Policy: MP048
Section: Medical Benefit Policy
Subject: Surgical and Minimally Invasive Therapies for the Treatment of Benign Prostatic Hypertrophy

I. Policy: Surgical and Minimally Invasive Therapies for the Treatment of Benign Prostatic Hypertrophy

II. Purpose/Objective:
To provide a policy of coverage regarding Surgical and Minimally Invasive Therapies for the Treatment of Benign Prostatic Hypertrophy

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:
(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.

(iii) The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Transurethral Microwave Thermotherapy (TUMT), Transurethral Radiofrequency Thermotherapy (TUNA), Laser Prostatectomy (Holmium laser ablation of the prostate [HoLAP]) , Holmium laser enucleation of the prostate [HoLEP] Holmium laser resection of the prostate ([HoLRP] ) and Water Induced Thermotherapy (WIT) are outpatient ablation treatments for symptomatic benign prostatic hypertrophy (BPH). These procedures are non-surgical alternatives to transurethral resection of the prostate (TURP). The desired outcome is to relieve urinary symptoms and improve urinary function by reducing urinary obstruction caused by BPH. A urethral probe is used to apply thermal energy to the prostate, causing damage and eventual necrosis of excess prostatic tissue. Prostatic Urethral Lift (UroLift ®) is a minimally invasive implant developed to treat lower urinary tract outflow obstruction secondary to BPH in men 50 years of age or older. Permanent implants are delivered trans-prostatically to retract the enlarged lateral lobes of the prostate.

INDICATIONS:
Outlet obstruction caused by benign prostatic hypertrophy

CRITERIA FOR COVERAGE: All must be met

- Diagnosis of symptomatic BPH with duration of symptoms greater than 3 months
- Failed trial or intolerance to medication therapy (alpha-blocker and/or finasteride)
- Recent PSA that resulted in a value of 2.5 ng/ml or less for members up to age 50; 4.0 ng/ml or less for members over age 50
- Peak urine flow rate (Qmax) less than 15 cc on a voided volume of greater than 125cc
- Post void residual (PVR) greater than 50cc or less than 350cc

CONTRAINDICATIONS:
Active urinary tract infection
Prostate malignancy
Prostate gland with obstructive median lobe
Hyperreflexive neurogenic bladder
Previous prostate surgery
Active cystolithiasis
Gross hematuria
Urethral stricture
Bladder neck contracture
Acute prostatitis
Prior radiation therapy to the pelvic area

EXCLUSIONS:
The Plan does NOT provide coverage for transurethral balloon dilation of the prostatic urethra because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does NOT provide coverage for Transurethral ethanol ablation of the prostate (TEAP) used in the treatment of prostatic hypertrophy because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does NOT provide coverage for High-intensity focused ultrasound (HIFU) ablation used in the treatment of prostatic hypertrophy because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.
CODING ASSOCIATED WITH: Surgical and Minimally Invasive Therapies for the Treatment of Benign Prostatic Hypertrophy: The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

52441 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
52442 each additional permanent adjustable transprostatic implant
52601 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatomomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included) [laser prostatectomy]
52630 Transurethral resection; residual or regrowth of obstructive prostatic tissue including control of postoperative bleeding, complete
52647 Non-contact laser coagulation of prostate, including control of post operative bleeding, complete
52648 Contact laser vaporization with or without transurethral resection of prostate, including control of postoperative bleeding, complete
52649 Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete
53850 Transurethral destruction of the prostate tissue; by microwave thermotherapy [TUMT]
53852 by radiofrequency thermotherapy [TUNA]
53855 insertion of a temporary prostatic urethral stent, including urethral measurement
55873 Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
C9739 Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants
C9740 4 or more implants


LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


This policy will be revised as necessary and reviewed no less than annually.