Laser Ablation Treatment of Prostate Cancer

MPM 12.3

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 this Medical Policy.

Description
Laser ablation is a minimally invasive therapy for the treatment of solid tumors that utilizes image guided laser probes to heat and destroy the affected tissue. The absorption of light energy results in volumetric heating which ultimately leads to thermal destruction of the tumor. The device is used to cut, destroy, or remove tissue ie; prostate tumors by light energy emitted by carbon dioxide.

Coverage Determination/ Clinical Indications
Laser Ablation Treatment of Prostate Cancer has been reviewed by the Technology Assessment Committee. Presbyterian considers Laser Ablation Treatment of Prostate Cancer Investigational and Experimental and there is not enough data to support efficacy therefore it is not covered.

Medicare-specific Coverage Determinations
Medicare has no NCD or LCD for this procedure.

Coding
The coding listed in this Medical Policy is for reference only. Covered and non-covered codes are within this list.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>53899</td>
<td>Unlisted Procedure, Urinary system</td>
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<tr>
<td>55899</td>
<td>Unlisted procedure, male genital system</td>
</tr>
<tr>
<td>52647</td>
<td>Laser coagulation of prostate, including control of postoperative bleeding, complete</td>
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<tr>
<td>52648</td>
<td>Laser vaporization of prostate, including control of postoperative bleeding, complete</td>
</tr>
<tr>
<td>52649</td>
<td>Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete</td>
</tr>
</tbody>
</table>

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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### HCPCS® Codes

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>NA</td>
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</table>

No specific code identified.

### ICD-9® Diagnosis Codes

<table>
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<tr>
<td>Experimental and Investigational and/or unproven for all diagnosis</td>
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### ICD-10 Diagnosis Codes

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### References:


3. CMS: No NCD or LCD for this topic found

4. MCG: No review of this procedure found

5. BCBSNM Providers Medical Policies # SUR 701.301.


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Approval Signatures:

Clinical Quality Committee: Norman White MD  Senior Medical Director

Medical Director: Pedro Cardona MD  Medical Director

Approval Date: September 23, 2015

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NA: Annual review
NA: Annual Review and Revision

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. This 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 on the Presbyterian Healthcare Services website at: http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm

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