Ablative Treatments for Lung Tumors

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

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 for malignant non-pulmonary lesion(s) metastatic to the lung when **ALL** of the following criteria is 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. Stage I, or selected node negative Stage II Non-Small Cell Lung cancer

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

Medicaid

PacificSource Community Solutions follows an internal hierarchal process in the *"Clinical Criteria Used in UM Decisions"* policy, which includes reviewing each code to identify relevant guideline notes from the OHP Prioritized List of Health Services and Oregon Administrative Rules (OAR).

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 follows the *"Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)"* criteria for members under 21 and Young Adults with Special Health Care Needs (YSHCN).

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow internal policy for determination of coverage and medical necessity.

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).

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 or More Pulmonary Tumor(s), Percut, Radiofrequency, Unilateral

32999 Unlisted Procedure, Lungs & Pleura

C9751 Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance

Related Policies

Liver Diagnostic Tests and Tumor Treatment

References

Aufranc, V., Farouil, G., Abdel-Rehim, M., Smadja, P., Tardieu, M., Aptel, S., & Guibal, A. (2019). Percutaneous thermal ablation of primary and secondary lung tumors: Comparison between microwave and radiofrequency ablation. Diagnostic and interventional imaging, 100(12), 781–791. https://doi.org/10.1016/j.diii.2019.07.008

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The Health Evidence Review Commission (HERC) Prioritized List of Health Services https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

Oregon Administrative Rules (OARs). Oregon Health Authority. Health Systems: Medical Assistance Programs – Chapter 410 https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87

Appendix

Policy Number:

Effective: 2/1/2022 **Next review:** 4/1/2026

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.Guideline Note 173 and 174 of the Oregon Health Plan (OHP) Prioritized List of Health Services

Commercial Ops: 3/2025

Government Ops: 3/2025