

MEDICAL POLICY – 7.01.95

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors

BCBSA Ref. Policy: 7.01.95


Effective Date: Dec. 1, 2018
 Last Revised: Nov. 6, 2018
 Replaces: 7.01.540

RELATED MEDICAL POLICIES:

- 7.01.526 Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors
- 8.01.24 Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults
- 8.01.505 Transcatheter Arterial Chemoembolization as a Treatment for Primary or Metastatic Liver Malignancies
- 8.01.521 Radioembolization for Primary and Metastatic Tumors of the Liver

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

Radiofrequency ablation (RFA) is a way to destroy a tumor. A probe is placed in the center of a tumor. Small areas at the end of the probe, called electrodes, carry electrical current. The electrical current flows from the electrodes and heats up nearby tissue. The heat is hot enough to destroy the tumor. The body naturally replaces the treated tissue with fibrous or scar tissue. This policy describes when RFA may be considered medically necessary for specific types of tumors, including lung and kidney tumors meeting certain criteria.

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.

Service	Medical Necessity
<p>Radiofrequency ablation</p>	<p>Radiofrequency ablation may be considered medically necessary to palliate pain in patients with osteolytic bone metastases who have failed or are poor candidates for standard treatments such as radiation or opioids.</p> <p>Radiofrequency ablation may be considered medically necessary to treat osteoid osteomas that cannot be managed successfully with medical treatment.</p> <p>Radiofrequency 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:</p> <ul style="list-style-type: none"> • When it is necessary to preserve kidney function in patients with significantly impaired renal function (ie, the patient has 1 kidney or renal insufficiency defined by a glomerular filtration rate of less than 60 mL/min/m²) <p>AND</p> <ul style="list-style-type: none"> ○ When the standard surgical approach (ie, resection of renal tissue) is likely to worsen existing kidney function substantially <p>OR</p> <ul style="list-style-type: none"> • The patient is not considered a surgical candidate <p>Radiofrequency ablation may be considered medically necessary to treat an isolated peripheral non-small-cell lung cancer lesion that is no more than 3 cm in size when the following criteria are met:</p> <ul style="list-style-type: none"> • When surgical resection or radiotherapy with curative intent is considered appropriate based on stage of disease, however medical comorbidity renders the individual unfit for those interventions <p>AND</p> <ul style="list-style-type: none"> • When the tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary



Service	Medical Necessity
	<p>artery and the heart</p> <p>Radiofrequency ablation may be considered medically necessary to treat malignant nonpulmonary tumor(s) metastatic to the lung that are no more than 3 cm in size when the following criteria are met:</p> <ul style="list-style-type: none"> • When it is necessary to preserve lung function because surgical resection or radiotherapy is likely to worsen pulmonary status substantially <p>OR</p> <ul style="list-style-type: none"> • When the patient is not considered a surgical candidate <p>AND</p> <ul style="list-style-type: none"> • When there is no evidence of extra pulmonary metastases <p>AND</p> <ul style="list-style-type: none"> • When the tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart <p>Note: The following are additional criteria developed by clinical judgment or consensus and existing guidelines for the use of radiofrequency ablation in metastatic tumors to the lung:</p> <ul style="list-style-type: none"> • No more than 3 tumors per lung should be ablated • Tumors should be amenable to complete ablation; <p>AND</p> <ul style="list-style-type: none"> • Twelve months should elapse before a repeat ablation is considered.

Drug	Investigational
Radiofrequency ablation	<p>Radiofrequency ablation is considered investigational as a technique for ablation of:</p> <ul style="list-style-type: none"> • Breast tumors • Lung cancer not meeting the criteria above • Renal cell cancer not meeting the criteria above • Osteoid osteomas that can be managed with medical treatment • Painful bony metastases as initial treatment • All other tumors outside the liver including, but not limited to, the head and neck, thyroid, pancreas, adrenal gland, ovary, and pelvic/abdominal metastases of unspecified origin



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:

- Detailed history and physical with relevant documentation of:
 - Type of malignancy diagnosis
 - Medical/radiation treatment tried

In addition, for:

- **Renal cell** carcinoma that is less than or equal to 4 cm in size and ONE of the following:
 - Documentation that patient has 1 kidney OR renal insufficiency as defined by a glomerular filtration rate of less than 60 mL/min/m²

AND

 - Resection of renal tissue is likely to worsen existing kidney function

OR

 - Patient is not considered a surgical candidate
- **Isolated peripheral non-small-cell lung cancer** lesion that is no more than 3 cm in size and ALL of the following:
 - Surgical or radiotherapy with curative intent is considered appropriate based on stage of disease, however medical co-morbidity renders the patient unfit for those interventions

AND

 - Tumors are located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart
- **Malignant nonpulmonary tumor(s) metastatic to the lung** that are no more than 3 cm in size and ALL of the following:
 - Documentation that it is necessary to preserve lung function because surgical resection or radiotherapy is likely to worsen pulmonary status

OR

 - Patient is not considered a surgical candidate

AND

 - There is no evidence of extra pulmonary metastases

AND

 - The tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart



Coding

Code	Description
CPT	
20982	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

N/A

Evidence Review

Description

In radiofrequency ablation (RFA), a probe is inserted into the center of a tumor; then, prong-shaped, non-insulated electrodes are projected into the tumor. Next, heat is generated locally by an alternating, high-frequency current that travels through the electrodes. The localized heat treats the tissue adjacent to the probe, resulting in a 3 cm to 5.5 cm sphere of dead tissue. The cells killed by RFA are not removed but are gradually replaced by fibrosis and scar tissue. If there is local recurrence, it occurs at the edge and can sometimes be retreated. RFA may be performed percutaneously, laparoscopically, or as an open procedure.



