Laser Interstitial Thermal Therapy (LITT)

Policy Number: PG0206
Last Review: 03/25/2016

GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

SCOPE
X Professional
   Facility

DESCRIPTION
Laser interstitial thermal therapy (LITT) is a minimally invasive cytoreductive treatment. A low voltage laser is used to induce hyperthermia and to kill tumor cells. The extent of thermal damage is controlled through use of real-time MR-thermography guidance. LITT can be considered as an alternative type of surgery for difficult to access brain tumors and also for tumors in patients who are deemed high risk for more traditional surgery. There are numerous devices used for this procedure such as the NeuroBlate® System by Monteris® Medical, Inc.

LITT has also been investigated as a potential means of treating breast tumors since there is minimal disruption to adjacent soft tissues. The purpose of this approach is to facilitate improved cosmesis and to offer treatment to women who are unfit for surgery. LITT may be a promising minimally invasive technique for many types of tumors/malignancies, however, there is insufficient evidence of its clinical effectiveness.

POLICY
Laser interstitial thermal therapy (LITT) (64999) does not warrant separate reimbursement.

COVERAGE CRITERIA
HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage
Paramount does not provide additional or separate reimbursement for LITT.

Paramount does not provide additional reimbursement based upon the type of instruments, technique or approach used in a procedure. Such matters are left to the discretion of the surgeon. Additional professional or technical reimbursement will not be made when a surgical procedure is performed using LITT.

Reimbursement for procedures in which LITT is used will be based on the contracted rate or usual and customary fee or maximum reimbursable charge for the base procedure. Separate reimbursement is not allowed for LITT. Reimbursement for the base procedure may be subject to medical necessity review.

Use of the 22 Modifier (increased procedural services) would not be appropriate if the sole purpose is to report and bill for the use of LITT. Modifier 22 should only be used to report unusual complications or complexities which occurred during the surgical procedure that are unrelated to the use of LITT and must be supported by documentation.
CODING/BILLING INFORMATION
The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

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REVISION HISTORY EXPLANATION
ORIGINAL EFFECTIVE DATE: 10/24/2014
10/24/14: Policy created to reflect most current clinical evidence per TAWG.
03/19/15: CPT code 61781 removed from policy. Policy reviewed and updated to reflect the most current clinical evidence per TAWG.
03/25/16: LITT (64999) does not warrant separate reimbursement. Policy reviewed and updated to reflect the most current clinical evidence per TAWG.
12/16/2020: Medical policy placed on the new Paramount Medical Policy Format

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
Industry Standard Review
Hayes, Inc.