

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

Policy # 00175

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Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Osteoid Osteomas

Based on review of available data, the Company may consider radiofrequency ablation (RFA) of osteoid osteomas to be **eligible for coverage****

Osteolytic Bone Metastases

Based on review of available data, the Company may consider radiofrequency ablation (RFA) to palliate pain **eligible for coverage**** when **EITHER** of the following criteria are met:

- In individuals with painful osteolytic bone metastases who have failed standard treatments such as opioids or radiation therapy; **OR**
- In individuals with painful osteolytic bone metastases who are poor candidates for standard treatments such as opioids or radiation therapy.

Localized Renal Malignancy

Based on review of available data, the Company may consider radiofrequency ablation (RFA) for renal malignancy to be **eligible for coverage**** when **BOTH** of the following criteria are met:

- Clinically localized, suspected renal malignancy; **AND**
- For individuals with peripheral lesions that are less than or equal to 4 cm in diameter.

Non-Small Cell Lung Cancer

Based on review of available data, the Company may consider radiofrequency ablation (RFA) of non-small cell lung cancer (NSCLC) to be **eligible for coverage**** when **ALL** of the following criteria are met:

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- Surgical or radiation treatment with curative intent is considered appropriate based on stage of disease, however medical co-morbidity renders the individual unfit for those interventions; **AND**
- No tumor has a maximum diameter of greater than 3.0 cm; **AND**
- Tumors are located at least 1 cm from **ALL** of the following:
 - Trachea; **AND**
 - Main bronchi; **AND**
 - Esophagus; **AND**
 - Aorta; **AND**
 - Aortic arch branches; **AND**
 - Pulmonary artery and the heart.

Metastatic Malignant Tumor(s) to the Lung

Based on review of available data, the Company may consider radiofrequency ablation (RFA) to treat malignant nonpulmonary tumor(s) metastatic to the lung to be **eligible for coverage**** when **ALL** of the following criteria are met:

- When **EITHER** of the following are met:
 - When it is necessary to preserve lung function because surgical resection or radiotherapy is likely to worsen pulmonary status substantially; **OR**
 - When the individual is not considered a surgical candidate; **AND**
- There is no evidence of extra-pulmonary metastases; **AND**
- No more than 3 tumors per lung should be ablated; **AND**
- No tumor has a maximum diameter greater than 3.0 cm; **AND**
- Tumors are located at least 1 cm from **ALL** of the following:
 - Trachea; **AND**
 - Main bronchi; **AND**
 - Esophagus; **AND**
 - Aorta; **AND**
 - Aortic arch branches; **AND**
 - Pulmonary artery and the heart; **AND**
- If a repeat procedure, at least 12 months have elapsed since the prior ablation.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers radiofrequency ablation (RFA) of tumors outside the liver when the above criteria are not met to be **not medically necessary****.

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers radiofrequency ablation (RFA) of tumors outside the liver to be **investigational*** for all other tumors, including but not limited to:

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- Breast tumors; **AND**
- Head and Neck; **AND**
- Thyroid; **AND**
- Pancreas; **AND**
- Adrenal gland; **AND**
- Ovary; **AND**
- Pelvic/abdominal metastasis of unspecific origin.

Background/Overview

Radiofrequency Ablation

Radiofrequency ablation (RFA) was initially developed to treat inoperable tumors of the liver (see medical policy 00182). Recently, studies have reported on the use of RFA to treat other tumors. For some of these, RFA is being investigated as an alternative to surgery for operable tumors. Well-established local or systemic treatment alternatives are available for each of these malignancies. The hypothesized advantages of RFA for these cancers include improved local control and those common to any minimally invasive procedure (eg, preserving normal organ tissue, decreasing morbidity, decreasing length of hospitalization).

Goals of RFA may include (1) controlling local tumor growth and preventing recurrence; (2) palliating symptoms; and (3) extending survival duration for patients with certain tumors. The effective volume of RFA depends on the frequency and duration of applied current, local tissue characteristics, and probe configuration (eg, single vs. multiple tips). RFA can be performed as an open surgical procedure, laparoscopically or percutaneously, with ultrasound or computed tomography guidance.

