

Cryoablation of the Prostate

MPM 3.5

Disclaimer Refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in these criteria.

Description Cryoablation of the prostate destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland and destroy cancerous cells.

Coverage Determination **Benefit Certification is not required for in-plan providers. However, all claims are subject to retrospective review.**

Cryoablation of the prostate is only covered for the indications listed in this Medical Policy.

Per CMS NCD 230.9, the following indications are appropriate for the use of cryoablation of the prostate:

1. As primary treatment for patients with clinically localized prostate cancer, stages T1-T3
2. As salvage cryosurgery of the prostate for recurrent cancer for patients with localized disease who:
 - Have failed a trial of radiation therapy as their primary treatment; **and**
 - Meet **one** of the following conditions:
 - ◇ Stage T2B or below, **or**
 - ◇ Gleason score <9, **or**
 - ◇ PSA <8 ng/ml.

This technology has been reviewed and approved by the Technology Assessment Committee and the Medical Policy Committee (formerly known as the Benefit Development and Interpretation Committee).

Coding **The coding listed in this Medical Policy is for reference only.**

CPT Codes	Description
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)

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ICD-9© Diagnosis Codes	Description
185	Malignant neoplasm of the prostate
198.82	Secondary malignant neoplasm of genital organs
233.4	Carcinoma in situ prostate

Reviewed by: V. Taylor Floyd, Jr. MD, Albuquerque Urology Associates, PA. March 2008.

References: 1. Centers for Medicare and Medicaid Services. NCD for Cryosurgery of Prostate (230.9). Effective date 7-1-01. Accessed on the Internet on 04-14-09 at: http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=230.9&ncd_version=1&basket=ncd%3A230%2E9%3A1%3ACryosurgery+of+Prostate

**Approval
Signatures**Clinical Quality Committee: Mark Whitaker, MDMedical Director: Albert Rizzoli, MD

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04-17-08: Transition to Medical Policy
04-22-09: Annual Review
05-25-11: Biennial Review

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at our website at: <http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm>

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage.
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