



**INTERSTITIAL LASER THERAPY
FOR BREAST TUMORS
HS-142**



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**Interstitial Laser Therapy
for Breast Tumors**

Policy Number: HS-142

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Revised Date(s): 11/12/2010; 10/6/2011

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

BACKGROUND

Interstitial laser therapy is used to treat small tumors of the breast. Standard treatments include lumpectomy or mastectomy (without preceding laser therapy), and minimally invasive techniques such as radiofrequency ablation or cryotherapy.

Interstitial laser therapy is a minimally invasive technique for treating small breast cancers. After locating the tumor using stereotactic techniques or ultrasound, laser energy is delivered into the tumor via a needle probe. This destroys tumor tissue – the aim is to ablate the tumor entirely.

The evidence was limited to three small case series and one case report. One study of interstitial laser therapy followed by surgery reported that 98% (43/44) of patients were disease-free at follow-up. However, follow-up ranged from 2 to 26 months, and it was difficult to determine whether the results were attributable to the laser therapy or the surgery. This study also found no histological sign of laser damage in the tumors of 9% (4/44) of patients.

Given the paucity of evidence ILT is considered experimental and investigational at this time. Further, support for ILT from professional societies or organizations does not exist.

POSITION STATEMENT

Interstitial Laser Therapy (ILT) **is considered experimental and investigational and NOT a covered benefit** for the treatment of breast tumors and all other indications.

CODING

Non- Covered CPT Codes

19499 Unlisted Procedure of the Breast when billed for ILT – Interstitial Laser Therapy of the breast

Non-Covered ICD-9-CM Procedure Codes

17.69 MRI Guided LITT - Laser interstitial thermal therapy of lesion of breast

HCPCS Code - No specified code

Non-Covered ICD-9-CM Diagnosis Codes

217 Benign neoplasm of breast
174.0 - 174.9 Malignant neoplasm of female breast
175.0 - 175.9 Malignant neoplasm of male breast

***Current Procedural Terminology (CPT) 2011 American Medical Association: Chicago, IL.**

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Peer Reviewed

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Government Agencies, Professional and Medical Organizations

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HISTORY AND REVISIONS

Date	Action
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
10/6/2011	<ul style="list-style-type: none">• Approved by MPC. Reformatted references; added comment that no professional organizations/societies have stated support of ILT.