Potential complications associated with RFA include those caused by heat damage to normal tissue adjacent to the tumor (eg, intestinal damage during RFA of kidney), structural damage along the probe track (eg, pneumothorax as a consequence of procedures on the lung), and secondary tumors (if cells seed during probe removal).

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

The U.S. Food and Drug Administration (FDA) issued a statement in September 2008, concerning the regulatory status of RFA. The FDA has cleared RFA devices for the general indication of soft tissue cutting, coagulation, and ablation by thermal coagulation necrosis. Under this general indication, RFA can be used to ablate tumors, including lung tumors. Some RFA devices have been cleared for additional specific treatment indications, including partial or complete ablation of nonresectable liver lesions and palliation of pain associated with metastatic lesions involving bone. The FDA has not cleared any RFA devices for the specific treatment indication of partial or complete ablation of lung tumors, citing lack of sufficient clinical data to establish safety and effectiveness for this purpose. The FDA has received reports of death and serious injuries associated with the use of RFA devices in the treatment of lung tumors.

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Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Description

In radiofrequency ablation (RFA), a probe is inserted into the center of a tumor; then, prong-shaped, non-insulated electrodes are projected into the tumor. Next, heat is generated locally by an alternating, high-frequency current that travels through the electrodes. The localized heat treats the tissue adjacent to the probe, resulting in a 3 cm to 5.5 cm sphere of dead tissue. The cells killed by RFA are not removed but are gradually replaced by fibrosis and scar tissue. If there is a local recurrence, it occurs at the edge and can sometimes be retreated. RFA may be performed percutaneously, laparoscopically, or as an open procedure.

Summary of Evidence

For individuals who have painful osteolytic bone metastases who have failed or are poor candidates for standard treatments who receive radiofrequency ablation (RFA), the evidence includes a prospective cohort study and case series. Relevant outcomes are symptoms, change in disease status, quality of life (QOL), medication use, and treatment-related morbidity. A prospective cohort study and case series have shown clinically significant pain relief (defined as a decrease of 2 units from baseline on the Brief Pain Inventory scale) or reduction in opioid use following treatment of painful osteolytic metastases. A multicenter, prospective study reported significant reductions in pain through the 6-month follow-up period, with 59% of patients achieving immediate improvement in pain within 3 days of RFA. The population is comprised of patients with few or no treatment options, for whom short-term pain relief is an appropriate clinical outcome. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have painful osteoid osteomas who receive RFA, the evidence includes numerous observational studies and systematic reviews of these studies. Relevant outcomes are symptoms, change in disease status, QOL, medication use, and treatment-related morbidity. In a systematic review of thermal ablation techniques, clinical success (pain-free) was achieved in 94% to 98% of patients. Most patients (89% to 96%) remained pain-free when assessed during longer-term follow-up. Another systematic review reported similar success rates noting an average 8.3% failure rate among patients receiving computed tomography (CT)-guided RFA. Although no randomized trials of RFA for osteoid osteomas have been performed, uncontrolled studies have demonstrated RFA can provide adequate symptom relief with minimal complications for a population for whom short-term symptom relief and avoidance of invasive procedures are appropriate clinical outcomes. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

