MMPRICAL POLICY – 7.01.526
Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors

BCBSA Ref. Policy: 7.01.92
Effective Date: Oct. 1, 2018
Last Revised: Sept. 20, 2018
Replaces: 7.01.92

RELATED MEDICAL POLICIES:
7.01.95 Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Cryosurgical ablation uses extreme cold to destroy certain types of tumors. A probe is inserted into the tumor and an extremely cold liquid is circulated through the probe. An icy ball forms around the probe to freeze part or all of the tumor. The probe can be positioned in such a way as to maximize harm to the tumor while sparing nearby health tissue. The frozen area thaws, allowing the body to absorb the treated tissue. The policy discusses when this technique is considered medically necessary for specific breast and kidney tumors. It’s also been tried for other kinds of tumors. Because larger and longer medical studies are needed, this technique is considered investigational (unproven) for other types of tumors.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
<table>
<thead>
<tr>
<th>Service</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cryosurgical ablation of benign breast fibroadenomas</strong></td>
<td><strong>Cryosurgical ablation of benign breast fibroadenomas may be considered medically necessary when ALL of the following criteria are met:</strong> &lt;ul&gt;&lt;li&gt;The lesion must be sonographically visible&lt;/li&gt;&lt;li&gt;AND&lt;/li&gt;&lt;li&gt;The diagnosis of fibroadenoma is confirmed histologically&lt;/li&gt;&lt;li&gt;AND&lt;/li&gt;&lt;li&gt;The lesion(s) is less than 3 cm in largest diameter&lt;/li&gt;&lt;li&gt;AND&lt;/li&gt;&lt;li&gt;There are none of the following contraindications in existence:&lt;br&gt; o Large core biopsy diagnosis suggestive of cystosarcoma phyllodes tumor or other malignancy&lt;br&gt; o Poor visualization of lesion by ultrasound&lt;br&gt; o Large core biopsy diagnosis of fibroadenoma where diagnosis is thought to be non-concordant with findings on imaging or physical examination&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td><strong>Cryosurgical ablation, localized renal cell carcinoma</strong></td>
<td><strong>Cryosurgical ablation may be considered medically necessary to treat localized renal cell carcinoma that is no more than 4 cm in size when either of the following criteria is met:</strong> &lt;ul&gt;&lt;li&gt;Preservation of kidney function is necessary (ie, the patient has one kidney or renal insufficiency defined by a glomerular filtration rate [GFR] of less than 60 mL/min per m²) and standard surgical approach (ie, resection of renal tissue) is likely to substantially worsen kidney function&lt;/li&gt;&lt;li&gt;OR&lt;/li&gt;&lt;li&gt;Patient is not considered a surgical candidate&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td><strong>Lung cancer</strong></td>
<td><strong>Cryosurgical ablation may be considered medically necessary to treat lung cancer when either of the following criteria is met:</strong> &lt;ul&gt;&lt;li&gt;The patient has early-stage non-small cell lung cancer and is a poor surgical candidate&lt;/li&gt;&lt;li&gt;OR&lt;/li&gt;&lt;li&gt;The patient requires palliation for a central airway obstructing lesion.&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td>Service</td>
<td>Investigational</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cryosurgical ablation, malignant tumors</td>
<td>Cryosurgical ablation is considered investigational to treat individuals with ANY of the following:</td>
</tr>
<tr>
<td></td>
<td>• Bone cancer</td>
</tr>
<tr>
<td></td>
<td>• Lung cancer (other than defined above)</td>
</tr>
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<td></td>
<td>• Malignant tumors of the breast</td>
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<td></td>
<td>• Other solid tumors or metastases outside the liver and prostate</td>
</tr>
<tr>
<td></td>
<td>• Pancreatic cancers</td>
</tr>
<tr>
<td></td>
<td>• Renal cell carcinomas in patients who are surgical candidates</td>
</tr>
</tbody>
</table>

**Documentation Requirements**

The patient’s medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- For cryosurgical ablation of benign breast fibroadenomas, clinical documentation that includes:
  - Lesion that is visible on an ultrasound
  - Histological result confirming the diagnosis of fibroadenoma
  - Size of the lesion
  - And none of the following contraindications:
    - Large core biopsy diagnosis that is suggestive of cystosarcoma phyllodes tumor or other malignancy
    - Poor visualization of lesion by ultrasound
    - Large core biopsy diagnosis of fibroadenoma where diagnosis is thought to be inconsistent with findings on imaging or physical examination

