



Cryoablation for Treatment of Malignant and/or Benign Breast Tumors

Origination: 4/12/18	Revised: 7/24/20	Annual Review: 11/05/20
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Purpose:

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to Cryoablation for the treatment of malignant and benign breast tumors in order to determine inclusion in the benefit plan.

Recommendation:

A recommendation was made by the MTAC following discussion by committee members based on current literature:

- Cryoablation is **not** covered for malignant breast tumors.
- Cryoablation is covered for benign breast tumors.

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.