

MEDICAL POLICY

POLICY TITLE	MICROWAVE TUMOR ABLATION
POLICY NUMBER	MP 2.090
CLINICAL BENEFIT	<input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN. <input type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. <input type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE. <input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. <input checked="" type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. <input type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	2/1/2026

POLICY

Microwave ablation of primary or metastatic hepatic tumors may be considered **medically necessary** under the following conditions:

- The tumor is unresectable due to location of lesion[s] and/or comorbid conditions
- A single tumor of ≤5 cm or up to 3 nodules ≤3 cm each

Microwave ablation of primary or metastatic lung tumors may be considered **medically necessary** under the following conditions:

- The tumor is unresectable due to location of lesion and/or comorbid conditions
- A single tumor of ≤3 cm

Microwave ablation of more than a single primary or metastatic tumor in the lung is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with these procedures.

Microwave ablation of primary or metastatic tumors other than liver or lung is considered **investigational**. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with these procedures.

Cross-reference:

MP 1.121 Cryosurgical Ablation of Primary or Metastatic Liver Tumors
MP 1.055 Radiofrequency Ablation of Primary or Metastatic Liver Tumors
MP 1.084 Radiofrequency Ablation of Miscellaneous Solid Tumors
Excluding Liver Tumors

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital BlueCross and subject to benefit variations. Please see additional information below.

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FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:

<https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies>.

DESCRIPTION/BACKGROUND

Microwave ablation (MWA) is a technique to destroy tumors and soft tissue by using microwave energy to create thermal coagulation and localized tissue necrosis. Microwave ablation is used to treat tumors not amenable to resection or to treat individuals ineligible for surgery due to age, comorbidities, or poor general health. Microwave ablation may be performed as an open procedure, laparoscopically, percutaneously, or thoracoscopically under image guidance (e.g., ultrasound, computed tomography or magnetic resonance imaging) with sedation, or local or general anesthesia. This technique may also be referred to as microwave coagulation therapy.

MICROWAVE ABLATION

Microwave ablation (MWA) uses microwave energy to induce an ultra-high speed, 915 MHz or 2450 MHz (2.45GHz), alternating electric field, which causes water molecule rotation and creates heat. This results in thermal coagulation and localized tissue necrosis. In MWA, a single microwave antenna or multiple antennas connected to a generator are inserted directly into the tumor or tissue to be ablated; energy from the antennas generates friction and heat. The local heat coagulates the tissue adjacent to the probe, resulting in a small, 2 to 3 cm elliptical area of tissue ablation. In tumors greater than 2 cm in diameter, 2 to 3 antennas may be used simultaneously to increase the targeted area of MWA and shorten operative time. Multiple antennas may also be used simultaneously to ablate multiple tumors. Tissue ablation occurs quickly, within 1 minute after a pulse of energy, and multiple pulses may be delivered within a treatment session depending on tumor size. The cells killed by MWA are typically not removed but are gradually replaced by fibrosis and scar tissue. If there is local recurrence, it occurs at the margins. Treatment may be repeated as needed. Microwave ablation may be used for the following purposes: 1) to control local tumor growth and prevent recurrence; 2) to palliate symptoms; and 3) to prolong survival.

Microwave ablation is similar to radiofrequency (RFA) and cryosurgical ablation. However, MWA has potential advantages over RFA and cryosurgical ablation. In MWA, the heating process is active, which produces higher temperatures than the passive heating of RFA and should allow for more complete thermal ablation in less time. The higher temperatures reached with MWA (>100°C) can overcome the “heat sink” effect in which tissue cooling occurs from nearby blood flow in large vessels, potentially resulting in incomplete tumor ablation. Microwave ablation does not rely on the conduction of electricity for heating and, therefore, does not flow electrical current through patients and does not require grounding pads, because there is no risk of skin burns. Additionally, MWA does not produce electric noise, which allows ultrasound guidance during the procedure without interference, unlike RFA. Finally, MWA can take 20% to 30% less time than RFA, because multiple antennas can be used simultaneously for multiple ablations.

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There is no comparable RFA system with the capacity to drive multiple electrically dependent electrodes.

Adverse Events

Complications from MWA may include pain and fever. Other complications associated with MWA include those caused by heat damage to normal tissue adjacent to the tumor (e.g., intestinal damage during MWA of the kidney or liver), structural damage along the probe track (e.g., pneumothorax as a consequence of procedures on the lung), liver enzyme elevation, liver abscess, ascites, pleural effusion, diaphragm injury or secondary tumors if cells seed during probe removal. Microwave ablation should be avoided in pregnant patients since potential risks to the patient and/or fetus have not been established, and in patients with implanted electronic devices (e.g., implantable pacemakers) that may be adversely affected by microwave power output.

