered grade 2 cancer.
II	Cancer is 5 cm or smaller; it has not spread to nearby lymph nodes or to distant sites. Considered grade 2 or 3 cancer.

III	Cancer is larger than 5 cm but no more than 10 cm; it has not spread to nearby lymph nodes or to distant sites. Considered grade 2 or 3 cancer.
IIIB	Cancer is larger than 10 cm; it has not spread to nearby lymph nodes or to distant sites. Considered a grade 3 cancer.
IV	Cancer can be any size and has spread to nearby lymph nodes and may or may not have spread to distant sites. It can be any grade.

The grade is partly used to determine the stage of sarcoma and utilizes a system known as the French or FNCLCC system. For more information on the grade system, please refer to the [American Cancer Society](#).

### Change Summary

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