Background

Osteolytic Bone Metastases

After lung and liver, bone is the third most common site of metastases and is relatively common among patients with primary malignancies of the breast, prostate, and lung. Bone metastases often cause osteolysis (bone breakdown), resulting in pain, fractures, decreased mobility, and reduced quality of life.

Treatment

External-beam irradiation often is the initial palliative therapy for osteolytic bone metastases. However, pain from bone metastases is refractory to radiotherapy in 20% to 30% of patients, while recurrent pain at previously irradiated sites may be ineligible for additional radiation due to risks of normal tissue damage. Other alternatives include hormonal therapy, radiopharmaceuticals (eg, strontium 89), and bisphosphonates. Less often, surgery or chemotherapy may be used for palliation, and intractable pain may require opioid medications. Radiofrequency ablation (RFA) has been investigated as another alternative for palliation of bone metastases.

Osteoid Osteomas

Osteomas are the most common benign bone tumor, comprising 10% to 20% of benign and 2% to 3% of all bone tumors. They are typically seen in children and young adults, with most diagnosed in patients between 5 and 20 years of age. Osteomas are most common in the lower extremity (usually the long bones, mainly the femur) and less common in the spine. These tumors typically have a characteristic clinical presentation and radiologic appearance, with pain, usually continuous and worse at night, and usually relieved by aspirin or other nonsteroidal anti-inflammatory drugs. The natural history of the osteoid osteoma varies based on its location, and although they rarely exceed 1.5 cm in diameter, may produce bone widening and deformation, limb length inequality, or angular deviations when near a growth plate. When located in the spine, these lesions may lead to painful scoliosis or torticollis. Sometimes, they heal spontaneously after 3 to 7 years.



Treatment

Treatment options include medical management with NSAIDs, surgical excision (wide/en bloc excision or curetting), or the use of computed tomography–guided or magnetic resonance imaging (MRI)–guided minimally invasive procedures including core drill excision, laser photocoagulation, or RFA. For many years, complete surgical excision was the classic treatment of osteomas, usually performed in patients with pain despite medical management. However, a substantial incision may be necessary, with removal of a considerable amount of bone (especially in the neck of the femur). This increases the need for bone grafting plus internal fixation (which often necessitates a second procedure to remove the metal work). Other possible risks include avascular necrosis of the femoral head and postoperative pathologic fracture. In addition, surgical excision leads to a lengthier period of convalescence and postoperative immobilization. Anatomically inaccessible tumors may not be completely resectable and may recur. RFA of osteoid osteoma is done with a needle puncture, so no incision or sutures are needed; further, patients may immediately walk on the treated extremity and return to daily activities when the anesthetic effect wears off. The risk of recurrence with RFA of an osteoma is 5% to 10%, and recurrent tumors can be retreated with RFA. In general, RFA is not performed in many spinal osteomas because of possible thermal-related nerve damage.

Localized Renal Cell Carcinoma

Radical nephrectomy remains the principal treatment of renal cell carcinoma; however, partial nephrectomy or nephron-sparing surgery has been shown to be as effective as radical nephrectomy, with comparable long-term recurrence-free survival rates, in a select group of patients. Alternative therapy such as RFA is of interest in patients with small renal tumors when preservation of renal function is necessary (eg, in patients with marginal renal function, a solitary kidney, bilateral tumors) and in patients with comorbidities that would render them unfit for surgery. Another consideration would be in patients at high risk of developing additional renal cancers (eg, von Hippel-Lindau disease).

Primary Pulmonary and Nonpulmonary Tumors

Surgery is the current treatment of choice in patients with stage 1 primary non-small-cell lung cancer (NSCLC; stage 1 includes 1a [T1N0M0] and 1b [T2N0M0]). Approximately 20% of patients present with stage 1 disease, although this number is expected to increase as a result of screening programs, advances in imaging modalities, and widespread use of computed



tomography scans for other indications. Postsurgical recurrence rates of stage 1 NSCLC have been reported as between 20% and 30%, with most occurring at distant sites; locoregional recurrences occur in approximately 12%. Large differences in survival outcome are observed after surgery in stage 1 patients, with 5-year overall survival rates ranging from 77% for small T1 tumors to 35% for large T2 tumors. Untreated, stage 1 NSCLC has a 5-year overall survival rate range from 6% to 14%.

Patients with early-stage NSCLC who are not surgical candidates may be candidates for radiotherapy with curative intent. In 2 large retrospective radiotherapy series, patients with inoperable disease treated with definitive radiotherapy achieved 5-year survival rates of 10% and 27%. In both studies, patients with T1N0 tumors had better 5-year survival rates of 60% and 32%, respectively.

Stereotactic body radiotherapy has gained more widespread use as a treatment option because it is a high-precision mode of therapy that delivers very high doses of radiation. Two-year to 3-year local control rates of stage 1 NSCLC with stereotactic body radiotherapy have ranged from 80% to 95%. Stereotactic body radiotherapy has been investigated in patients unfit to undergo surgery, with survival rates similar to surgical outcomes.

RFA is also being investigated in patients with small primary lung cancers or lung metastases who are deemed medically inoperable.