Applications

Microwave ablation was first used percutaneously in 1986 as an adjunct to liver biopsy. Since then, MWA has been used to ablate tumors and tissue to treat many conditions including hepatocellular carcinoma, breast cancer, colorectal cancer metastatic to the liver, renal cell carcinoma, renal hamartoma, adrenal malignant carcinoma, non-small-cell lung cancer, intrahepatic primary cholangiocarcinoma, secondary splenomegaly and hypersplenism, abdominal tumors, and other tumors not amenable to resection. Well-established local or systemic treatment alternatives are available for each of these malignancies. The potential advantages of MWA for these cancers include improved local control and other advantages common to any minimally invasive procedure (e.g., preserving normal organ tissue, decreasing morbidity, shortening length of hospitalization). Microwave ablation also has been investigated as a treatment for unresectable hepatic tumors, as both primary and palliative treatment, and as a bridge to a liver transplant. In the latter setting, MWA is being assessed to determine whether it can reduce the incidence of tumor progression while awaiting transplantation and thus maintain a patient's candidacy while awaiting a liver transplant.

Regulatory Status

Multiple MWA devices have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. These devices are indicated for soft tissue ablation, including partial or complete ablation of nonresectable liver tumors. Some devices are specifically cleared for use in open surgical ablation, percutaneous ablation, or laparoscopic procedures. Table 1 is a summary of selected MWA devices cleared by FDA.

The FDA used determinations of substantial equivalence to existing radiofrequency and MWA devices to clear these devices. FDA product code: NEY.

This evidence review does not address MWA for the treatment of splenomegaly, ulcers, for cardiac applications, or as a surgical coagulation tool.

Table 1. Selected Microwave Ablation Devices Cleared by FDA

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Device	Indication	Manufacturer	Date Cleared	510(k) No.
MedWaves Microwave Coagulation/Ablation System	General surgery use in open procedures for the coagulation and ablation of soft tissues	MedWaves Incorporated	12/2007	K070356
Acculis Accu2i pMTA Microwave Tissue Ablation Applicator	Intraoperative coagulation of soft tissue	Microsoulis Holdings, Ltd	8/2010	K094021
Acculis Accu2i pMTA Applicator and SulisV pMTA Generator	Software addition		11/2012	K122762
MicroThermX Microwave Ablation System	Coagulation (ablation) of soft tissue. May be used in open surgical as well as percutaneous ablation procedures	BSD Medical Corporation	8/2010	K100786

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Device	Indication	Manufacturer	Date Cleared	510(k) No.
Emprint™ Ablation System	Percutaneous, laparoscopic, and intraoperative coagulation (ablation) of soft tissue, including partial or complete ablation of non-resectable liver tumors	Medtronic	4/2014	K133821
Emprint™ Ablation System	Same with design modification of device antenna for percutaneous use		12/2016	K163105
Emprint™ SX Ablation Platform with Thermosphere™ Technology	3-D navigation feature assists in the placement of antenna using real-time image guidance during intraoperative and laparoscopic ablation procedures		9/2017	K171358
Emprint™ Ablation Platform with Thermosphere™ Technology and Emprint™ SX Ablation Platform with Thermosphere™ Technology	Antenna modification and update to instructions for use		2/2020	K193232

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Device	Indication	Manufacturer	Date Cleared	510(k) No.
Certus 140 2.45 GHz Ablation System and Accessories	Ablation (coagulation) of soft tissue	Johnson & Johnson	10/2010	K100744
Certus 140™ 2.45 GHz Ablation System and Accessories	Ablation (coagulation) of soft tissue in percutaneous, open surgical and in conjunction with laparoscopic surgical settings		01/2012	K113237
CertuSurg^{GT} Surgical Tool	Surgical coagulation (including Planar Coagulation) in open surgical settings		7/2013	K130399
Certus 140™ 2.45 GHz Ablation System and Accessories	Same indication with probe redesign		5/2016	K160936
Certus 140 2.45GHz Ablation System	Ablation (coagulation) of soft tissue in percutaneous, open surgical and in conjunction with laparoscopic surgical settings, including the partial or complete ablation of non-resectable liver tumors		10/2018	K173756
NEUWAVE Flex Microwave Ablation System (FLEX)	Ablation (coagulation) of soft tissue Design evolution of Certus 140 2.45GHz Ablation System (K160936)	Johnson & Johnson	3/2017	K163118

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Device	Indication	Manufacturer	Date Cleared	510(k) No.
Solero Microwave Tissue Ablation (MTA) System and Accessories	Ablation of soft tissue during open procedures	Angiodynamics, Inc.	5/2017	K162449
Microwave Ablation System	Coagulation (ablation) of soft tissue	Surgnova Healthcare Technologies (Zhejiang) Co., Ltd	7/2019	K183153
NEUWAVE Microwave Ablation System and Accessories	Ablation (coagulation) of soft tissue in percutaneous, open surgical and in conjunction with laparoscopic surgical settings, including the partial or complete ablation of non-resectable liver tumors; not intended for use in cardiac procedures	Johnson & Johnson	11/2020	K200081
IntelliBlate Microwave Ablation System	Coagulation (ablation) of soft tissue	Varian Medical Systems, Inc	7/2024	K240480

