

Evidence Based Guideline

Cryosurgery Ablation of the Prostate

File Name: cryosurgery_ablation_of_the_prostate
Guideline Number: EBG.SUR6180
Origination: 3/31/97
Last Review: 5/2005

Active guideline, no longer scheduled for routine literature review.

Description of Procedure or Service

The prostate gland is a part of the male reproductive system. It is located below the bladder and in front of the rectum and surrounds the urethra, the tube-like structure that carries urine from the bladder out through the penis. Prostate cancer is the most common cancer seen in men and is the second most common cause of cancer deaths in men. Cryosurgical ablation is one of several methods available for treating clinically localized prostate cancer (cancer confined within the prostate gland) and may be considered as an alternative to radical [prostatectomy](#) or radiation therapy. It may also be used for salvage of non-metastatic relapse following initial therapy for clinically localized disease. Cryosurgery is a procedure that reduces or eliminates [malignant](#) tumors of the prostate gland by applying extremely cold temperatures (freezing) to the prostate tissue.

Evidence Based Guideline for Cryosurgical Ablation of the Prostate

Cryosurgical ablation of the prostate may be appropriate as a primary treatment for localized prostate cancer.

Salvage Cryosurgery of the prostate for recurrent cancer may be appropriate only for those patients with localized disease who:

- ◆ Have failed a trial of radiation therapy as their primary treatment; **and**
- ◆ Meet **one** of the following conditions: Stage T2B or below, Gleason score less than 9, PSA less than 8 ng/mL.

Medical Evidence regarding Cryosurgical Ablation of the Prostate indicates it is not recommended in the following situations:

Cryosurgical ablation of the prostate is not recommended as a treatment of last resort for extensive prostate cancer.

Benefits Application

Please refer to certificate for availability of benefit. This guideline relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore certificate language should be reviewed before applying the terms of the policy.

Policy: Cryosurgery Ablation of the Prostate

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 55873

Medical Term Definitions

Malignant

cancerous, not benign; describes a tumor that invades and destroys the tissues in which it originates and can spread to other sites in the body via the bloodstream and lymphatic system. If untreated, these tumors cause progressive deterioration and death.

Prostatectomy

surgical removal of the prostate gland.

Scientific Background and Reference Sources

Urological Consultant Review, 10/93

ECRI Executive Briefings - No. 65 - 1/98

Medical Policy Advisory Group Review, 3/99

Specialty Matched Consultant Advisory Panel - 5/2001

BCBSA Medical Policy Reference Manual, 8/15/01; 7.01.79

ECRI Hotline Response: Cryosurgery for Prostate Cancer. Accessed 4/24/2003

Specialty Matched Consultant Advisory Panel - 5/2003

Interventional procedures overview of salvage cryotherapy for recurrent prostate cancer. IP overview: Salvage cryotherapy for recurrent prostate cancer. National Institute for Clinical Excellence (NICE). [6/2004]. Retrieved on 3/29/05 from <http://www.nice.org.uk/pdf/ip/ip130overview.pdf>

ECRI Hotline Response - Cryosurgery for Prostate Cancer (Update of full TA Report) (09/01/2004) retrieved on 3/29/05 from http://www.ta.ecri.org/Hotline/Prod/summary/detail.aspx?doc_id+7408&q=prostate&anm

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.79, 11/9/04.

Specialty Matched Consultant Advisory Panel - 5/2005

Policy Implementation/Update Information

10/93	Original policy issued
3/96	Reviewed: Remains investigational
3/97	Reaffirmed
3/99	Reaffirmed

Policy: Cryosurgery Ablation of the Prostate

- 7/99 Reformatted, Description of Procedure or Service changed, Medical Term Definitions added.
- 11/99 Revised. Available for coverage for certain indications.
- 12/00 New 2001 CPT added; 55873. Coding system changes.
- 5/01 Specialty Matched Consultant Advisory Panel review (5/2001). Removed local failure after radical prostatectomy as a covered indication.
- 12/01 Implementation information from 5/01 corrected. Removal of "local failure after radical prostatectomy" was removed from "When Cryosurgery Ablation of the Prostate is Not Covered" section of policy.
- 6/03 Specialty Matched Consultant Advisory Panel review (5/23/03). No change to criteria. Revised Description section for clarity. Removed codes G0160 and G0161 from Billing/Coding section. Codes have been deleted from HCPCS. Benefits Application section revised.
- 3/04 Billing/Coding section updated for consistency.
- 6/2/05 Specialty Matched Consultant Advisory Panel review 5/23/05. Description section revised. Under "When Covered" section added salvage cryosurgery of the prostate for recurrent cancer as covered for patients with localized disease who have failed a trial of radiation therapy as their primary treatment **and** meet **one** of the following conditions: Stage T2B or below, Gleason score less than 9, PSA less than 8 ng/mL. Under "When not Covered" removed numbers 2 & 3 and incorporated number 1 into the first sentence. Policy status changed to "Active policy, no longer scheduled for routine literature review." Notice given 6/2/05. Effective date 8/4/05.
- 8/28/06 Medical Policy changed to Evidence Based Guideline.

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.