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For individuals who have localized renal cell carcinoma (RCC) that is no more than 4 cm in size who receive RFA, the evidence includes a randomized controlled trial (RCT), numerous observational studies, and systematic reviews of these studies. Relevant outcomes are overall survival (OS), change in disease status, QOL, and treatment-related morbidity. A recent meta-analysis that included only an RCT and cohort studies found that RFA was as effective as nephrectomy for small renal tumors, with a reduction in complications. Another recent meta-analysis found that partial nephrectomy (PN) was superior to ablative techniques (the study included RFA but also cryoablation and microwave ablation) in overall mortality and local recurrence but not in cancer-specific mortality. It also found fewer complications and improved renal function with ablation. A meta-analysis from 2022 found that PN was superior to ablation (RFA, cryoablation, and microwave ablation) in local recurrence. Overall complications, decline in renal function, and cancer-specific mortality rates did not differ between ablation and PN. A 2025 meta-analysis found that RFA achieved high local control and cancer-specific survival rates comparable to other ablative therapies, although SBRT showed superior local control for larger tumors. Although inconsistent, the evidence does suggest that, for small renal tumors, RFA may result in a similar rate of disease progression with a lower complication rate than nephrectomy. However, comparative trials are needed to determine with greater certainty the effects of these treatments in the same patient population. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have inoperable primary pulmonary tumors or nonpulmonary tumors metastatic to the lung who receive RFA, the evidence includes prospective observational studies and systematic reviews of these studies. Relevant outcomes are OS, change in disease status, QOL, and treatment-related morbidity. A multicenter study found that for tumors less than 3.5 cm in size, RFA can lead to a complete response in as many as 88% of patients for at least 1 year. Two-year survival rates have been reported to range from 41% to 75% in case series, with 5-year survival rates of 20% to 27%. In general, the evidence suggests that RFA results in adequate survival and tumor control in patients who are not surgical candidates, with low morbidity rates. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have breast tumors who receive RFA, the evidence includes observational studies and systematic reviews of these studies. Relevant outcomes are OS, change in disease status, QOL, and treatment-related morbidity. Evidence has reported varied and incomplete ablation rates with concerns about postablation tumor cell viability. Long-term improvements in health outcomes have not been demonstrated. Additionally, available studies do not permit comparisons with conventional breast-conserving procedures. Further prospective studies, with long-term follow-up, should focus on whether RFA of the breast for small tumors can provide local control and survival rates compared with conventional breast-conserving treatment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have benign thyroid tumors who receive RFA, the evidence includes RCTs, prospective studies, case series, and systematic reviews of these studies. Relevant outcomes are symptoms, change in disease status, QOL, medication use, and treatment-related morbidity. Systematic reviews have demonstrated that RFA results in a significant reduction in thyroid nodule

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size, with a 2020 review showing that these changes remain durable through at least 36 months and a 2024 review indicating durability up to 5 years. Complication rates are generally low but include voice changes. The data are limited by significant heterogeneity in meta-analyses, a lack of generalizability to populations outside Republic of Korea and Italy, and a lack of comparators more relevant to practice in the United States. Further studies comparing RFA to percutaneous ethanol injection (PEI) or surgery would be more informative in determining the potential utility of RFA in patients with symptomatic or large benign thyroid tumors as these are the recommended treatment options per the American Thyroid Association. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have miscellaneous tumors (eg, head and neck, thyroid cancer, pancreas) who receive RFA, the evidence includes a few case series, prospective observational studies, and retrospective comparative studies. Relevant outcomes are OS, change in disease status, QOL, and treatment-related morbidity. There is a limited evidence base for these tumor types. Reporting on outcomes or comparisons with other treatments is limited. These studies do not permit conclusions on the health benefits of RFA. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Additional Information

Clinical input obtained in 2010 supported use of RFA for localized RCC that is no more than 4 cm in size when preservation of kidney function is necessary, and a standard surgical approach is likely to worsen kidney function substantially or when the patient is not considered a surgical candidate. Thus, absent other treatment options, RFA for small renal cell tumors was judged to be medically necessary.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2010 Input

In response to requests, input was received from 2 physician specialty societies (4 reviewers) and 2 academic medical centers (4 reviewers) while this policy was under review in 2010. Input was similar to that received in 2009, except support for the use of radiofrequency ablation (RFA) to treat lung tumors was declined (only 1 respondent indicated this was an option in tumors metastatic to lung). One respondent also indicated a potential use for adrenal tumors. Input supported RFA for localized renal cell carcinoma no more than 4 cm in size when preservation of kidney function is necessary and a standard surgical approach would likely substantially worsen kidney function or when the patient is not considered a surgical candidate.

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2009 Input

In response to requests, input was received from 1 physician specialty society (4 reviews) and from 2 academic medical centers (3 reviews) while this policy was under review in 2009. All reviewers supported the use of RFA in the treatment of painful bone metastases that have failed standard treatment and in the treatment of osteoid osteomas. Reviewers were divided over the use of RFA for lung tumors, although several agreed that, while it may be useful in a select population of patients, it should be used in the clinical trial setting. Reviewers were also split with regard to RFA in the treatment of renal tumors, with some supporting its use in a select population of patients. With the exception of 1 disagreement and 1 nonresponse, the reviewers agreed to the investigational statement on the use of RFA in all other tumors outside the liver that are addressed in this policy.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Chest Physicians

The American College of Chest Physicians (2025) guidelines on management of patients with early-stage non-small cell lung cancer state that "image-guided thermal ablation therapies such as radiofrequency ablation (RFA), microwave ablation (MWA), and cryoablation (CA) have also been used to treat lung tumors, particularly in patients with contraindications to surgery. For patients deemed to have "high operative risk" (i.e., those who cannot tolerate lobectomy, but are candidates for sublobar resection) stage I NSCLC, the appropriateness of potential alternatives [e.g., SBRT; ablation] to surgery is an active area of investigation". They also state that "To date, no specific technique of ablation (radiofrequency, microwave, or cryoablation) has proven superior, and therefore outcomes from various modalities are most often combined to evaluate local control and overall survival."