- For cryosurgical ablation of localized renal cell carcinoma, documentation of:
  - The need to preserve the kidney because:
    - Patient has one kidney
    - OR
    - Patient has renal insufficiency as defined by a glomerular filtration rate (GFR) of less than or equal to 60 mL/min/m, and standard surgical approach (ie, resection of renal tissue) is likely to substantially worsen kidney function
    - OR
    - Patient is considered not a surgical candidate

- For lung cancer, documentation of:
  - Patient has early-stage non-small cell lung cancer and is a poor surgical candidate
  - OR
**Documentation Requirements**

- The patient requires palliation for a central airway obstructing lesion

**Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>0340T</td>
<td>Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance (code terminated 1/1/18, replaced by 32994)</td>
</tr>
<tr>
<td>19105</td>
<td>Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma</td>
</tr>
<tr>
<td>20983</td>
<td>Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation</td>
</tr>
<tr>
<td>32994</td>
<td>Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation (new code effective 1/1/18)</td>
</tr>
<tr>
<td>50250</td>
<td>Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed</td>
</tr>
<tr>
<td>50542</td>
<td>Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed</td>
</tr>
<tr>
<td>50593</td>
<td>Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy</td>
</tr>
</tbody>
</table>

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**Related Information**

N/A
Evidence Review

Description

Cryosurgical ablation (hereafter referred to as cryosurgery or cryoablation) involves freezing of target tissues; this is most often performed by inserting a coolant-carrying probe into the tumor. Cryosurgery may be performed as an open surgical technique or as a closed procedure under laparoscopic or ultrasound guidance.

Background

Breast Tumors

Early-stage primary breast tumors are treated surgically. The selection of lumpectomy, modified radical mastectomy, or another approach is balanced against the patient’s desire for breast conservation, the need for tumor-free margins in resected tissue, and the patient’s age, hormone receptor status, and other factors. Adjuvant radiation therapy decreases local recurrences, particularly for those who select lumpectomy. Adjuvant hormonal therapy and/or chemotherapy are added, depending on presence and number of involved nodes, hormone receptor status, and other factors. Treatment of metastatic disease includes surgery to remove the primary lesion and combination chemotherapy.

Fibroadenomas are common, benign tumors of the breast that can either present as a palpable mass or a mammographic abnormality. These benign tumors have been frequently surgically excised to rule out a malignancy.

Lung Tumors

Early-stage lung tumors are typically treated surgically. Patients with early-stage lung cancer who are not surgical candidates may be candidates for radiotherapy with curative intent. Cryoablation is being investigated in patients who are medically inoperable, with small primary lung cancers or lung metastases. Patients with more advanced local disease or metastatic disease may undergo chemotherapy with radiation following resection. Treatment is rarely curative: rather, it seeks to retard tumor growth or palliate symptoms.
**Pancreatic Cancer**

Pancreatic cancer is a relatively rare solid tumor that occurs almost exclusively in adults, and it is largely considered incurable. Surgical resection of tumors contained entirely within the pancreas is currently the only potentially curative treatment. However, the nature of the cancer is such that few tumors are found at such an early and potentially curable stage. Patients with more advanced local disease or metastatic disease may undergo chemotherapy with radiation following resection. Treatment focuses on slowing tumor growth and palliation of symptoms.

**Renal Cell Carcinoma (RCC)**

Localized renal cell carcinoma is treated with radical nephrectomy or nephron-sparing surgery. Prognosis drops precipitously if the tumor extends outside the kidney because chemotherapy is relatively ineffective against metastatic renal cell carcinoma.

**Cryosurgical Treatment**

Cryosurgical treatment of various tumors including malignant and benign breast disease, lung cancer, pancreatic cancer, and renal cell carcinoma has been reported in the literature. The hypothesized advantages of cryosurgery include improved local control and benefits common to any minimally invasive procedure (eg, preserving normal organ tissue, decreasing morbidity, decreasing length of hospitalization).

