



## Ablative Treatments for Lung Tumors

<b>LOB(s):</b> <input checked="" type="checkbox"/> Commercial  <input checked="" type="checkbox"/> Medicare  <input checked="" type="checkbox"/> Medicaid	<b>State(s):</b> <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:  <input checked="" type="checkbox"/> Oregon <input type="checkbox"/> Washington
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### Enterprise Policy

*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. MWA is an ablative technique similar to radiofrequency or cryosurgical ablation; however, in MWA, the heating process is active, which produces higher temperatures than radiofrequency ablation. MWA may be indicated for treating tumors, controlling local tumor growth, and palliating symptoms.

MWA may be performed as an open procedure, laparoscopically, percutaneously, or thoracoscopically under image guidance with sedation, or local or general anesthesia. MWA is most often performed by a specially trained interventional radiologist in a radiology suite or in the operating room. Once the tumor is identified, the rendering provider inserts a small needle with probe directly into the tumor using guided imagery.

After probe placement is verified, a single microwave antenna or multiple antennas are attached to the probe and connected to a generator. Energy from the antennas generates friction and heat directly into the tumor. The local heat coagulates the tissue adjacent to the probe, resulting in tissue ablation. In tumors greater than 2 cm in diameter, 2-3 antennas may be used simultaneously to increase the targeted area of MWA and shorten operative time. The cells ablated by MWA are typically not removed but are gradually replaced by fibrosis and scar tissue. If there is local recurrence, it occurs at the edges and this treatment may be repeated.

## **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. Cryosurgery may be performed as an open surgical technique or as a closed procedure under laparoscopic or ultrasound guidance. Cryosurgical ablation is most often performed by a specially trained interventional radiologist in a radiology suite or in the operating room.

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. Potential complications associated with cryosurgery include potential structural or nerve damage to the adjacent tissues and secondary tumors. This treatment may be repeated for local recurrence.

## **Criteria**

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### **Commercial**

#### **Prior authorization is required**

#### **I. Microwave Ablation**

PacificSource may consider Microwave Ablation to treat lung tumors to be medically necessary when **ONE or more** of the following criteria are met:

- A.** Isolated peripheral non-small cell lung cancer (NSCLC) lesion(s) that is no more than 3 cm in size when **BOTH** of the following criteria are met:
  - 1. Surgical resection or radiation treatment with curative intent is considered appropriate based on stage of disease, however, member is not a candidate for surgery/radiation due to medical co-morbidities
  - 2. Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery, and the heart

**OR**

- B.** Malignant non-pulmonary lesion(s) metastatic to the lung that are no more than 3 cm in size when **ALL** of the following criteria are met:
  - 1. In order 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. There is no evidence of extrapulmonary metastases
  - 3. 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 may consider Cryosurgical Ablation to treat lung tumors to be medically necessary when **EITHER** of the following criteria are met:

- A.** For non-small cell lung cancer when the patient has early-stage (Stage I, and selected node negative Stage IIA) non-small cell lung cancer

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

### Medicaid

PacificSource Community Solutions follows Guideline Note 173 of the Oregon Health Plan (OHP) Prioritized List of Health Services for Radiofrequency Ablation of Lung Tumors and Microwave Ablation of Lung Tumors to be considered insufficient evidence of effectiveness and Guideline Note 174 of the Oregon Health Plan (OHP) for Bronchoscopy with laser or cryotherapy and Ablation therapy with cryoablation.

### 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

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

### Coding Information

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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
- C2618 Probe/needle, cryoablation
- C9751 Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

### Related Policies

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Ablation of Primary and Metastatic Liver Tumors

## References

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## Appendix

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**Policy Number:**

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**Policy type:** Enterprise

**Author(s):**

**Depts.:** Health Services

**Applicable regulation(s):** Guideline Note 173 and 174 of the Oregon Health Plan (OHP) Prioritized List of Health Services

**Commercial Ops:** 11/2023

**Government Ops:** 11/2023