American Head and Neck Society - Endocrine Surgery Section

An international, multidisciplinary consensus statement on RFA and related ultrasound-guided ablation technologies for the treatment of benign and malignant thyroid disease was released in 2022 through a collaboration of international professional societies, including the Endocrine Surgery Section of the American Head and Neck Society. Select relevant recommendations from the guideline are listed in Table 1.

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Table 1. Summary of RFA Recommendations for Treatment of Benign and Malignant Thyroid Disease*

Recommendation 1	US-guided ablation procedures may be used as a first-line alternative to surgery for patients with benign thyroid nodules contributing to compressive and/or cosmetic symptoms.
Recommendation 2	Although less efficacious than surgery or RAI in normalizing thyroid function, thermal ablation procedures can be a safe therapeutic alternative in patients with an autonomously functional thyroid nodule and contraindications to first-line techniques.
Recommendation 3a	US-guided ablation procedures may be considered in patients with suitable primary papillary microcarcinoma who are unfit for surgery or decline surgery or active surveillance
Recommendation 3b	US-guided ablation procedures may be considered in patients with suitable recurrent papillary thyroid carcinoma who are unfit for surgery or decline surgery or active surveillance
Recommendation 3c	Repeat ablation of a benign nodule can be considered for remnant nodular tissue contributing to unresolved symptomatic or cosmetic concerns

*This is not a comprehensive list of recommendations from the guideline.

RAI: radioactive iodine; RFA: radiofrequency ablation; US: Ultrasound.

American Urological Association

The American Urological Association (AUA; 2017) guideline on renal masses and localized renal cancer affirms that partial nephrectomy should be prioritized for the management of cT1a renal masses when intervention is indicated. Thermal ablation should be considered "as an alternate approach for the management of cT1a renal masses <3 cm in size." The guidelines were updated in 2021 and recommendations are generally consistent with what was published in the 2017 guideline. The 2021 AUA guideline explicitly states that RFA and cryoablation may be offered as options to patients who elect thermal ablation.

American Thyroid Association

The American Thyroid Association (2015) guideline on the management of thyroid nodules and differentiated thyroid cancer provides recommendations for management. Patients with a benign cytology diagnosis or those very unlikely to be malignant (eg, purely cystic nodule) should undergo surveillance with the frequency determined by the level of suspicion for a missed malignancy. Medical or surgical intervention is considered if the nodules are large (>4 cm), causing compressive or structural symptoms, or if there is clinical concern. Recurrent cystic thyroid nodules with benign cytology should be considered for surgical removal or percutaneous ethanol injection. For differentiated thyroid cancer, "localized treatments with thermal (radiofrequency or cryo-) ablation, ethanol ablation, or chemoembolization may be beneficial in patients with a single or a few metastases and in those with metastases at high risk of local complications."

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National Comprehensive Cancer Network

The National Comprehensive Cancer Network (NCCN) guidelines for the treatment of NSCLC (v.7.2025) state: "For medically operable disease, resection is the preferred local treatment modality (other modalities include SABR [stereotactic ablative radiotherapy], thermal ablation such as radiofrequency ablation, and cryotherapy)." For patients who are not amenable to surgery, image-guided thermal ablation therapy (IGTA; includes RFA, microwave ablation, and cryoablation) may be considered. The guidance states "IGTA is an option for the management of NSCLC lesions <3 cm. Ablation for NSCLC lesions >3 cm may be associated with higher rates of local recurrence and complications."

The NCCN guidelines for thyroid carcinoma (v.1.2025) indicate that local therapies such as RFA may be considered for locoregional recurrence of thyroid carcinoma-papillary carcinoma in select patients with limited burden nodal disease. Additionally, local therapies, including RFA, can be considered in those with metastatic disease.