Breast Tumors

The treatment of small cancers of the breast has evolved from total mastectomy to more conservative treatment options such as lumpectomy, with more acceptable cosmetic outcomes and preservation of the breast. The selection of surgical approach balances the patient's desire for breast conservation and the need for tumor-free margins in resected tissue. Minimally invasive nonsurgical techniques such as RFA are appealing if they can produce local control and survival equivalent to breast-conserving surgical alternatives. Nonsurgical ablative techniques pose difficulties such as the inability to determine tumor size, complete tumor cell death, and local recurrence. Additionally, RFA can burn the skin and do damage to muscle, possibly limiting use in patients with tumors near the skin or chest wall.



Thyroid Tumors

Surgical resection is the primary treatment choice for medically unresponsive, symptomatic benign thyroid tumors and thyroid carcinomas. However, techniques for ablation of thyroid tumors (eg, RFA, microwave ablation) are being investigated.

Miscellaneous Tumors

RFA has been investigated for use in individuals with a number of different lesions in different anatomic sites. These anatomic sites include, but are not limited to, the breast, head and neck.

Head and Neck Cancer

In patients with head and neck cancer with recurrent disease, surgical salvage attempts are poor in terms of local control, survival, and quality of life; further, these recurrent tumors are often untreatable with standard salvage therapies. Palliative chemotherapy or comfort measures may be offered. The safety and efficacy of RFA has been investigated as an option for palliative treatment in these situations.

Radiofrequency Ablation

RFA was initially developed to treat inoperable tumors of the liver. Recently, studies have reported on the use of RFA to treat other tumors. For some of these, RFA is being investigated as an alternative to surgery for operable tumors. Well-established local or systemic treatment alternatives are available for each of these malignancies. The hypothesized advantages of RFA for these cancers include improved local control and those benefits common to any minimally invasive procedure (eg, preserving normal organ tissue, decreasing morbidity, decreasing length of hospitalization).

Goals of RFA may include (1) controlling local tumor growth and preventing recurrence; (2) palliating symptoms; and (3) extending survival duration for patients with certain tumors. The effective volume of RFA depends on the frequency and duration of applied current, local tissue characteristics, and probe configuration (eg, single vs multiple tips). RFA can be performed as an open surgical procedure, laparoscopically or percutaneously, with ultrasound or computed tomography guidance.



Potential complications associated with RFA include those caused by heat damage to normal tissue adjacent to the tumor (eg, intestinal damage during RFA of kidney), structural damage along the probe track (eg, pneumothorax as a consequence of procedures on the lung), and secondary tumors (if cells seed during probe removal).

Summary of Evidence

Bone Tumors

For individuals with painful osteolytic bone metastases who have failed or are poor candidates for standard treatments who receive RFA, the evidence includes case series. Relevant outcomes are symptoms, change in disease status, quality of life, medication use, and treatment-related morbidity. Case series have shown clinically significant pain relief and reduction in opioid use following treatment of painful osteolytic metastases. The population is comprised of patients with few to no treatment options, for whom short-term pain relief is an appropriate clinical outcome. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with painful osteoid osteomas who receive RFA, the evidence includes numerous observational studies and a systematic review of these studies. Relevant outcomes are symptoms, change in disease status, quality of life, medication use, and treatment-related morbidity. In a systematic review of thermal ablation techniques, clinical success (pain free) was achieved in 94% to 98% of patients. Most patients (89%-96%) remained pain free when assessed during longer term follow-up. Although no randomized trials of RFA for osteoid osteomas have been performed, the uncontrolled studies have demonstrated RFA can provide adequate symptom relief with minimal complications, for a population for whom short-term symptom relief and avoidance of invasive procedures are appropriate clinical outcomes. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

Localized Renal Cell Carcinoma

For individuals with localized renal cell carcinoma that is no more than 4 cm in size who receive RFA, the evidence includes a randomized controlled trial (RCT), numerous observational studies, and systematic reviews of these studies. Relevant outcomes are overall survival, change in disease status, quality of life, and treatment-related morbidity. A recent meta-analysis that



included only an RCT and cohort studies found that RFA was as effective as nephrectomy for small renal tumors, with a reduction in complications. Another recent meta-analysis, which included case series of stage 1 (≤ 7 cm across) renal tumors, found that the rate of local progression was greater with RFA than with nephrectomy. The differing meta-analytic results may be due to differences in tumor size in selected studies as well as potential selection bias when evaluating case series. Although inconsistent, the evidence does suggest that for small renal tumors, RFA may result in a similar rate of disease progression with a lower complication rate than nephrectomy. However, comparative trials are needed to determine with greater certainty the effects of these treatments in the same patient population. The evidence is insufficient to determine the effects of the technology on health outcomes.

Inoperable Primary Pulmonary Tumors and Nonpulmonary Metastases

For individuals with inoperable primary pulmonary tumors or nonpulmonary tumors metastatic to the lung who receive RFA, the evidence includes observational studies and systematic reviews of these studies. Relevant outcomes are overall survival, change in disease status, quality of life, and treatment-related morbidity. A multicenter study found that, for tumors less than 3.5 cm, RFA can lead to a complete response in as many as 88% of patients for at least 1 year. Two-year survival rates have been reported to range from 41% to 75% in case series, with 5-year survival rates of 20% to 27%. In general, the evidence suggests that RFA results in adequate survival and tumor control in patients who are not surgical candidates, with low morbidity rates. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Breast Tumors

For individuals with breast tumors who receive RFA, the evidence includes observational studies and systematic reviews of these studies. Relevant outcomes are overall survival, change in disease status, quality of life, and treatment-related morbidity. Evidence has reported varied and incomplete ablation rates with concerns about postablation tumor cell viability. Long-term improvements in health outcomes have not been demonstrated. Additionally, available studies do not permit comparisons with conventional breast-conserving procedures. Further studies, with long-term follow-up, should focus on whether RFA of the breast for small tumors can provide local control and survival rates comparable with conventional breast-conserving treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.



