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
Prior Authorization 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.

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

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55873</td>
<td>Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD10 DIAGNOSIS CODES</th>
<th>ICD10 DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>C61</td>
<td>Malignant neoplasm of prostate</td>
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</tbody>
</table>
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<th>Code</th>
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<tbody>
<tr>
<td>C79.82</td>
<td>Secondary malignant neoplasm of other specified sites</td>
</tr>
<tr>
<td>C79.82</td>
<td>Secondary malignant neoplasm of genital organs</td>
</tr>
<tr>
<td>D07.5</td>
<td>Carcinoma in situ of other and unspecified genital organs</td>
</tr>
<tr>
<td>D07.5</td>
<td>Carcinoma in situ of prostate</td>
</tr>
</tbody>
</table>

**Approval Signatures**

**Clinical Quality Committee:** Norman White MD

**Medical Director:** Pedro Cardona MD

**Date:** May 18, 2017

**Publication History:**
- 03-28-05: Benefit Alert, Original Effective Date
- 04-17-08: Transition to Medical Policy
- 04-22-09: Annual Review
- 06-27-12: Biennial Review
- 01-29-14: Biennial Review
- 03-23-16: Annual Review. NCD 230.9 Last updated 9/2012. No changes since.

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](http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm)