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Contractor's Policy Number

00-05-R1

Contractor's Name

CareFirst of Maryland Inc., Medicare Part A

Contractor Number

00190

Contractor Type

Fiscal Intermediary

LMRP Title

Cryosurgery in the Treatment of Liver Tumors

AMA CPT Copyright Statement

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CMS National Coverage Policy

- Establishment of national policy supersedes all previous contractor policy statements, including Local Medical Policy coverage guidelines
- Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Title XVIII of the Social Security Act, section 1862 (a) (1) (D). This section excludes services

determined to be investigational or experimental.

Primary Geographic Jurisdiction

Maryland

Washington, DC

Secondary Geographic Jurisdiction

Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, Washington state, and Wyoming

CMS Region

Region III

CMS Consortium

Northeast

Original Policy Effective Date

06/26/2000

Original Policy Ending Date

Revision Effective Date

02/19/2003

Revision Ending Date

LMRP Description

Cryosurgery is a means for surgical destruction of diseased tissue. It has been used for many years in many medical fields including dermatology, neurosurgery, proctology, gynecology, and otolaryngology. In the last 10-15 years, much work has been done in applying this modality to the treatment of liver tumors, both primary and metastatic. The biggest breakthrough in the field of cryosurgery for liver tumors has been the application of intraoperative ultrasound both to detect small lesions and to monitor the cryosurgical destruction process in order to assure complete ablation of the desired lesion, with a margin of normal tissue. In the treatment of liver tumors, cryosurgical destruction is often used in addition to surgical resection.

Indications and Limitations of Coverage and/or Medical Necessity

Cryosurgery in the treatment of certain selected primary and secondary liver tumors is considered safe and effective in the following clinical scenarios:

- Primary hepatocellular carcinoma when conventional surgical resection is felt to be contraindicated or when cryosurgical ablation is used as an adjunct to surgical resection,
- Carcinomas metastatic to the liver from colon, small intestine, ovarian, or neuroendocrine primaries,
- Carcinomas metastatic to the liver must meet all of the following qualifying conditions:
 - the primary cancer site must be effectively controlled,
 - the metastatic lesions must be limited to the liver and not present in other organs,
 - the open laparotomy approach must be used,
 - the patient must have no more than three liver metastases (except as described in the "Other Comments" section of this policy, and;
 - no lesion should be larger than 7 cm. in size.

Note: Metastases to the liver from primary carcinomas of the breast, lung, stomach, pancreas, adenocarcinoma of unknown origin, and other such primaries that tend to be disseminated widely at the same time that liver metastases are present, are not appropriate for treatment by cryosurgical ablation.

- The cryosurgical device used must be FDA approved for the indications used.

CPT/HCPCS Section & Benefit Category

Surgery/Digestive System

Type of Bill Code

11X, 13X, 21X, 83X

Revenue Codes

36X, 49X

32X, 333, 34X, 35X, 40X, 61X

CPT/HCPCS Codes

The AMA and CMS require the use of short descriptors for policies published on the Web. Refer to the CPT book for the long description of the following codes:

47371	Laparo ablate liver cryosurg
47381	Open ablate liver tumor cryo
76986	Ultrasound guide intraoper
76490	Ultrasound guidance, tissue ablation

Not Otherwise Classified (NOC)

ICD-9 Codes that Support Medical Necessity

When procedure code 47381 with or without 76490 or 76986 are used to report "Cryosurgery in the Treatment of Liver Tumors" as described within this policy, the following diagnosis code(s) will be considered by Medicare to support medical necessity:

152.0	Malignant neoplasm of small intestine; duodenum
152.1	jejunum
152.2	ileum
152.8	Other specified sites of small intestine
152.9	Small intestine, unspecified
153.0	Malignant neoplasm of colon; hepatic flexure
153.1	transverse colon
153.2	descending colon

153.3	sigmoid colon
153.4	cecum
153.5	appendix
153.6	ascending colon
153.7	splenic flexure
153.8	other specified sites of large intestine
153.9	unspecified
154.0	Malignant neoplasm; rectosigmoid junction
154.1	rectum
154.2	anal canal
154.3	anus, unspecified
154.8	Other
155.0	Malignant neoplasm of liver, primary
183.00	Malignant neoplasm of ovary
197.7	Secondary malignant neoplasm of liver

Diagnoses that Support Medical Necessity

As listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy

ICD-9 Codes that DO NOT Support Medical Necessity

Any diagnosis codes not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy

Diagnoses that DO NOT Support Medical Necessity

Conditions not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Reasons for Denial

- Non-FDA approved probe(s) and/or off-label uses of FDA approved probe(s).
- All other indications not listed in the "Indications and Limitations of Coverage" section of this policy.
- The service was performed for a diagnosis other than those identified under "ICD-9-CM Codes that Support Medical Necessity."
- The service does not follow the guidelines of this policy.
- The cryosurgery is carried out using laparoscopic surgical technique.

Non-covered ICD-9 Codes

Any diagnosis codes not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy

Non-covered Diagnoses

Conditions not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Coding Guidelines

- Criteria listed in "Indications and Limitations of Coverage" must be met for Medicare reimbursement.
- HCPCS code 49200 has been replaced with code 47381 as a more accurate description of the procedure (CPT 2002).
- By definition code 47381 includes the treatment of more than one tumor and therefore, cannot be quantity billed greater than one.
- HCPCS 76986 or 76490 should be billed only once per operative session regardless of the specialty billing for this code.
- If cryosurgery is performed in addition to surgical resection of the liver tumors, specific HCPCS codes must be submitted to reflect this along with the pertinent modifiers. The operative report must specify that both surgical resection and cryosurgery were performed.

Documentation Requirements

- Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and available to Medicare upon request.
- There must be a written report of the intraoperative echography in the patient's medical records. This requirement is considered to be met when the surgeon's operative note describes the use of intraoperative echography during the procedure.

Utilization Guidelines

Other Comments

In rare instances, such as multiple neuroendocrine liver metastases, more than three (3) liver metastases might be appropriately treated with cryosurgery or a combination of cryosurgery and surgical excision. When this occurs, the operative note should explain in detail the clinical situation necessitating treatment of more than three (3) metastases. This detailed operative note should be available to Medicare upon request.

Sources of Information and Basis for Decision

- TrailBlazer Carrier, LMRP
- Carrier Medical Director, New Technology Workgroup
- Wellmark, Part B Local Medical Policy

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups , which includes representatives from the appropriate specialty(ies).

Advisory Committee Meeting Date:

Start Date of Comment Period

04/05/2000

End Date of Comment Period

05/26/2000

Start Date of Notice Period

05/26/2000

Revision History

Number	Date	Change
00-05- R1	02/19/2003	Expanded coverage with addition of HCPCS 47371,47381, and 76490. HCPCS 47381 replaced 49200. CPT descriptors changed to short descriptor, ICD-9 codes unranked.

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE FROM OUR WEBSITE AT www.marylandmedicare.com

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