Benign Thyroid Tumors

For individuals with benign thyroid tumors who receive RFA, the evidence includes RCTs, prospective studies, case series, and systematic reviews of these studies. Relevant outcomes are symptoms, change in disease status, quality of life, medication use, and treatment-related morbidity. A systematic review that included 4 RCTs and 5 observational studies found significant reductions in nodule size and withdrawal from methimazole following treatment with RFA when compared to a variety of other local treatments. Reports of complications vary. The most frequent major complication from a large multicenter series of specialty centers was voice change. The evidence is insufficient to determine the effects of the technology on health outcomes.

Miscellaneous Solid Tumors

For individuals with miscellaneous tumors (eg, head and neck, thyroid cancer, pancreas) who receive RFA, the evidence includes a few case series and retrospective comparative studies. Relevant outcomes are overall survival, change in disease status, quality of life, and treatment-related morbidity. There is a limited evidence base for these tumor types. Reporting on outcomes or comparisons with other treatments is limited. These studies do not permit conclusions on the health benefits of RFA. The evidence is insufficient to determine the impact of the technology on health outcomes.

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

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT01051037	Phase II Study Evaluating Safety and Efficacy of Stereotactic Body Radiotherapy and Radiofrequency	17	Dec 2017 (ongoing)



NCT No.	Trial Name	Planned Enrollment	Completion Date
	Ablation for Medically Inoperable and Recurrent Lung Tumors Near Central Airways		
Unpublished			
NCT00776399	Radiofrequency Ablation in Resectable Colorectal Lung Metastasis: A Phase-II Clinical Trial	70	Aug 2018 (completed)

NCT: national clinical trial.

Clinical Input Received 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.

2010 Input

In response to requests, input was received from 2 physician specialty societies (4 reviewers) and 2 academic medical centers (4 reviewers) while this policy was under review in 2010. The input was similar to that in 2009, except support for use of radiofrequency ablation (RFA) to treat lung tumors was declined (only 1 respondent indicated this was an option in tumors metastatic to lung). One respondent also indicated a potential use for adrenal tumors. Input supported RFA for localized renal cell carcinoma no more than 4 cm in size when preservation of kidney function is necessary, and a standard surgical approach could substantially worsen kidney function or when the patient is not considered a surgical candidate.

2009 Input

In response to requests, input was received from 1 physician specialty society (4 reviews) and from 2 academic medical centers (3 reviews) while this policy was under review in 2009. All reviewers supported the use of RFA in the treatment of painful bone metastases that have failed standard treatment and in the treatment of osteoid osteomas. Reviewers were divided over the



use of RFA for lung tumors, although several agreed that, while it may be useful in a select population of patients, it should be used in the clinical trial setting. Reviewers were also split with regard to RFA in the treatment of renal tumors, with some supporting its use in a select population of patients. With the exception of 1 disagreement and 1 nonresponse, the reviewers agreed to the investigational statement on the use of RFA in all other tumors outside the liver that are addressed in this policy.

Practice Guidelines and Position Statements

American College of Chest Physicians

The American College of Chest Physicians guidelines (2013) on the treatment of stage I and II non-small-cell lung cancer (NSCLC) have indicated radiofrequency ablation (RFA) has been used effectively in clinical stage I NSCLC.⁶³ Therefore, in medically inoperable patients, peripheral NSCLC tumors less than 3 cm may be treated with RFA. The College also collaborated with the Society of Thoracic Surgeons to develop consensus guidelines on the treatment of high-risk patients with stage I NSCLC.⁶⁴ These 2012 consensus guidelines indicated RFA is an alternative treatment option in patients who are not surgical candidates due to severe medical comorbidity.

National Comprehensive Cancer Network

National Comprehensive Cancer Network (NCCN) practice guidelines for the treatment of NSCLC (v.6.2018) state, "Resection is the preferred local treatment modality (other modalities include radiofrequency ablation, cryotherapy and SABR [stereotactic ablative radiotherapy])."⁶⁵

NCCN guidelines for thyroid carcinoma (v.2018) indicate that local therapies such as RFA may be considered for locoregional recurrence of thyroid carcinoma-papillary carcinoma.⁶⁶

NCCN guidelines (v.2018) for renal cancer indicate that ablative techniques such as RFA "can be considered for selected patients with clinical stage T1 renal disease."⁶⁷ The guidelines note that ablative techniques are associated with higher rates of local recurrence than traditional surgery.

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) guidance (2004) on osteoid osteoma has indicated that "current evidence on the safety and efficacy of computed



tomography (CT)-guided thermocoagulation of osteoid osteoma appears adequate to support its use...⁶⁸

Updated NICE guidance (2010) on renal cancer has indicated that “evidence on the safety and efficacy of percutaneous radiofrequency ablation (RFA) ... in the short and medium term appears adequate to support the use of this procedure provided that patients are followed up in the long term.”⁶⁹

NICE guidance (2010) on RFA for primary and secondary lung cancers has stated: “[C]urrent evidence on the efficacy of percutaneous radiofrequency ablation (RFA) ... is adequate in terms of tumor control.”⁷⁰ NICE also indicated RFA might “be used in patients with small, early-stage lung cancers or small numbers of lung metastases who are unsuitable for, or prefer not to undergo, surgery. It may also have a place in multi-modality treatment of more advanced primary lung cancers.” The guidance warned of serious complications (eg, pneumothorax) among lung cancer patients.