**Summary of Evidence**

For individuals who have solid tumors (located in areas of the breast, lung, pancreas, kidney, or bone) who receive cryosurgical ablation, the evidence includes nonrandomized comparative studies, case series, and systematic reviews of these nonrandomized studies. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related morbidity. There is a lack of randomized controlled trials and high-quality comparative studies to determine the efficacy and comparative effectiveness of cryoablation. The largest amount of evidence assesses renal cell carcinoma in select patients (ie, those with small tumors who are not surgical candidates, or those who have baseline renal insufficiency of such severity that standard
surgical procedures would impair their kidney function). Cryoablation results in short-term tumor control and less morbidity than surgical resection, but long-term outcomes may be inferior to surgery. For other indications, there is less evidence, with single-arm series reporting high rates of local control. Due to the lack of prospective controlled trials, it is difficult to conclude that cryoablation improves outcomes for any indication better than alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes. However, based on clinical input, cryosurgical ablation of benign breast fibroadenomas is considered medically necessary when criteria are met.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01957787</td>
<td>Study of Cryoablation for Metastatic Lung Tumors (SOLSTICE)</td>
<td>134</td>
<td>Sep 2018</td>
</tr>
<tr>
<td>NCT02399124</td>
<td>ICE-SECRET PROSENSE™ Cryotherapy for Renal Cell Carcinoma Trial</td>
<td>100</td>
<td>Jan 2022</td>
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<tr>
<td>NCT03390413</td>
<td>Robot-assisted Surgical Resection vs. Cryoablation of Localised Renal Cancer - a Randomised Trial of Functional, Oncological and Financial Aspects</td>
<td>190</td>
<td>Mar 2028</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.
^a Denotes industry-sponsored or cosponsored trial.

Clinical Input From Physician Specialty Societies And Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.
2017 Input

In response to requests, clinical input on use of cryosurgical ablation to manage individuals with localized renal cell cancer, use of cryosurgical ablation to manage individuals with lung cancer, and use of cryosurgical ablation to manage individuals with breast, pancreatic, or bone cancers was received from 9 respondents, including 2 specialty society-level responses, 3 physician-level responses identified by specialty societies, and 4 physicians identified by 1 health system, while this policy was under review in 2017.

Based on the evidence and independent clinical input, the clinical input supports that the following indications provide a clinically meaningful improvement in the net health outcome and are consistent with generally accepted medical practice.

- Use of cryosurgical ablation to manage individuals with localized renal cell cancer when either of the following criteria is met:
  - No more than 4 cm in size when preservation of kidney function is necessary (ie, the patient has 1 kidney or renal insufficiency defined by a glomerular filtration rate <60 mL/min/m²), and standard surgical approach (ie, resection of renal tissue) is likely to worsen kidney function substantially; or
  - When the patient is not considered a surgical candidate.

- Use of cryosurgical ablation to manage individuals with lung cancer when either of the following criteria is met:
  - Poor surgical candidates with early-stage non-small-cell lung cancer; or
  - Palliation of a central airway obstructing lesion

Based on the evidence and independent clinical input, the clinical input does not support whether the following indication provides a clinically meaningful improvement in the net health outcome or is consistent with generally accepted medical practice.

- Use of cryosurgical ablation to manage individuals with:
  - Malignant or benign tumors of the breast;
  - Pancreatic cancer; or
  - Bone cancer
2009 Input

In response to requests, input was received from 2 physician specialty societies (5 reviews) and from 2 academic medical centers (3 reviews) while this policy was under review in 2009. There was strong support for the use of cryoablation in the treatment of select patients with renal tumors. There also was support for its use in the treatment of benign breast disease. Reviewers generally agreed cryoablation was investigational in the treatment of pancreatic cancer.

Practice Guidelines and Position Statements

The American Society of Breast Surgeons

The American Society of Breast Surgeons 2008 consensus statement on management of fibroadenomas of the breast indicated cryoablation is appropriate for histologically confirmed fibroadenoma lesions that are less than 4 cm in largest diameter and sonographically visible. Cryoablation of fibroadenoma of the breast is contraindicated when ultrasound visualization is poor or core biopsy suggests a diagnosis of cystosarcoma phyllodes tumor or other malignancy or if physical examination or imaging is discordant with a biopsy diagnosis of fibroadenoma.

American College of Radiology

The 2009 American College of Radiology Appropriateness Criteria for renal cell carcinoma, updated most recently in 2014, indicated that “As an alternative to partial nephrectomy, energy-ablative therapies, such as cryoablation... are being used to treat small renal cell carcinomas. These therapies have been shown to be effective and safe.” These recommendations are based on review of the data and consensus.

