



**EFFECTIVE DATE:** 07|01|2012  
**POLICY LAST UPDATED:** 06|19|2018

## OVERVIEW

Microwave ablation (MWA) is a technique to destroy tumors and soft tissue by using microwave energy to create thermal coagulation and localized tissue necrosis. MWA is used to treat tumors considered to be inoperable or not amenable to resection or to treat patients ineligible for surgery due to age, presence of comorbidities, or poor general health. MWA may be performed as an open procedure, laparoscopically, percutaneously, or thoracoscopically under image guidance (e.g., ultrasound, computed tomography [CT] or magnetic resonance imaging [MRI]) with sedation, or local or general anesthesia. This technique may also be referred to as microwave coagulation therapy.

## MEDICAL CRITERIA

Not applicable

## PRIOR AUTHORIZATION

Not applicable

## POLICY STATEMENT

### BlueCHiP for Medicare

Microwave ablation of primary and metastatic tumors is not covered as the evidence is insufficient to determine the effects of the technology on health outcomes.

### Commercial Products

Microwave ablation of primary and metastatic tumors is considered not medically necessary as the evidence is insufficient to determine the effects of the technology on health outcomes.

## COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate section of the Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable not medically necessary/not covered benefits/coverage.

## BACKGROUND

Microwave ablation (MWA) is a technique in which the use of microwave energy induces an ultra-high speed, 915 MHz or 2450MHz (2.45GHz), alternating electric field that causes water molecule rotation and the creation of heat. This results in thermal coagulation and localized tissue necrosis. In MWA, a single microwave antenna or multiple antennas connected to a generator are inserted directly into the tumor or tissue to be ablated; energy from the antennas generates friction and heat. The local heat coagulates the tissue adjacent to the probe, resulting in a small, approximately 2-3 cm elliptical area (5 x 3 cm) of tissue ablation. In tumors > 2 cm in diameter, 2-3 antennas may be used simultaneously to increase the targeted area of MWA and shorten operative time. Multiple antennas may also be used simultaneously to ablate multiple tumors. Tissue ablation occurs quickly, within one minute after a pulse of energy, and multiple pulses may be delivered within a treatment session depending on the size of the tumor. The cells killed 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. Treatment may be repeated as needed. MWA may be used to: 1) control local tumor growth and prevent recurrence; 2) palliate symptoms; and 3) extend survival duration.

Complications from MWA are usually mild and may include pain and fever. Other complications associated with MWA include those caused by heat damage to normal tissue adjacent to the tumor (e.g., intestinal damage during MWA of the kidney or liver), structural damage along the probe track (e.g., pneumothorax as a consequence of procedures on the lung), liver enzyme elevation, liver abscess, ascites, pleural effusion, diaphragm injury, or secondary tumors if cells seed during probe removal. MWA should be avoided in pregnant patients since potential risks to the patient and/or fetus have not been established and in patients with implanted electronic devices (e.g. implantable pacemakers) that may be adversely affected by microwave power output.

For individuals who have an unresectable primary or metastatic tumor (eg, breast, hepatic [primary or metastatic], pulmonary, renal) who receive MWA, the evidence includes case series, observational studies, cohort studies, randomized controlled trials, and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, symptoms, quality of life, and treatment-related mortality and morbidity. Available studies have shown that MWA results in a wide range of complete tissue ablation (50%-100%) depending on tumor size, with complete ablation common and nearing 100% with smaller tumors (eg,  $\leq 3$  cm). Tumor recurrence rates at ablated sites are very low. However, tumor recurrence at nonablated sites is common and may correlate with disease state (eg, in hepatocellular carcinoma). Intraoperative and postoperative minor and major complications are low, especially when tumors are smaller and accessible. Patient selection criteria and rationale for using MWA over other established techniques (eg, surgical resection, radiofrequency ablation) are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

#### **CODING**

There are no CPT codes specific to microwave tumor ablation. Report the unlisted CPT code for the anatomic area.

The following related HCPCS code is not covered for BlueCHIP for Medicare and not medically necessary for Commercial products:

**C9751** Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-d rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s) (Code effective 1/1/2019)

#### **RELATED POLICIES**

None

#### **PUBLISHED**

Provider Update, August 2018

Provider Update, June 2017

Provider Update, May 2016

Provider Update, May 2015

Provider Update, June 2014

Provider Update, November 2013

Provider Update, May 2012

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