NICE guidance (2016) on benign thyroid nodules stated, “Current evidence on the safety and efficacy of ultrasound-guided percutaneous radiofrequency ablation ... is adequate to support the use of this procedure....”⁷¹

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

The U.S. Food and Drug Administration (FDA) issued a statement in September 2008 concerning the regulatory status of RFA. FDA has cleared RFA devices for the general indication of soft tissue cutting, coagulation, and ablation by thermal coagulation necrosis. Under this general indication, RFA can be used to ablate tumors, including lung tumors. Some RFA devices have been cleared for additional specific treatment indications, including partial or complete ablation of nonresectable liver lesions and palliation of pain associated with metastatic lesions involving bone. FDA has not cleared any RFA devices for the specific treatment indication of partial or complete ablation of lung tumors, citing lack of sufficient clinical data to establish safety and effectiveness for this purpose. FDA has received reports of death and serious injuries associated with the use of RFA devices in the treatment of lung tumors.



References

1. Goetz MP, Callstrom MR, Charboneau JW, et al. Percutaneous image-guided radiofrequency ablation of painful metastases involving bone: a multicenter study. *J Clin Oncol*. Jan 15 2004;22(2):300-306. PMID 14722039
2. Gronemeyer DH, Schirp S, Gevargez A. Image-guided radiofrequency ablation of spinal tumors: preliminary experience with an expandable array electrode. *Cancer J*. Jan-Feb 2002;8(1):33-39. PMID 11898806
3. Kojima H, Tanigawa N, Kariya S, et al. Clinical assessment of percutaneous radiofrequency ablation for painful metastatic bone tumors. *Cardiovasc Intervent Radiol*. Nov-Dec 2006;29(6):1022-1026. PMID 16988875
4. Lanza E, Thouvenin Y, Viala P, et al. Osteoid osteoma treated by percutaneous thermal ablation: when do we fail? A systematic review and guidelines for future reporting. *Cardiovasc Intervent Radiol*. Dec 2014;37(6):1530-1539. PMID 24337349
5. Albisinni U, Facchini G, Spinnato P, et al. Spinal osteoid osteoma: efficacy and safety of radiofrequency ablation. *Skeletal Radiol*. Aug 2017;46(8):1087-1094. PMID 28497160
6. Lassalle L, Campagna R, Corcos G, et al. Therapeutic outcome of CT-guided radiofrequency ablation in patients with osteoid osteoma. *Skeletal Radiol*. Jul 2017;46(7):949-956. PMID 28429047
7. Rimondi E, Mavrogenis AF, Rossi G, et al. Radiofrequency ablation for non-spinal osteoid osteomas in 557 patients. *Eur Radiol*. Jan 2012;22(1):181-188. PMID 21842430
8. Knudsen M, Riishede A, Lucke A, et al. Computed tomography-guided radiofrequency ablation is a safe and effective treatment of osteoid osteoma located outside the spine. *Dan Med J*. May 2015;62(5). PMID 26050823
9. Rosenthal DI, Hornicek FJ, Torriani M, et al. Osteoid osteoma: percutaneous treatment with radiofrequency energy. *Radiology*. Oct 2003;229(1):171-175. PMID 12944597
10. Katsanos K, Mailli L, Krokidis M, et al. Systematic review and meta-analysis of thermal ablation versus surgical nephrectomy for small renal tumours. *Cardiovasc Intervent Radiol*. Apr 2014;37(2):427-437. PMID 24482030
11. Wang S, Qin C, Peng Z, et al. Radiofrequency ablation versus partial nephrectomy for the treatment of clinical stage 1 renal masses: a systematic review and meta-analysis. *Chin Med J (Engl)*. Jul 2014;127(13):2497-2503. PMID 24985591
12. El Dib R, Touma NJ, Kapoor A. Cryoablation vs radiofrequency ablation for the treatment of renal cell carcinoma: a meta-analysis of case series studies. *BJU Int*. Aug 2012;110(4):510-516. PMID 22304329
13. Kunkle DA, Uzzo RG. Cryoablation or radiofrequency ablation of the small renal mass: a meta-analysis. *Cancer*. Nov 15 2008;113(10):2671-2680. PMID 18816624
14. Liu SY, Chu CM, Kong AP, et al. Radiofrequency ablation compared with laparoscopic adrenalectomy for aldosterone-producing adenoma. *Br J Surg*. Oct 2016;103(11):1476-1486. PMID 27511444
15. Park BK, Gong IH, Kang MY, et al. RFA versus robotic partial nephrectomy for T1a renal cell carcinoma: a propensity score-matched comparison of mid-term outcome. *Eur Radiol*. Jul 2018;28(7):2979-2985. PMID 29426988
16. Dai Y, Covarrubias D, Uppot R, et al. Image-guided percutaneous radiofrequency ablation of central renal cell carcinoma: assessment of clinical efficacy and safety in 31 tumors. *J Vasc Interv Radiol*. Dec 2017;28(12):1643-1650. PMID 28673657
17. Dvorak P, Hoffmann P, Brodak M, et al. Percutaneous radiofrequency and microwave ablation in the treatment of renal tumors - 10 years of experience. *Wideochir Inne Tech Maloinwazyjne*. Dec 2017;12(4):394-402. PMID 29362655
18. Pantelidou M, Challacombe B, McGrath A, et al. Percutaneous radiofrequency ablation versus robotic-assisted partial nephrectomy for the treatment of small renal cell carcinoma. *Cardiovasc Intervent Radiol*. Nov 2016;39(11):1595-1603. PMID 27435582