RATIONALE

SUMMARY OF EVIDENCE

For individuals who have an unresectable primary or metastatic hepatic tumor who receive MWA, the evidence includes randomized controlled trials (RCTs), comparative observational studies, and systematic reviews comparing MWA to radiofrequency ablation (RFA) and to surgical resection. Relevant outcomes are overall survival, disease-specific survival, symptoms,

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quality of life, and treatment-related mortality and morbidity. The body of evidence indicates that MWA is an effective option in patients for whom resection is not an option. Although studies had methodological limitations, results consistently showed that MWA and RFA had similar survival outcomes with up to 5 years of follow up in patients with a single tumor ≤ 5 cm or up to 3 nodules ≤ 3 cm each. In meta-analyses of observational studies, patients receiving MWA had higher local recurrence rates and lower survival than those who received resection, but the patient populations were not limited to those who had unresectable tumors. Microwave ablation was associated with lower complications, intraoperative blood loss, and hospital length of stay. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have an unresectable primary or metastatic lung tumor who receive MWA, the evidence includes a single RCT, retrospective observational studies, and systematic reviews of these studies. Relevant outcomes are overall survival, disease-specific survival, symptoms, quality of life, and treatment-related mortality and morbidity. The body of evidence indicates that MWA is an effective option in patients for whom resection is not an option. In the RCT, direct comparison of MWA and RFA in patients with primary or metastatic lung cancer (mean tumor size 1.90 cm [\pm 0.89] at baseline) found similar mortality rates up to 12 months of follow-up. In the first of three systematic reviews that included 12 retrospective observational studies, local recurrence rates were similar for MWA and RFA at a range of 9 to 47 months of follow-up. In the second systematic review with a meta-analysis, there was lower overall survival with MWA compared to RFA, but studies were not directly comparable due to clinical and methodological heterogeneity. However, the authors concluded that percutaneous RFA and MWA were both effective with a high safety profile. In the third systematic review using a network meta-analysis, the weighted average overall survival rates for MWA were 82.5%, 54.6%, 35.7% 29.6%, and 16.6% at 1, 2, 3, 4, and 5 years, respectively. Limitations of the body of evidence included a lack of controlled studies and heterogeneity across studies. The RCT did not report results by tumor size or number of metastases. The observational studies included in the systematic reviews did not report sufficient information to assess effectiveness or safety of MWA in subgroups based on the presence of multiple tumors or total tumor burden. Therefore, conclusions about the evidence sufficiency can only be made about patients with single tumors. For this population, the evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have an unresectable primary or metastatic renal tumor who receive MWA, the evidence includes a single RCT that compared MWA to partial nephrectomy, retrospective reviews, systematic reviews, and meta-analyses of the retrospective reviews (with or without the single RCT) and case series. Relevant outcomes are overall survival, disease-specific survival, symptoms, quality of life, and treatment-related mortality and morbidity. In the RCT, overall local recurrence-free survival at 3 years was 91.3% for MWA and 96.0% for partial nephrectomy ($p=.54$). This positive outcome should be replicated in additional RCTs. There are also no controlled studies comparing MWA to other ablation techniques in patients with renal tumors. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

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For individuals who have unresectable primary or metastatic solid tumors other than hepatic, lung, or renal who receive MWA, the evidence includes systematic reviews and case series. No RCTs on the use of MWA for other malignant tumors or conditions were identified. Relevant outcomes are overall survival, disease-specific survival, symptoms, quality of life, and treatment-related mortality and morbidity. One RCT in benign thyroid tumors found MWA to be noninferior to RFA, but the study is limited by the small number of sites and lack of blinding. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

DEFINITIONS

N/A

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes							
32998	32999	47382	47399				

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POLICY HISTORY

MP 2.090	09/04/2020 Consensus Review. Policy statement unchanged. References updated.
	10/25/2021 Minor Review. For the first policy statement, in the second bullet, changed "A single tumor of ≤5 cm or up to 3 nodules <3 cm each" to "A single tumor of ≤5 cm or up to 3 nodules ≤3 cm each". Removed "or lung" from the first policy statement (first statement is now for primary or metastatic hepatic tumors, the second is for primary or metastatic lung tumors). Added NCCN statement. Updated references.
	11/22/2022 Consensus Review. No change to policy statement. Product variation and FEP language revised. Background, Rationale and References updated.
	11/20/2023 Consensus Review. No change to policy statement. Rationale and References updated.
	11/19/2024 Consensus Review. No change to policy statement. NCCN statement removed. References updated.
	10/17/2025 Consensus Review. No change to policy statement. Background, Rationale, and References updated. Coding reviewed with no changes.

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