Benign Prostatic Hyperplasia (BPH) Treatments

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Benign Prostatic Hyperplasia (BPH) is a noncancerous increase in size of the prostate gland. The enlarged prostate gland presses against the urethra. BPH can lead to symptoms like frequent urination, trouble starting to urinate, weak stream, inability to urinate, or loss of bladder control. BPH is treated with lifestyle changes, medication, and surgery (transurethral resection of the prostate (TURP). Alternative available treatment options include the prostatic urethral lift

The prostatic urethral lift procedure is a treatment for benign prostatic hyperplasia (BPH) symptoms using implant(s) to separate enlarged prostate lobes to reduce pressure on the urethra.

Transurethral Water Vapor Therapy delivers sterile water vapor (steam) directly into hyperplastic tissue. Heat is released as the vapor condenses, causing cell death and improving BPH symptoms

Waterjet tissue ablation is a medical device that is controlled with electromechanical precision and live ultrasound which delivers a high-velocity saline stream to ablate prostatic glandular tissue without the production of heat. High-velocity sterile saline is delivered to the prostate tissue. The ablated tissue from the procedure is removed and a laser light beam is used to cauterize the excised area.

Criteria

Commercial

Prior authorization is required

I. Prostatic Urethral Lift

PacificSource considers coverage of prostatic urethral lift, for the treatment of lower urinary tract symptoms due to BPH medically necessary when **ALL** of the following criteria is met:

- **A.** Member is at least 45 years old
- **B.** Prostate volume is not greater than 100 mL based on ultrasound imaging
- **C.** Median lobe of prostate is not obstructed
- **D.** Peak flow rate (Qmax) is less than or equal to 12 mL/second
- **E.** Intolerance to or failure of medication management (3 month or longer) for treatment of BPH symptoms (e.g., alpha blockers, PDE5 Inhibitor, finasteride, dutasteride)
- **F.** Lower urinary tract symptoms, to including **ANY** of the following:
  1. urinary frequency
  2. urgency
  3. nocturia
  4. weak stream
  5. straining
  6. intermittency

II. Transurethral Water Vapor Therapy

PacificSource considers transurethral water vapor therapy (e.g., Rezum system procedure), for lower urinary tract symptoms associated with Benign Prostatic Hyperplasia, medically necessary when **ALL** the following criteria have been met:

- **A.** Member is at least 50 years old
- **B.** Symptomatic despite maximal medical management including **ALL** of the following:
  1. International Prostate Symptom Score (IPSS) ≥13
  2. Maximum urinary flow rate (Qmax) of ≤15 mL/s (voided volume no greater than 125 mL)
  3. Intolerance to or failure of medication management (3 month or longer) for treatment of BPH symptoms (e.g., alpha blockers, PDE5 Inhibitor, finasteride, dutasteride)
  4. Prostate gland volume is estimated to be ≥30 to ≤ 100 mL (or grams in weight) by clinical or ultrasound assessment

III. Waterjet Tissue Ablation

PacificSource considers coverage of Waterjet Tissue Ablation (e.g., AquaBeam® System) medically necessary for treatment of lower urinary tract symptoms (LUTS) secondary to Benign Prostatic Hyperplasia (BPH) when **ALL** of the following criteria is met:

A. Prostate gland volume is less than or equal to 150 mL based on ultrasound imaging

B. International Prostate System Score (PPSS) ≥ 13

C. Intolerance to or failure of medication management (3 month or longer) for treatment of BPH symptoms (e.g., α1-adrenergic antagonists, 5α-reductase inhibitors, or combination medication therapy)

Medicaid

PacificSource Community Solutions (PCS) follows Oregon Administrative Rules (OARs) 410-141-3820, 410-141-3825, and 410-141-3830, and Guideline Note 145 of the OHP Prioritized List of Health Services for coverage of Benign Prostatic Hyperplasia (BPH) Treatments. PacificSource Community Solutions (PCS) follows Excluded Services E2 of the OHP Prioritized List of Health Services for codes 53855 and C9769 to have insufficient evidence of effectiveness.

PacificSource Community Solutions (PCS) follows EPSDT coverage requirements in OAR 410-151-0002 for members EPSDT Beneficiaries.. Coverage of Benign Prostatic Hyperplasia (BPH) Treatments is determined through case-by-case reviews for EPSDT Medical Necessity and EPSDT Medical Appropriateness defined in OAR 410-151-0001. Guideline Note 145 and Excluded Services E2 may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review.

PacificSource Community Solutions (PCS) follows the “Unlisted and Unspecified Procedure Codes” policy for requests for unlisted codes.

Medicare

PacificSource Medicare follows Local Coverage Determination (LCD) L38707 for coverage of Transurethral Waterjet Ablation of the Prostrate.

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow an internal policy for determination of coverage and medical necessity.

Experimental/Investigational/Unproven

PacificSource considers the use of temporary removable or biodegradable prostatic urethral stents to be experimental, investigational, and unproven.

PacificSource considers Transurethral Balloon Dilation (TUDP) (e.g., Optilume BPH Catheter System) to be experimental, investigational, and unproven.

PacificSource considers the Tulsa Procedure or transurethral ultrasound ablation to be experimental, investigational, and unproven.

PacificSource considers Prostate Arterial Embolization (PAE) (Transcatheter Embolization) for treatment of Benign Prostate Hyperplasia to be experimental, investigational, and unproven.

PacificSource considers UroCuff test (Penile Cuff test) to be experimental, investigational, and unproven.*****

PacificSource considers Waterjet Tissue Ablation to be experimental, investigational, and unproven for all other indications.

Note: * indicates the item remains E/I/U but will not be reviewed annually by the NTOC Committee, unless requested.

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive.

Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

0421T Transurethral waterjet ablation prostate control post-op bleeding including US guide/complete (vasect/meatotomy/cystourethro/urethral calibration/dilation & internal urethrot)

37242 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary

51721 Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed

52284 Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed

52441 Cystourethroscopy with transurethral resection or incision of ejaculatory ducts

52442 Each additional permanent adjustable transprostatic implant

53854 Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy

53855 Insertion of a temporary prostatic urethral stent, including urethral measurement

53865 Cystourethroscopy with insertion of temporary device for ischemic remodeling (i.e., pressure necrosis) of bladder neck and prostate

53866 Catheterization with removal of temporary device for ischemic remodeling (i.e., pressure necrosis) of bladder neck and prostate

53899 Unlisted procedure, urinary system

55881 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation

55882 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

55899 Unlisted procedure, male genital system

75894 Transcatheter therapy, embolization, any method, radiological supervision, and interpretation

C2596 Probe, image guided, robotic, waterjet ablation -–

C9739 Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants

C9740 Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants

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Appendix

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Author(s):

Depts: Health Services

Applicable regulation(s) LCD L38707, LCD L37808, OARs 410-141-3820,410-141-3825, 410-141-3830, 410-151-0000, 410-151-0001, 410-151-0002, 410-151-0003

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