19. Iannuccilli JD, Dupuy DE, Beland MD, et al. Effectiveness and safety of computed tomography-guided radiofrequency ablation of renal cancer: a 14-year single institution experience in 203 patients. *Eur Radiol.* Jun 2016;26(6):1656-1664. PMID 26373755
20. Stern JM, Svatek R, Park S, et al. Intermediate comparison of partial nephrectomy and radiofrequency ablation for clinical T1a renal tumours. *BJU Int.* Aug 2007;100(2):287-290. PMID 17617136
21. Schlijper RC, Grutters JP, Houben R, et al. What to choose as radical local treatment for lung metastases from colo-rectal cancer: surgery or radiofrequency ablation? *Cancer Treat Rev.* Feb 2014;40(1):60-67. PMID 23768754
22. Ratko TA, Vats V, Brock J, et al. Local Nonsurgical Therapies for Stage I and Symptomatic Obstructive Non-Small-Cell Lung Cancer (Comparative Effectiveness Review No. 112). Rockville, MD: Agency for Healthcare Research and Quality; 2013.
23. Bilal H, Mahmood S, Rajashanker B, et al. Is radiofrequency ablation more effective than stereotactic ablative radiotherapy in patients with early stage medically inoperable non-small cell lung cancer? *Interact Cardiovasc Thorac Surg.* Aug 2012;15(2):258-265. PMID 22581864
24. Chan VO, McDermott S, Malone DE, et al. Percutaneous radiofrequency ablation of lung tumors: evaluation of the literature using evidence-based techniques. *J Thorac Imaging.* Feb 2011;26(1):18-26. PMID 20829720
25. Huang L, Han Y, Zhao J, et al. Is radiofrequency thermal ablation a safe and effective procedure in the treatment of pulmonary malignancies? *Eur J Cardiothorac Surg.* Mar 2011;39(3):348-351. PMID 20663679
26. Zemlyak A, Moore WH, Bilfinger TV. Comparison of survival after sublobar resections and ablative therapies for stage I non-small cell lung cancer. *J Am Coll Surg.* Jul 2010;211(1):68-72. PMID 20610251
27. Lencioni R, Crocetti L, Cioni R, et al. Response to radiofrequency ablation of pulmonary tumours: a prospective, intention-to-treat, multicentre clinical trial (the RAPTURE study). *Lancet Oncol.* Jul 2008;9(7):621-628. PMID 18565793
28. Zhu JC, Yan TD, Glenn D, et al. Radiofrequency ablation of lung tumors: feasibility and safety. *Ann Thorac Surg.* Apr 2009;87(4):1023-1028. PMID 19324122
29. Pennathur A, Abbas G, Gooding WE, et al. Image-guided radiofrequency ablation of lung neoplasm in 100 consecutive patients by a thoracic surgical service. *Ann Thorac Surg.* Nov 2009;88(5):1601-1606; discussion 1607-1608. PMID 19853119
30. Peek MC, Ahmed M, Napoli A, et al. Minimally invasive ablative techniques in the treatment of breast cancer: a systematic review and meta-analysis. *Int J Hyperthermia.* Oct 2 2016;33(2):1-12. PMID 27575566
31. Zhao Z, Wu F. Minimally-invasive thermal ablation of early-stage breast cancer: a systemic review. *Eur J Surg Oncol.* Dec 2010;36(12):1149-1155. PMID 20889281
32. Soukup B, Bismohun S, Reefy S, et al. The evolving role of radiofrequency ablation therapy of breast lesions. *Anticancer Res.* Sep 2010;30(9):3693-3697. PMID 20944155
33. Ito T, Oura S, Nagamine S, et al. Radiofrequency ablation of breast cancer: a retrospective study. *Clin Breast Cancer.* Aug 2018;18(4):e495-e500. PMID 29079443
34. Li P, Xiao-Yin T, Cui D, et al. Evaluation of the safety and efficacy of percutaneous radiofrequency ablation for treating multiple breast fibroadenoma. *J Cancer Res Ther.* Dec 2016;12(Supplement):C138-C142. PMID 28230006
35. Wilson M, Korourian S, Boneti C, et al. Long-term results of excision followed by radiofrequency ablation as the sole means of local therapy for breast cancer. *Ann Surg Oncol.* Oct 2012;19(10):3192-3198. PMID 22911363
36. Kinoshita T, Iwamoto E, Tsuda H, et al. Radiofrequency ablation as local therapy for early breast carcinomas. *Breast Cancer.* Jan 2011;18(1):10-17. PMID 20072824
37. Imoto S, Wada N, Sakemura N, et al. Feasibility study on radiofrequency ablation followed by partial mastectomy for stage I breast cancer patients. *Breast.* Apr 2009;18(2):130-134. PMID 19324550
38. Garbay JR, Mathieu MC, Lamuraglia M, et al. Radiofrequency thermal ablation of breast cancer local recurrence: a phase II clinical trial. *Ann Surg Oncol.* Nov 2008;15(11):3222-3226. PMID 18709415
39. Chen F, Tian G, Kong D, et al. Radiofrequency ablation for treatment of benign thyroid nodules: A PRISMA-compliant systematic review and meta-analysis of outcomes. *Medicine (Baltimore).* Aug 2016;95(34):e4659. PMID 27559968