American Urological Association (AUA)

The American Urological Association (2017) updated its guidelines on evaluation and management of clinically localized sporadic renal masses suspicious for renal cell carcinoma. The guideline statements on thermal ablation (radiofrequency ablation, cryoablation) are listed in Table 2.
Table 2. Guidelines on Localized Masses Suspicious for Renal Cell Carcinoma

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>LOR</th>
<th>LOE</th>
</tr>
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<tbody>
<tr>
<td><strong>Guideline statement 24</strong></td>
<td></td>
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<tr>
<td>Physicians should consider thermal ablation (TA) as an alternate approach for the</td>
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<tr>
<td>management of cT1a renal masses &lt;3 cm in size. For patients who elect TA, a percutaneous</td>
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<tr>
<td>technique is preferred over a surgical approach whenever feasible to minimize morbidity.</td>
<td>Conditional</td>
<td>C</td>
</tr>
<tr>
<td><strong>Guideline statement 25</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both radiofrequency ablation and cryoablation are options for patients who elect thermal ablation</td>
<td>Conditional</td>
<td>C</td>
</tr>
<tr>
<td><strong>Guideline statement 27</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling about thermal ablation should include information regarding an increased likelihood of tumor persistence or local recurrence after primary thermal ablation relative to surgical extirpation, which may be addressed with repeat ablation if further intervention is elected</td>
<td>Strong</td>
<td>B</td>
</tr>
</tbody>
</table>

LOE: level of evidence; LOR: level of recommendation.

**National Comprehensive Cancer Network**

National Comprehensive Cancer Network (NCCN) guidelines on kidney cancer (v.4.2018) state that based on lower level evidence and uniform NCCN consensus, cryosurgery: “can be considered for patients with clinical stage T1 renal lesions who are not surgical candidates. Biopsy of small lesions may be considered to obtain or confirm a diagnosis of malignancy and guide surveillance, cryosurgery ... [and] ablation strategies.”\(^{52}\) NCCN guidelines also note that “Randomized phase III comparison with surgical resection (ie, radical or partial nephrectomy by open or laparoscopic techniques) has not been done” and “ablative techniques are associated with a higher local recurrence rate than conventional surgery.”

NCCN guidelines for non-small cell lung cancer (v.4.2108) indicate surgical “resection is the preferred local treatment modality” and “other modalities include ... cryotherapy.”\(^{53}\)
Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Regulatory Status

Several cryoablation devices have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process for use in open, minimally invasive or endoscopic surgical procedures in the areas of general surgery, urology, gynecology, oncology, neurology, dermatology, proctology, thoracic surgery and ear, nose, and throat. Examples include:

- Cryocare® Surgical System (Endocare)
- CryoGen Cryosurgical System (Cryosurgical)
- CryoHit® (Galil Medical) for the treatment of breast fibroadenoma
- SeedNet™ System (Galil Medical)
- Visica® System (Sanarus Medical)

