Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP353

Section: Medical Policy

Subject: Laser Interstitial Thermal Therapy

I. Policy: Laser Interstitial Thermal Therapy

II. Purpose/Objective: To provide a policy of coverage regarding: Laser Interstitial Thermal Therapy

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

DESCRIPTION:
Laser interstitial thermal therapy (LITT) [e.g., MRgLITT , Neuroablate, Visulase)], utilizes a laser fiber probe to deliver thermal energy for the targeted ablation of diseased tissue. The LITT treatment produces focal thermal ablation leading to cellular apoptosis, necrosis, tissue coagulation or tumor cytoreduction and is managed by the use of real-time magnetic resonance (MR) thermography and controlled with the use of actively cooled applicators.

INDICATIONS:
Epilepsy
Laser Interstitial Thermal Therapy (LITT) is considered medically necessary in the treatment of refractory epilepsy when ALL of the following criteria are met:

- there is documentation of medically-refractory epilepsy despite use of two or more antiepileptic drug regimens
- a well-defined epileptogenic focus in the temporal lobe or hypothalamus is identified and is accessible by LITT
- a multidisciplinary team of physicians to include at least two specialists (e.g., neurosurgery, neurology) agree that LITT is the best treatment option

Malignant Brain Neoplasms and/or Radiation Necrosis
Laser Interstitial Thermal Therapy (LITT) is considered medically necessary in the treatment of symptomatic, recurrent metastatic malignant brain neoplasms when ALL of the following criteria are met:

- the neoplasm measures ≤30 cubic centimeters (cc) in volume
- the member is not considered a suitable candidate for craniotomy
- a multidisciplinary team of physicians including at least two specialists (e.g., neurosurgery, oncology) agree that LITT is the best treatment option

EXCLUSIONS:
The Plan does **NOT** provide coverage for LITT for any indication not specifically listed because it is otherwise considered **experimental, investigational or unproven**. The Geisinger Technology Assessment Committee determined there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this therapy on health outcomes when compared to established treatments or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Laser Interstitial Thermal Therapy
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

61736 Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion
61737 Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually**.**

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Revised:

Reviewed: 3/23, 2/24

CMS UM Oversight Committee Approval: 12/23