40. Fuller CW, Nguyen SA, Lohia S, et al. Radiofrequency ablation for treatment of benign thyroid nodules: systematic review. *Laryngoscope*. Jan 2014;124(1):346-353. PMID 24122763
41. Jung SL, Baek JH, Lee JH, et al. Efficacy and safety of radiofrequency ablation for benign thyroid nodules: a prospective multicenter study. *Korean J Radiol*. Jan-Feb 2018;19(1):167-174. PMID 29354014
42. Lim HK, Lee JH, Ha EJ, et al. Radiofrequency ablation of benign non-functioning thyroid nodules: 4-year follow-up results for 111 patients. *Eur Radiol*. Apr 2013;23(4):1044-1049. PMID 23096937
43. Baek JH, Lee JH, Sung JY, et al. Complications encountered in the treatment of benign thyroid nodules with US-guided radiofrequency ablation: a multicenter study. *Radiology*. Jan 2012;262(1):335-342. PMID 21998044
44. Spiezia S, Garberoglio R, Milone F, et al. Thyroid nodules and related symptoms are stably controlled two years after radiofrequency thermal ablation. *Thyroid*. Mar 2009;19(3):219-225. PMID 19265492
45. Kim JH, Yoo WS, Park YJ, et al. Efficacy and safety of radiofrequency ablation for treatment of locally recurrent thyroid cancers smaller than 2 cm. *Radiology*. Sep 2015;276(3):909-918. PMID 25848897
46. Owen RP, Khan SA, Negassa A, et al. Radiofrequency ablation of advanced head and neck cancer. *Arch Otolaryngol Head Neck Surg*. May 2011;137(5):493-498. PMID 21576561
47. Brook AL, Gold MM, Miller TS, et al. CT-guided radiofrequency ablation in the palliative treatment of recurrent advanced head and neck malignancies. *J Vasc Interv Radiol*. May 2008;19(5):725-735. PMID 18440462
48. Owen RP, Silver CE, Ravikumar TS, et al. Techniques for radiofrequency ablation of head and neck tumors. *Arch Otolaryngol Head Neck Surg*. Jan 2004;130(1):52-56. PMID 14732768
49. Yang MH, Tyan YS, Huang YH, et al. Comparison of radiofrequency ablation versus laparoscopic adrenalectomy for benign aldosterone-producing adenoma. *Radiol Med*. Oct 2016;121(10):811-819. PMID 27300650
50. Yin G, Chen M, Yang S, et al. Treatment of uterine myomas by radiofrequency thermal ablation: a 10-year retrospective cohort study. *Reprod Sci*. May 2015;22(5):609-614. PMID 25355802
51. Mayo-Smith WW, Dupuy DE. Adrenal neoplasms: CT-guided radiofrequency ablation--preliminary results. *Radiology*. Apr 2004;231(1):225-230. PMID 14990812
52. Locklin JK, Mannes A, Berger A, et al. Palliation of soft tissue cancer pain with radiofrequency ablation. *J Support Oncol*. Sep-Oct 2004;2(5):439-445. PMID 15524075
53. Rosenthal DI. Radiofrequency treatment. *Orthop Clin North Am*. Jul 2006;37(3):475-484, viii. PMID 16846772
54. Liapi E, Geschwind JF. Transcatheter and ablative therapeutic approaches for solid malignancies. *J Clin Oncol*. Mar 10 2007;25(8):978-986. PMID 17350947
55. Spiliotis JD, Datsis AC, Michalopoulos NV, et al. Radiofrequency ablation combined with palliative surgery may prolong survival of patients with advanced cancer of the pancreas. *Langenbecks Arch Surg*. Jan 2007;392(1):55-60. PMID 17089173
56. Zou YP, Li WM, Zheng F, et al. Intraoperative radiofrequency ablation combined with 125 iodine seed implantation for unresectable pancreatic cancer. *World J Gastroenterol*. Oct 28 2010;16(40):5104-5110. PMID 20976848
57. Cantore M, Girelli R, Mambrini A, et al. Combined modality treatment for patients with locally advanced pancreatic adenocarcinoma. *Br J Surg*. Aug 2012;99(8):1083-1088. PMID 22648697
58. Rombouts SJ, Vogel JA, van Santvoort HC, et al. Systematic review of innovative ablative therapies for the treatment of locally advanced pancreatic cancer. *Br J Surg*. Feb 2015;102(3):182-193. PMID 25524417
59. Kameyama S, Murakami H, Masuda H, et al. Minimally invasive magnetic resonance imaging-guided stereotactic radiofrequency thermocoagulation for epileptogenic hypothalamic hamartomas. *Neurosurgery*. Sep 2009;65(3):438-449; discussion 449. PMID 19687687
60. Vavra P, Dostalík J, Zacharoulis D, et al. Endoscopic radiofrequency ablation in colorectal cancer: initial clinical results of a new bipolar radiofrequency ablation device. *Dis Colon Rectum*. Feb 2009;52(2):355-358. PMID 19279436