The NCCN guidelines (v.1.2026) for renal cell carcinoma indicate that "percutaneous ablation (eg, cryosurgery, radiofrequency ablation, microwave ablation) is an option for the management of clinical stage T1 renal lesions. Percutaneous ablation is an option for clinical T1b masses in select patients not eligible for surgery. Biopsy of lesions is recommended to be done prior to or at time of ablation. Percutaneous ablation may require multiple treatments to achieve the same oncologic outcomes as conventional surgery."

The NCCN colon cancer guidelines (v.4.2025) state that "resection is the standard approach for the local treatment of resectable metastatic disease. However, patients with liver or lung oligometastases can also be considered for tumor ablation therapy, particularly in cases that may not be optimal for resection." "There is extensive evidence on the use of RFA as a reasonable treatment option for non-surgical candidates and for recurrent disease after hepatectomy with small liver metastases that can be treated with clear margins."

The NCCN guidelines for head and neck cancers (v.4.2025), breast cancer (v.4.2025), bone cancer (v.2.2025), and pancreatic adenocarcinoma (v.2.2025) do not mention RFA.

National Institute for Health and Care Excellence

The NICE guidance (2004) on osteoid osteoma indicated that "current evidence on the safety and efficacy of computed tomography (CT)-guided thermocoagulation of osteoid osteoma appears adequate to support its use...."

Updated NICE guidance (2010) on renal cancer has indicated that "evidence on the safety and efficacy of percutaneous radiofrequency ablation (RFA) ... in the short and medium term appears adequate to support the use of this procedure provided that patients are followed up in the long term."

The NICE guidance (2010) on RFA for primary and secondary lung cancers has stated: "Current evidence on the efficacy of percutaneous radiofrequency ablation (RFA) ... is adequate in terms of tumor control." The NICE also indicated RFA might "be used in patients with small, early-stage

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lung cancers or small numbers of lung metastases who are unsuitable for, or prefer not to undergo, surgery. It may also have a place in multi-modality treatment of more advanced primary lung cancers." The guidance warned of serious complications (eg, pneumothorax) among lung cancer patients.

The NICE guidance (2016) on thyroid nodules stated: "Current evidence on the safety and efficacy of ultrasound-guided percutaneous radiofrequency ablation ... is adequate to support the use of this procedure...."

Society of Interventional Radiology

The Society of Interventional Radiology (2020) published a position statement on the role of percutaneous ablation in renal cell carcinoma. Their relevant recommendations are as follows:

- "In patients with small renal tumors (stage T1a), percutaneous thermal ablation is a safe and effective treatment with fewer complications than nephrectomy and acceptable long-term oncological and survival outcomes. (Level of Evidence: C; Strength of Recommendation: Moderate)"
- "In selected patients with suspected T1a renal cell carcinoma, percutaneous thermal ablation should be offered over active surveillance. (Level of Evidence: C; Strength of Recommendation: Moderate)"
- "In high-risk patients with T1b renal cell carcinoma who are not surgical candidates, percutaneous thermal ablation may be an appropriate treatment option; however, further research in this area is required. (Level of Evidence: D; Strength of Recommendation: Weak)"
- "Radiofrequency ablation, cryoablation, and microwave ablation are all appropriate modalities for thermal ablation, and method of ablation should be left to the discretion of the operating physician. (Level of Evidence: D; Strength of Recommendation: Weak)"

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 2.

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Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT05189821	RFA Treatment for Papillary Thyroid Microcarcinoma Cohort	50	Nov 2027
NCT05189808	Radiofrequency Ablation for Indeterminate Bethesda III Thyroid Nodules	50	Aug 2027
<i>Unpublished</i>			
NCT04619472	A Multicenter, Single Group Target Value Clinical Study to Evaluate Safety and Effectiveness of Radiofrequency Ablation System in the Treatment of Peripheral Lung Tumors	126	Mar 2023
NCT01051037	Phase II Study Evaluating Safety and Efficacy of Stereotactic Body Radiotherapy and Radiofrequency Ablation for Medically Inoperable and Recurrent Lung Tumors Near Central Airways	17	Dec 2017 (completed)

NCT: national clinical trial.

