02-54000-14

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Reviewed: 09/28/23

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Subject: Whole Gland Cryoablation of Prostate Cancer

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

DESCRIPTION:

Whole gland cryoablation of the prostate (also known as total cryoablation, cryotherapy, or cryosurgery) is one of several methods to treat clinically localized prostate cancer. Whole gland cryoablaltion of the prostate may be considered an alternative to radical prostatectomy or external-beam radiotherapy (EBRT). Also, whole gland cryoablaltion of the prostate may be used for salvage of nonmetastatic relapse following initial therapy for clinically localized disease. Using percutaneously inserted cryoprobes, the glandular tissue is rapidly frozen and thawed to cause tissue necrosis. Cryosurgical ablation is less invasive than radical prostatectomy and recovery time may be shorter. EBRT requires multiple treatments, whereas only 1 treatment is usually required for total cryoablation.

There are several medical devices in use for ablation of prosthetic tissue that have received U.S. Food and Drug Administration (FDA) 510(k) clearance to market (e.g., AccuProbe® System modes 450, 550/530, and 600 series manufactured by Cryomedical Sciences Inc. and the Endocare Cryocare® CS manufactured by Endocare Inc.)

POSITION STATEMENT:

Whole gland cryoablation of the prostate **meets the definition of medical necessity** as treatment of clinically localized (organ-confined (T1, T2)) prostate cancer for the following when performed with an FDA device approved for ablation of prostate tissue:

- As initial treatment; **OR**
- As salvage treatment of disease that recurs following radiotherapy.

BILLING/CODING INFORMATION:

CPT Coding:

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

ICD-10 Diagnosis Codes That Support Medical Necessity:

C61	Malignant neoplasm of prostate
C79.82	Secondary malignant neoplasm of genital organs
D07.5	Carcinoma in situ of prostate
Z85.46	Personal history of malignant neoplasm of prostate

REIMBURSEMENT INFORMATION:

None applicable.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products:

No Local Coverage Determination (LCD) was found at the time of the last guideline reviewed date.

The following National Coverage Determinations (NCDs) was reviewed on the last guideline reviewed date: Cryosurgery of Prostate, (230.9) located at cms.gov.

DEFINITIONS:

Gleason Grading System (Score): a method of classifying the grade of cancer. The pathologist assigns a primary grade from 1 to 5 to the pattern occupying the greatest area of the specimen. A secondary grade is assigned to the pattern occupying the second largest area. These two grades are added to determine the Gleason score, which ranges from 2 to 10. Tumors with a Gleason score of 2 to 4 have lower biological aggressiveness, those with a score of 5 to 6 have an intermediate aggressiveness, and those with a score of 7 or higher are biologically aggressive tumors (American Urological Association, 2009).

Prostate: a gland in the male, which surrounds the neck of the bladder and the urethra. The prostate consists of a median lobe and two lateral lobes, and is made up partly of glandular matter.

Stages T1 or T2: organ-confined cancer.

Stages T3: locally advanced cancer.

Stage T2B (B2): cancer detected during digital rectal examination as a hard lump on the prostate and involves both sides of the prostate gland or is larger than 2 centimeters.

RELATED GUIDELINES:

Cryosurgical Ablation of Solid Tumors Other Than Liver or Prostate Tumors, 02-99221-12

OTHER:

Other names used to report cryosurgical ablation of the prostate:

Note: The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

Ablation, Prostate
Cryosurgery, Prostate
Cryotherapy, Prostate
Salvage Cryotherapy
Transperineal Percutaneous Prostate Cryosurgery

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 09/28/23.

GUIDELINE UPDATE INFORMATION:

05/25/00	Medical Coverage Guideline Developed.
06/15/02	Annual review. Revised description section. Added coverage criteria.
06/15/04	Scheduled review, no revisions. No longer scheduled for review.
08/15/07	Reformatted guideline. Revise coverage statement. Updated description section. Revised ICD-9 diagnoses code (185) descriptor, and updated references.
09/15/08	Scheduled review. No change in position statement, and updated references.
10/15/09	Annual review. No change in position statement, and updated references.
01/01/10	Annual HCPCS coding update. Revised descriptor for code 55873.
01/01/11	Revision; added related ICD-10 codes.
05/11/14	Revision: Program Exceptions section updated.
11/01/15	Revision: ICD-9 Codes deleted.
03/15/17	Revision; Changed guideline name to Whole Gland Cryoablation of Prostate Cancer, revised description and position statement. Updated ICD-10 diagnoses codes (added C79.2, D07.5 and Z85.46). Updated other section and references.
09/15/19	Review; no change in position statement. Updated references.
10/15/21	Review; no change in position statement. Updated references.
10/15/23	Review; no change in position statement. Updated references.