61. Mylona S, Karagiannis G, Patsoura S, et al. Palliative treatment of rectal carcinoma recurrence using radiofrequency ablation. *Cardiovasc Intervent Radiol*. Aug 2012;35(4):875-882. PMID 22167304
62. Ripley RT, Gajdos C, Reppert AE, et al. Sequential radiofrequency ablation and surgical debulking for unresectable colorectal carcinoma: thermo-surgical ablation. *J Surg Oncol*. Feb 2013;107(2):144-147. PMID 22927225
63. Howington JA, Blum MG, Chang AC, et al. Treatment of stage I and II non-small cell lung cancer: Diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians evidence-based clinical practice guidelines. *Chest*. May 2013;143(5 Suppl):e278S-313S. PMID 23649443
64. Donington J, Ferguson M, Mazzone P, et al. American College of Chest Physicians and Society of Thoracic Surgeons consensus statement for evaluation and management for high-risk patients with stage I non-small cell lung cancer. *Chest*. Dec 2012;142(6):1620-1635. PMID 23208335
65. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Non-small cell lung cancer. Version 6.2018. https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed November 2018.
66. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Thyroid Carcinoma. Version 1.2018. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed November 2018.
67. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Kidney Cancer. Version 4.2018. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed November 2018.
68. National Institute for Health and Care Excellence (NICE). Computed tomography-guided thermocoagulation of osteoid osteoma [IPG53]. 2004; <https://www.nice.org.uk/guidance/ipg53>. Accessed November 2018.
69. National Institute for Health and Care Excellence (NICE). Percutaneous radiofrequency ablation of renal cancer [IPG353]. 2010; <https://www.nice.org.uk/guidance/ipg353>. Accessed November 2018.
70. National Institute for Health and Care Excellence (NICE). Percutaneous radiofrequency ablation for primary and secondary lung cancers [IPG372]. 2010; <https://www.nice.org.uk/guidance/ipg372>. Accessed November 2018.
71. National Institute for Health and Care Excellence (NICE). Ultrasound-guided percutaneous radiofrequency ablation for benign thyroid nodules [IPG562]. 2016; <https://www.nice.org.uk/guidance/IPG562/chapter/1-Recommendations>. Accessed November 2018.

History

Date	Comments
12/11/12	New policy. This policy replaces 7.01.540. Policy updated with literature review, reworded investigational policy statement and added thyroid as investigational. References 12, 19, 29, 42, 50-53, 59, 62-63 added. Other references deleted.
07/16/13	Update Related Policies. Add 8.01.528.
12/09/13	Replace policy. Note added to Policy stating "Radiofrequency ablation of liver tumors is not subject to medical review". Related policies 8.01.521, 8.01.505 added. Policy Guidelines reformatted for usability with coding more clearly detailed. Rationale updated with literature review through August 2013. References 24-25, 38-39, 52 added; others renumbered/removed. Policy statements unchanged, note added for clarification. CPT codes 47380 and 47382 removed from policy; these procedures are



Date	Comments
	not addressed in this policy.
03/11/14	Coding Update. Codes 55.32, 55.34 and 55.35 were removed per ICD-10 mapping project; these codes are not utilized for adjudication of policy.
09/03/14	Interim review. Revised note in policy stating: Radiofrequency ablation of liver tumors is not addressed in this policy and does require medical review. ICD-9 and ICD-10 diagnosis and procedure codes removed; these are not utilized in adjudication of the policy.
12/17/14	Annual Review. Policy updated with literature review through September 18, 2014; policy statements unchanged. References 13, 18-19 and 47 added.
11/10/15	Annual Review. Policy updated with literature review through July 28, 2015; references 4, 48, and 56 added; other references deleted. Policy statements unchanged.
11/01/16	Annual Review, approved October 11, 2016. Policy updated with literature review through July 26, 2016; references 13 and 34 added; references 54-56 updated; some references removed. Policy statements unchanged.
11/24/16	Updated Related Policies, removed 8.01.528 as it was archived.
11/01/17	Annual Review, approved October 19, 2017. Policy updated with literature review through July 20, 2017; reference 59 added. Policy statements unchanged.
12/01/18	Annual Review, approved November 6, 2018. Policy updated with literature review through July 2018; references 5-7, 15-19, 31, 34-35, 40, 42, and 50 added. Policy statements unchanged.

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.



Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

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 425-918-5592, 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 <http://www.hhs.gov/ocr/office/file/index.html>.

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).

አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀናት ሊኖሩ ይችላሉ። የጤና ሽፋንዎን ለመጠበቅና በአስፈላጊ እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና የለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መሰታወቅ አለዎት። በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):

يحتوي هذا الإشعار على معلومات هامة. قد يحتوي هذا الإشعار على معلومات مهمة بخصوص طلبك أو التخطيط التي تزيد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تاريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ 800-722-1471 (TTY: 800-842-5357)

中文 (Chinese):

本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Oromoo (Cushite):

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisni kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):

Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):

Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resewva enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong):

Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam hnuv ntawm Premera Blue Cross. Tej zaum muaj cov hnuv tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas pab kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano):

Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenna coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyto wenna tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):

Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese):

この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):

ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມຄົມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີ່ສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈໍາເປັນຕ້ອງດໍາເນີນການຕາມກຳນົດ ເວລາສະເພາະເພື່ອຮັກສາຄວາມຄົມຄອງປະກັນສະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເວັ້ນເວົ້ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໃບທາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរៀបចំរបស់អ្នកកាមរយ: Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជាក់សមត្ថភាព ដល់កំណត់ថ្លៃជាតំបន់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងអន្តរជាតិរបស់អ្នក ឬប្រាក់ដុល្លារចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងដុល្លារនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):

ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਟਿਸ ਨਵ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਰਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਕੱਠ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਢੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੋਂ ਅਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):

این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کلیربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):

To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):

Prezenta notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența provizorie la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):

Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):

Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganiitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับกาการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страховального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).