MEDICAL POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Radiofrequency and Microwave Ablation of Tumors-GA MCD-MM-1350	02/01/2024

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

C. Definitions

- **Tumor Ablation** ±Direct application of energy to eradicate or destroy focal tumors. The method of ablation is dependent on the characteristics of the lesion and risk mitigation.
  - **Microwave Ablation (MWA)** ±Delivery of high-frequency microwave energy to rapidly agitate water molecules in the target tissue; the energy is converted to heat, which causes tissue necrosis.
  - **Radiofrequency Ablation (RFA)** ±Delivery of radio waves to generate heat and induce tissue destruction in the targeted area.

D. Policy

I. Microwave ablation for tumor treatment using an FDA-approved device is considered medically necessary when **ANY** (either A or B) of the following indications are met:

A. Member has primary or metastatic hepatic (liver) tumor and **ALL** the following:

1. The tumor is unresec

1. differentiated thyroid carcinoma (eg, follicular, papillary) with **at least ONE** of the following:
   a. distant metastasis or persistent disease not amenable to treatment with radioactive iodine
   b. recurrent disease following treatment of locoregional disease
2. medullary carcinoma with **at least ONE** of the following:
   a. palliative treatment of symptomatic metastases or progressive disease needed
   b. patient asymptomatic, with **at least ONE** of the following:
      01. disease metastasis
      02. persistent disease following treatment of locoregional disease
      03. recurrent disease following treatment of locoregional disease

I. Uterine leiomyomas with **ALL** the following:
1. laparoscopic ultrasound-guided procedure planned
2. leiomyomas documented by imaging study (eg, ultrasound) or hysteroscopy)
3. patient desires uterine conservation
4. patient is premenopausal
5. persistent symptoms (3 months or greater in duration) directly attributed to presence of leiomyomas, as indicated by **at least ONE** of the following:
   a. abnormal uterine bleeding unresponsive to conservative management (eg, hormonal therapy)
   b. bowel dysfunction
   c. dyspareunia
   d. infertility
   e. iron deficiency anemia
   f. pelvic pain or pressure
   g. urinary dysfunction
6. testing has ruled out other potential causes of symptoms

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

DATE		ACTION
Date Issued	10/12/2022	
Date Revised	09/27/2023	Annual review: updated references, approved at Committee
Date Effective	02/01/2024	
Date Archived		

H. References

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Independent medical review ±September 2022

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