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.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). 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 CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG 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. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

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...
INTERSTITIAL LASER THERAPY FOR BREAST TUMORS
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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.1,2,3

POSITION STATEMENT

Applicable To:
☑ Medicaid – All Markets
☑ Medicare – All Markets

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 *This list is not all inclusive
19499 Unlisted Procedure of the Breast when billed for ILT – Interstitial Laser Therapy of the breast

NOTE: There is no CPT code designated for ILT – Interstitial Laser Therapy of the breast

Non-Covered ICD-10-PCS Codes *This list is not all inclusive
DMY0KZZ Laser interstitial thermal therapy of left breast
DMY1KZZ Laser interstitial thermal therapy of right breast

HCPCS Code - No specified codes

Non-Covered ICD-10-CM Diagnosis Codes *This list is not all inclusive
C50.011 – C50.929 Malignant neoplasm of breast
C79.81 Secondary malignant neoplasm of breast
D24.1 – D24.9 Benign neoplasm of breast

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<td>9/7/2016</td>
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<td>11/5/2015</td>
<td>• Approved by MPC. Coding updates only.</td>
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<tr>
<td>11/6/2014</td>
<td>• Approved by MPC. Updates to ICD-10 codes.</td>
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<td>11/1/2012</td>
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<td>12/1/2011</td>
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<td>10/6/2011</td>
<td>• Approved by MPC. Reformatted references; added comment that no professional organizations/societies have stated support of ILT.</td>
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