Ablative Treatments for Lung Tumors

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

The treatment of choice for primary non-small cell lung cancer (NSCLC) or metastatic tumors in the lung is surgical resection. For members who are not surgical candidates, locoregional therapies such as Microwave Ablation or Cryosurgical Ablation may be treatment options.

Microwave Ablation

Microwave Ablation (MWA) uses microwave thermal energy to create coagulation and necrosis of localized tissue. Microwave Ablation may be indicated for treating tumors, controlling local tumor growth, and palliating symptoms.

Cryosurgical Ablation

Cryosurgical ablation (also known as cryosurgery) destroys cells by freezing target tissues, most often by inserting a probe into the tumor through which coolant is circulated. Ice crystals form around the probe and when the cells thaw, the body absorbs the tissue.

The goals of cryosurgical ablation include the destruction or shrinkage of tumor tissue, controlling local tumor growth and preventing recurrence. This may be indicated for palliating symptoms and to extend survival for members with certain type of tumors.

Criteria

Commercial

Prior authorization is required.

I. Microwave Ablation

PacificSource considers Microwave Ablation for lung tumors to be medically necessary when **ONE** of the following criteria is met:

A. Treatment for isolated peripheral non-small cell lung cancer (NSCLC) lesion(s) when:

1. Member is not a candidate for surgery/radiation due to medical co-morbidities

2. Tumor is 3 cm or smaller in size and **BOTH** of the following criteria is met:

a. Surgical resection or radiation treatment with curative intent is considered appropriate based on stage of disease

b. Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery, and the heart

B. Treatment of metastatic lung lesion(s) when **ALL** of the following criteria are met:

1. To preserve lung function when surgical resection or radiation treatment is likely to worsen pulmonary status, or member is not considered a surgical candidate

2. Tumor is 3 cm or smaller in size

3. There is no evidence of extrapulmonary metastases

4. The tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery, and the heart

II. Cryosurgical Ablation

PacificSource considers Cryosurgical Ablation to treat lung tumors to be medically necessary when **ONE** of the following criteria is met:

A. Non-Small Cell Lung Cancer that is **EITHER** Stage I, or node negative Stage II

B. The member requires palliation for a central airway obstructing lesion

Medicaid

PacificSource Community Solutions follows the criteria hierarchy described in the “Clinical Criteria Used in UM Decisions” policy for coverage of [service]. PCS covers these services when the condition and service(s) pair on a funded line of the HERC Prioritized List of Health Services; any relevant Guideline criteria is met, including Guideline Note 174 and Excluded Services Guideline E2, and service(s) are medically necessary and appropriate for the specific member. Additional coverage options for unfunded conditions and services are provided as described in Covered Services OAR 410-141-3820. Service(s) may be limited or excluded in accordance with OARs 410-141-3825 and 410-120-1200, except as otherwise provided in the Covered Services Rule.

PacificSource Community Solutions follows specific regulation for the coverage of:

- Radiofrequency Ablation of Lung Tumors and Microwave Ablation of Lung Tumors - Excluded Services Guideline E2 of the Oregon Health Plan (OHP) Prioritized List of Health Services which states there is insufficient evidence of effectiveness for this service.
- Bronchoscopy with laser or cryotherapy and Ablation therapy with cryoablation - Guideline Note 174 of the Oregon Health Plan (OHP)

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0002 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance, including but not limited to Guideline Note 174 and Excluded Services Guideline E2, may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow the PacificSource Commercial clinical criteria above for determination of coverage and medical necessity of Ablative Treatments for Lung Tumors.

Experimental/Investigational/Unproven

PacificSource considers microwave ablation (MWA) and cryosurgical ablation to be experimental, investigational, or unproven for all other indications, except for liver tumors (see PacificSource Liver Diagnostic Tests and Tumor Treatment policy).

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

31641 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser therapy, cryotherapy)

32994 Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved in tumor extension, percutaneous, including imaging guidance when performance, unilateral; cryoablation

32998 Ablation therapy for reduction or eradication of one (1) or more pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency

32999 Unlisted procedure, lungs and pleura

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Appendix

Policy Number:

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Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): OARs 410-120-1200, 410-141-3820, 410-141-3825, 410-151-0001, 410-151-0002, 410-151-0003.

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