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07/13/2005	Medical Director review
07/19/2005	Medical Policy Committee review
08/24/2005	Managed Care Advisory Council approval
07/07/2006	Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
08/08/2006	Medical Director review
08/09/2006	Medical Policy Committee approval.
07/10/2007	Medical Director review
07/18/2007	Medical Policy Committee approval. Policy Statement added for osteoid osteoma and rationale/source updated.
07/02/2008	Medical Director review
07/16/2008	Medical Policy Committee approval. Coverage eligibility unchanged.
07/02/2009	Medical Director review
07/22/2009	Medical Policy Committee approval. Coverage statement added to indicate that use of radiofrequency ablation as treatment of osteoid osteomas that cannot be managed successfully with medical treatment may be considered eligible for coverage.

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	Coverage statement added that treatment of localized renal cell carcinoma no more than 4cm in size may be considered eligible for coverage when specific criteria are met. Added that radiofrequency ablation for the treatment of osteoid osteomas that can be managed with medical treatment is considered to be investigational.
08/05/2010	Medical Policy Committee review
08/18/2010	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/04/2011	Medical Policy Committee review
08/17/2011	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/02/2012	Medical Policy Committee review
08/15/2012	Medical Policy Implementation Committee approval. Added options for primary and metastatic pulmonary tumors to be eligible for coverage with criteria.
12/12/2013	Medical Policy Committee review
12/18/2013	Medical Policy Implementation Committee approval. Reformatted investigational statement and added thyroid as investigational.
06/25/2015	Medical Policy Committee review
07/15/2015	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/30/2016	Medical Policy Committee review
07/20/2016	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2017	Coding update: Removing ICD-9 Diagnosis codes
07/06/2017	Medical Policy Committee review
07/19/2017	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2018	Coding update
07/05/2018	Medical Policy Committee review
07/11/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/31/2018	Coding update
07/03/2019	Medical Policy Committee review
07/18/2019	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/13/2019	Coding update
01/14/2020	Coding update
07/02/2020	Medical Policy Committee review
07/08/2020	Medical Policy Implementation Committee approval. Added an eligible for coverage statement for RFA to treat osteoid osteomas that cannot be managed successfully with medical treatment. Added a reference to the Policy Guidelines after the eligible for coverage criteria for treatment of malignant nonpulmonary tumor(s) metastatic to the lung.
07/01/2021	Medical Policy Committee review

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07/14/2021	Medical Policy Implementation Committee approval. Added pancreas to the list for radiofrequency ablation of all other tumors to be investigational. Coverage eligibility unchanged.
07/07/2022	Medical Policy Committee review
07/13/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/06/2023	Medical Policy Committee review
07/12/2023	Medical Policy Implementation Committee approval. Revised the coverage section.
07/02/2024	Medical Policy Committee review
07/10/2024	Medical Policy Implementation Committee approval. Removed thyroid carcinoma as eligible for coverage. Removed biopsy proven requirement for non-small cell lung cancer. Deleted first criteria bullet for metastatic malignant lung tumor(s) for surgical or radiation treatment with curative intent. Metastatic malignant lung tumor(s) criteria with 1st bullet added regarding preserving lung function and surgical candidacy, and criteria for extrapulmonary metastatic disease and for number of tumors per lung were reworded. Added breast and thyroid tumors to the investigational statement.
12/10/2024	Coding update
07/03/2025	Medical Policy Committee review
07/09/2025	Medical Policy Implementation Coverage eligibility unchanged.
07/02/2026	Medical Policy Committee review
07/08/2026	Medical Policy Implementation Committee review
07/16/2026	Medical Quality Management Committee approval. Created a not medically necessary section for radiofrequency ablation (RFA) of tumors outside the liver when criteria are not met.

Next Scheduled Review Date: 07/2027

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)†, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of Louisiana Blue Medical Policy Coverage Guidelines is with Louisiana Blue and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Louisiana Blue Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Louisiana Blue Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which

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contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	20982, 32998, 50542, 50592, 60660, 60661, 60699, 76940, 77013, 77022 Add codes effective 08/01/2026: 19499, 20999, 32999, 48999
HCPCS	No codes
ICD-10 Diagnosis	C73, D09.3, D34, D44.0, E04.0-E04.9

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan’s authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan’s pharmacy benefit.