MEDICAL POLICY STATEMENT
Georgia Medicaid

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

Radiofrequency and Microwave Ablation of Tumors-GA MCD-MM-1350 Effective Date: 02/01/2024



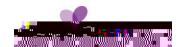
C. Definitions

- x **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.
 - o 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 രണ്ണ് project and the properties of the following indications are met:
 - ML 1Member has primary or metastatic hepatic (liver) tumor and ALL the following:
 - 1. The tumor is unresec22 Tm0 gBT/F1 11.04 Tf1 0515.23 .3 duQ(o)13(rl(et)c-4(o)13(r)-3()6(t)-

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- 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 (eq. 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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