

Policy Name: Cryotherapy

Policy Number: CMO 501

Effective date of current policy: 9/1/2018

Description and Scope

This policy refers to treatments of medical conditions with cryotherapy (the destruction of tissue by freezing).

Position Statement

Affinity Health Plan considers cryotherapy medically necessary in some circumstances where evidence-based medicine has proved benefit. Affinity Health Plan considers cryotherapy experimental and investigational where there is insufficient evidence that cryotherapy is safe and effective for this indication. Cryotherapy can be considered medically necessary for treatment of the following conditions:

1. cervical intraepithelial neoplasia
2. uterine bleeding (exclude cancer, pre-cancer or hyperplasia) for menorrhagia or excessive bleeding (as an alternative to hysterectomy)
3. isolated colorectal cancer liver metastases
4. isolated hepatocellular carcinoma (unresectable)
5. unresectable neuroendocrine tumors metastatic to the liver
6. prostate cancer as a primary therapy alternative to surgery or irradiation in individuals with localized disease (T1 or T2 [organ confined] or T3 [locally advanced]) or as salvage therapy for recurrent cancer following failure of radiation therapy
7. malignant endobronchial obstruction
8. renal cell carcinoma, up to 4 cm in size, when any of the following criteria is met:
 - a. persons who are considered high-risk surgical candidates; or
 - b. persons with renal insufficiency, as defined by a glomerular filtration rate of less than or equal to 60 ml/min/m²; or
 - c. persons with a solitary kidney
9. atrial fibrillation
10. skin lesions if either of the following criteria are met:
 - a. biopsy suggests or clinically the lesion is indicative of pre-malignancy or malignancy, or
 - b. the lesion restricts vision or obstructs a body orifice
11. low-risk superficial basal cell carcinoma, and squamous cell carcinoma in situ (Bowen disease), where surgery or radiation is contraindicated or impractical
12. soft tissue sarcoma of the extremities or the trunk in symptomatic persons with disseminated metastases

Affinity Health Plan considers cryotherapy experimental and investigational for any other indication based on lack of sufficient supportive evidence, including:

- plantar fasciitis
- plantar fibroma
- Barrett's esophagus
- benign prostatic hypertrophy
- neck pain
- back pain
- varicose veins or venous valvular incompetence
- breast cancer
- breast fibroadenoma

Background

Definitions: Cryotherapy, also called cryosurgery, cryoablation, percutaneous cryotherapy or targeted cryoablation therapy, is a minimally invasive treatment that uses extreme cold to freeze and destroy diseased tissue, including some cancer cells. Several cryogens such as liquid nitrogen, nitrous oxide and carbon dioxide are available, but liquid nitrogen is the most commonly used.

Definitions

NOT APPLICABLE

Coding

Inclusion of a code in the following list does not imply that the procedure is medically necessary or that the code represents a covered benefit. Codes used to identify services associated with this policy may include (but may not be limited to) the following:

0441T	Ablation, percutaneous, cryoablation, includes imaging guidance, lower extremity distal/peripheral nerve
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation
31641	Bronchoscopy (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser therapy, cryotherapy)
32994	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; cryoablation
33254	Operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure)
33256	Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); with cardiopulmonary bypass
+ 33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (e.g., modified maze procedure) (List separately in addition to code for primary procedure.)
+ 33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (e.g., maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure.)
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)
57511	Cautery of cervix; cryocautery, initial or repeat

64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch (cryoablation of chronic headaches)
 Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation

+93657 (List separately in addition to code for primary procedure.)

References

- Public Health Law, Sections 201 and 206 and Social Services Law, Sections 363-a and 365-a(2) New York Codes, Rules and Regulations Title 18 Section 505.2(l)

Medical Policy Committee History and Revisions

Date	Action
July 24, 2018	Initial approval by Medical Policy and Benefits Committee
June 25, 2019	Removed 20982 from code list
May 26, 2020	Reapproved with no changes

Disclaimer

Affinity Health Plan has developed medical policies that serve as one of the sets of guidelines for coverage decisions. Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Medical policy does not constitute plan authorization, nor is it an explanation of benefits. The policies are not medical advice. Affinity Health Plan reserves the right to change medical policies.