Food and Drug Administration product code: GEH

References


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**History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>03/30/04</td>
<td>Add to Surgery Section - New Policy</td>
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<tr>
<td>10/11/05</td>
<td>Replace Policy BC.7.01.92 - Policy statement revised to indicate that benign breast fibroadenomas may be considered medically necessary if certain criteria are met. References added regarding cryoablation of breast cancer, benign fibroadenomas and renal tumors.</td>
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<tr>
<td>02/06/06</td>
<td>Codes updated - No other changes.</td>
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<tr>
<td>06/06/09</td>
<td>Disclaimer and Scope update - No other changes.</td>
</tr>
<tr>
<td>10/10/06</td>
<td>Replace Policy - Policy updated with literature search; reference added. No change to policy statement</td>
</tr>
<tr>
<td>04/10/07</td>
<td>Replace Policy - Policy updated with literature review; no change in policy statement. Policy reviewed and recommended by OAP on February 22, 2007. Codes updated.</td>
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<tr>
<td>03/11/08</td>
<td>Replace Policy - Policy updated with literature search; no change to policy statement. References added.</td>
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<tr>
<td>10/14/08</td>
<td>Cross Reference Update - No other changes.</td>
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<tr>
<td>03/10/09</td>
<td>Replace Policy - Policy updated with literature review; no change in policy statement. References added. OAP reviewed on February 19, 2009 and recommended that BCBSA statement of medical necessity for renal cell carcinoma not be adopted.</td>
</tr>
<tr>
<td>08/11/09</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>03/09/10</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
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<tr>
<td>09/14/10</td>
<td>Replace Policy - Policy updated with literature review. Policy statement changed: Renal cell carcinoma, previously considered investigational, may now be considered medically necessary when criteria are met.</td>
</tr>
<tr>
<td>08/09/11</td>
<td>Replace Policy – Policy updated with literature search; no change in policy statement. References added.</td>
</tr>
<tr>
<td>02/27/12</td>
<td>Related Policies updated; 7.01.133 added.</td>
</tr>
<tr>
<td>03/23/12</td>
<td>Replace Policy – Policy updated with literature search; no change in policy statement. References added. Reviewed and recommended by OAP on February 16, 2012.</td>
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<tr>
<td>09/27/12</td>
<td>Update Related Policy – 8.01.516 as it was archived.</td>
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<tr>
<td>12/20/12</td>
<td>Update Related Policies; policy number 7.01.540 was replaced with 7.01.95.</td>
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<tr>
<td>09/27/13</td>
<td>Replace policy. Description section, policy guidelines, and rationale section updated. No change to policy statement. References added.</td>
</tr>
<tr>
<td>12/03/13</td>
<td>Coding Update. Add ICD-10 codes.</td>
</tr>
<tr>
<td>01/12/15</td>
<td>Coding update. New CPT codes 20983 and 47383, effective 1/1/15, added to the policy.</td>
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<tr>
<td>09/08/15</td>
<td>Annual Review. Minor edits for readability. Policy updated with literature review through June 7, 2015; reference 24 added. Removed CPT codes 47383 and 0304T (replaced with 0340T, the correct code) as not related to this policy. CPT code 50542 in the policy guidelines added to coding table at end of policy. Policy statements unchanged.</td>
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<tr>
<td>09/01/16</td>
<td>Interim Review, approved August 9, 2016. Update Related Policies. Remove 8.01.27 as it was archived. Removed coding table at end of policy.</td>
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<tr>
<td>11/01/16</td>
<td>Annual Review, approved October 11, 2016. No changes made to the Policy Statement.</td>
</tr>
<tr>
<td>01/01/18</td>
<td>Annual Review, approved December 12, 2017. Coverage has been increased by addition of lung cancer as medically necessary indication; harmonized with prostate and liver local therapy policies. References and Clinical Trials section updated. Added CPT code 32994 (new code effective 1/1/18).</td>
</tr>
<tr>
<td>10/01/18</td>
<td>Annual Review, approved September 20, 2018. Policy updated with literature review through May 2018; references 52-54 updated. Policy statement changed to include bone cancer and other solid tumors or metastases outside the prostate as investigational.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and
local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2018 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
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Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at:

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800-722-1471 (TTY: 800-842-5357) x5555

中文 (Chinese):
请注意重要信息。本通知可能有关于您通过 Premera Blue Cross 提交的申请或保险的重要信息。本通知可能有重要日期。您可能需要在截止日期之前采取行动，以保留您的健康保险或费用补贴。您有权免费以您的母语得到本信息和帮助。请拨打电话 800-722-1471 (TTY: 800-842-5357)。

English:

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5952, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at:

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Français (French):


Kreyòl ayisyen (Creole):

A vi a se a enn fòmasyon enn pòtèt teyann. A vi a se a kapab enn fòmasyon enn pòtèt konpansyon ak lòt osa konpansyon kouvet. Lòt osa lan a se a travay Premera Blue Cross. Kapab enn fòmasyon dat ki eppott nan a vi a se a.
O ka se a pou pran kòk akson avan sèten dat limit pou ka enbye kouvet jisans sant a lan osa pou yo ka ede avèk depans yo.
Se dwa w pou seyound enn fòmasyon sa a ak asistans nan lang ou pale a, san ou pa se a pou peye pou se a.
Rate nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):


Hmoob (Hmong):


Iloko (Ilocano):

Daytoy a Pakdaak ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaak mabalina nga adda ket naglaon iti napateg nga impormasion maianggep iti aplikasyon ny enben coverage babaen iti Premera Blue Cross. Daytoy ket mabalina dagiti importanta a pelta iti daytoy a pakdaak. Mabalina nga adda rumbega nga aramidenyo nga addang sakyab dagiti partikular a naitleung nga aldaw tapo napagmatilinayo te coverage ti salun-ayyo nena tulong kadaygit gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagasasao nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):

This notification contains important information. It may contain information about your claim or the coverage you are entitled to. It may also contain rules and guidelines for filing claims or obtaining medical services. This notification is intended to inform you of your rights and responsibilities under your insurance policy. It is important to read this notification carefully and understand its contents. If you have any questions or concerns, please contact your insurance provider or agent. Thank you for choosing our insurance services.