Cryosurgical Ablation of the Prostate

For the list of services and procedures that need preauthorization, please refer to www.mcs.com.pr Go to “Comunicados a Proveedores”, and click “Cartas Circulares”.

Medical Policy: MP-SU-02-07
Original Effective Date: December 22, 2007
Reviewed: August 19, 2013
Revised:

This policy applies to products subscribed by the following corporations, MCS Life Insurance Company (Commercial), and MCS Advantage, Inc. (Classicare) and Medical Card System, Inc., provider’s contract; unless specific contract limitations, exclusions or exceptions apply. Please refer to the member’s benefit certification language for benefit availability. Managed care guidelines related to referral authorization, and precertification of inpatient hospitalization, home health, home infusion and hospice services apply subject to the aforementioned exceptions.

DESCRIPTION

Cryosurgery of the prostate gland, also known as Cryosurgical Ablation of the Prostate (CAP), destroys prostate tissue by applying extremely cold temperature in order to reduce the size of the prostate gland.

An Ultrasound or magnetic resonance imaging (MRI) is use to guide the cryoprobe and monitor the freezing of the cells to avoid collateral damage to nearby healthy tissue.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate member certificate and subscriber agreement contract for applicable diagnostic imaging, DME, laboratory, machine tests, benefits and coverage.

INDICATIONS

Medical Card System (MCS) considers Cryosurgical ablation of the prostate (CSAP) medically reasonable and necessary as primary treatment for:

1. Clinically localized prostate cancer Stage T1 (i.e., clinically in apparent tumors), Stage T2 (i.e., tumor confined within the prostate), Stage T3 (i.e., tumor locally advanced) when lymph nodes are negative for cancer.
2. Salvage cryosurgery of prostate after radiation failure for:
   a. Having recurrent, localized prostate cancer;
   b. Have failed a trial of radiation therapy as their primary treatment; AND
   c. Meet one of these conditions:
      - Stage T2B or below
      - Gleason Score < 9
      - PSA < 8ng/mL
CONTRAINDICATIONS/LIMITATIONS

1. Cryosurgery as salvage therapy is not covered after failure of other therapies as the primary treatment.
2. Cryosurgery as salvage is ONLY covered after the failure of a trial of radiation therapy, under the conditions noted above.
3. If the patient has a very large prostate. In this case patient may be required to have hormone treatment first to shrink the prostate to an appropriate size.
4. If the patient has had prior TURP (Transurethral Prostatectomy) surgery which has left a large defect.
5. If the patient has any rectal pathology or disease such as rectal stenosis.
6. If patient suffers from inflammatory bowel disease with fistula formation.
7. If patient has had previous pelvic surgery; scarring may interfere with ability to perform procedure.

CODING INFORMATION

CPT® CODES (LIST MAY NOT BE ALL INCLUSIVE)

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>55873</td>
<td>Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)</td>
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CURRENT PROCEDURAL TERMINOLOGY (CPT®) 2013 American Medical Association: Chicago, IL.

ICD-9 CM® DIAGNOSIS CODES (LIST MAY NOT BE ALL INCLUSIVE)

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<tr>
<th>ICD-9 CM® Codes</th>
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<tr>
<td>185</td>
<td>Malignant Neoplasm of Prostate</td>
</tr>
<tr>
<td>233.4</td>
<td>Carcinoma in Situ (prostate)</td>
</tr>
<tr>
<td>236.5</td>
<td>Neoplasm of uncertain behavior of (prostate)</td>
</tr>
<tr>
<td>239.5</td>
<td>Neoplasm of unspecified nature (other genitourinary organs)</td>
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HCPCS® CODES (List may not be all inclusive)

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<thead>
<tr>
<th>HCPCS Codes</th>
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<tr>
<td>C2618</td>
<td>Probe Cryoablation</td>
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REFERENCES


POLICY HISTORY

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<tr>
<th>DATE</th>
<th>ACTION</th>
<th>COMMENT</th>
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<tr>
<td>December 22, 2007</td>
<td>Origination of Policy</td>
<td></td>
</tr>
<tr>
<td>August 11, 2009</td>
<td>Yearly Review</td>
<td></td>
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<tr>
<td>August 25, 2010</td>
<td>Yearly Review</td>
<td>Deleted ICD-9 Codes from the policy: 198.82</td>
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<td>August 18, 2011</td>
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<td>July 12, 2012</td>
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<td>References updated.</td>
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<tr>
<td>December 10, 2012</td>
<td>Review</td>
<td>Policy was reviewed and approved by the Medical Card System (MCS) Medical Advisory Committee (MAC) on December 10, 2012.</td>
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<td>August 19, 2013</td>
<td>Yearly Review</td>
<td>References updated.</td>
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This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member’s plan in effect as of the date services are rendered. Medical Card System, Inc., (MCS) medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Medical Card System, Inc., (MCS) reserves the right to review and update its medical policies at its discretion. Medical Card System, Inc., (MCS) medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan’s ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.