# Interventional Treatment for Renal Cell Cancer

| LOB(s): | State(s): |
|---|---|
| ☒ *Commercial*<br>☒ *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

Renal cell cancer treatment options may include cryoablation (cryotherapy, cryosurgery), radiofrequency ablation (RFA), or renal artery embolization. Cryoablation uses subfreezing temperatures, radiofrequency ablation uses heat from high energy radio waves. Renal artery embolization utilizes an injected substance to block the blood supply of a kidney tumor. All techniques use imaging guidance, such as a CT scan, and needle-like probes to reach the cancer cells.

## Criteria

### Commercial

**Prior authorization is required.**

**I. Cryoablation and Radiofrequency Ablation**

PacificSource considers cryoablation and radiofrequency ablation of renal cell cancer to be medically necessary when **ONE OR MORE** of the following criteria is met:

**A.** Member is not a candidate for partial nephrectomy or radical nephrectomy (e.g., comorbidities, single kidney)

**B.** Member has renal insufficiency as defined by a glomerular filtration rate (GFR) of less than or equal to 60 mL/min/m2

**C.** Renal cell carcinoma tumor(s) are less than or equal to 4 cm in diameter

**II. Renal artery embolization**

PacificSource considers renal artery embolization to be medically necessary when **ONE OR MORE** of the following criteria is met:

**A.** Pre-operative adjunct to nephrectomy in the treatment of persons with large, hypervascular renal cell carcinomas

**B.** Palliative specific treatment for renal cell carcinomas

**Note:** Specific injectable substances used in renal artery embolization are considered bundled and not separately reimbursable.

### Medicaid

PacificSource Community Solutions follows the general coverage, limitations, and exclusions outlined in OARs 410-141-3820, 410-141-3825, and 410-120-1200 for coverage of Cryoablation and Radiofrequency ablation for Renal Cell Cancer.

PacificSource Community Solutions follows Guideline Note 225 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services for coverage of Thermal Ablation of Renal Cell Carcinoma.

PacificSource Community Solutions (PCS) follows Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0002 through 410-151-0003 for EPSDT beneficiaries. Coverage of Cryoablation and Radiofrequency Ablation for Renal Cell Cancer is determined through case-by-case reviews for EPSDT Medical Necessity and EPSDT Medical Appropriateness defined in OAR 410-151-0001. Guideline Note 225 may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review.

### Medicare

PacificSource Medicare follows National Coverage Determination (NCD) 20.28 for coverage of Renal artery embolization.

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow the commercial clinical criteria of this specific PacificSource policy, as applicable, or external clinical criteria for determination of coverage and medical necessity.

## 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.

37242 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (e.g., congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

37243 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction

50250 Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed

50542 Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed

50592 Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency

50593 Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy



## Definitions

**Ablation** - The destruction of a body part or tissue or its function. Ablation may be achieved by surgery, hormones, drugs, radiofrequency, heat, or other methods.

**Cryosurgical ablation** (cryotherapy or cryoablation) - A surgical procedure where cancerous or diseased cells are destroyed using extreme cold.

**Metastasis** - The spread of cancer from one part of the body to another. A metastatic tumor contains cells that are like those in the original (primary) tumor and have spread.

**Radiofrequency ablation** (RFA) - A surgical procedure where cancerous or diseased cells are destroyed using heat produced by high-frequency radio waves.

**Renal artery embolization -** A non-surgical technique, using a catheter to inject material into the artery causing the blood to clot and block blood flow to the kidney.

**Tumor** - An abnormal mass of tissue that results from excessive cell division that is uncontrolled and progressive, also called a neoplasm.

**Unresectable -** Refers to a tumor that cannot safely be removed surgically due to size or location.

## References

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## Appendix

**Policy Number:**

**Effective**: 12/1/2020 **Next review:** 2/1/2027

**Policy Type:** Enterprise

**Author(s):**

**Depts:** Health Services

**Applicable regulation(s): ):** OARs 410-120-1200, 410-141-3820, 410-141-3825, 410-141-3830, 410-151-0002, and 410-151-0001.

**OPs Approval:** 12/2025