Microwave Thermotherapy

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

Please refer to CMS website for the most current applicable CMS Online Manual System (IOMs)/National Coverage Determination (NCD)/ Local Coverage Determination (LCD)/Local Coverage Article (LCA)/ Transmittals.

There are no NCDs and/or LCDs for Microwave Thermotherapy.

Description

Microwave thermotherapy, also known as microwave ablation or microwave therapy, is similar to radiofrequency ablation (RFA) in that it is a treatment used for cancer that involves heating of tissues to destroy cancer cells. Electromagnetic energy is utilized to heat the target tissue, which causes damage to the cell's membrane resulting in cell death or increasing the sensitivity of the cells to radiation therapy. The microwave energy radiates into the tissue through an antenna that allows direct heating of a volume of tissue around the antenna.

Microwave thermotherapy systems include a generator and electrodes that are placed into the targeted area via an access needle. Microwaves are then distributed to the site. Liquids may be circulated through the needle shaft to permit continuous cooling to the insertion site; thereby avoiding burning of the skin.

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 following criteria:

Microwave Thermotherapy

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

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
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	
20999	Unlisted procedure, musculoskeletal system, general	
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	
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	
47399	Unlisted procedure, liver	
48999	Unlisted procedure, pancreas	
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	
53899	Unlisted procedure, urinary system	
60699	Unlisted procedure, endocrine system	
94799	Unlisted pulmonary service or procedure	
CPT® Category III Code(s)	**Description**	**Comments**
No code(s) identified		
HCPCS Code(s)	**Description**	**Comments**
C9751	Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)	

Change Summary

- 01/01/2024 New Policy.