Prostate Cancer Treatment

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

High-intensity focused ultrasound (**HIFU**) is a non-invasive therapeutic technique that uses non-ionizing ultrasonic waves to ablate cancer tissue in a focused area. Treatment of recurrent prostate cancer depends on factors such as the primary treatment method, and extent of the cancer.

Perirectal spacers may be utilized during treatment prostate cancer. These products increase the distance between the rectum and the prostate to reduce incidental radiation of the rectum during.

Proton Beam Therapy is a type of external radiation treatment in which positively charged subatomic particles (protons) are precisely targeted to a specific tissue mass.

Criteria

Commercial

Prior authorization is required.

I. High-Intensity Focused Ultrasound (HIFU)

A. PacificSource considers High-Intensity Focused Ultrasound (HIFU) medically necessary when **ALL** of the following criteria is met:

1. Radiorecurrent prostate cancer documented by **ONE** or more of the following:

a. Rising prostate-specific antigen (PSA) consistent with biochemical recurrence

b. Positive biopsy confirming recurrent disease

c. Imaging findings consistent with localized recurrence

2. Absence of metastatic disease

II. Radiation for Prostate Cancer Therapy

A. Stereotactic Body Radiotherapy

1. PacificSource considers Stereotactic Body Radiotherapy medically necessary when MCG criteria: A-0694 (AC) is met

B. Proton Beam

1. PacificSource plans in ID, MT, WA follows Proton Beam Therapy radiation for Prostate Cancer, MCG criteria: A-0389 (AC)
2. PacificSource plans in Oregon cover proton beam therapy for members' diagnosed with prostate cancer in accordance with Oregon Senate Bill 463, ORS 743A.130

Note: Coverable diagnosis include the following:

1. C61 Malignant neoplasm of prostate
2. D07.5 Carcinoma in situ of prostate
3. D40.0 Neoplasm of uncertain behavior of prostate
4. Z85.46 Personal history of malignant neoplasm of prostate

III. Hydrogel Perirectal Spacers

A. PacificSource considers the use of hydrogel perirectal spacers (e.g., SpaceOAR™, Barrigel) medically necessary for reducing rectal toxicity when **ALL** of the following criteria are met:

1. Diagnosis of clinically localized prostate cancer, without posterior extraprostatic extension involving the rectal wall
2. External beam radiation therapy is planned (e.g., Intensity-Modulated Radiation Therapy (IMRT), Stereotactic Body Radiation Therapy (SBRT))

Medicaid

PacificSource Community Solutions (PCS) follows the general coverage, limitations, and exclusions outlined in OARs 410-141-3820, 410-141-3825, and 410-120-1200. Relevant coverage guidance, including but not limited to Guideline Note 16 and Excluded Services Guideline E2 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services; as well as any applicable Oregon Administrative Rules (OARs) may be used to determine coverage of Prostate Cancer Treatment.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0000 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance, including but not limited to Guideline Note 16 and Excluded Services Guideline E2, may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical

Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow the PacificSource commercial criteria above for determination of coverage and medical necessity coverage for prostate cancer treatment.

Experimental/Investigational/Unproven

PacificSource considers High-intensity focused ultrasound (HIFU) for the treatment for prostate cancer, including magnetic resonance (MRI)-guided focused ultrasound, to be experimental, investigational, or unproven for all other indications.

PacificSource considers the use of hydrogel perirectal spacers experimental, investigational, or unproven for all other indications.

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

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.

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-

55874 Transperineal placement of biodegradable material, periprostatic, single or multiple injections, including image guidance, when performed

55880 Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance

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 (when specified as image-guided focused ultrasound ablation of prostate tissue for non-oncologic indications, such as benign prostatic hyperplasia)

77520 Proton treatment delivery; simple, without compensation

77522 Proton treatment delivery; simple, with compensation

77523 Proton treatment delivery; intermediate

77525 Proton treatment delivery; complex

C9734 Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

Definitions

Biochemical Recurrence (Post-Radiation Therapy) - A rise in PSA level of greater than or equal to 2.0ng/mL above the PSA nadir, consistent with the Phoenix definition of biochemical failure.

Prostate-Specific Antigen (PSA) - A serum biomarker produced by prostate tissue used in the detection, risk stratification, and monitoring of prostate cancer.

Prostate-Specific Antigen (PSA) Nadir - The lowest PSA level achieves following definitive treatment (e.g., radiation therapy or surgery).

Prostate Cancer Staging - Classification of prostate cancer based on tumor extent, lymph node involvement, and presence of metastases using the TNM staging system.

Radiorecurrent Prostate Cancer - Prostate cancer that recurs after prior definitive radiation therapy, as evidenced by biochemical recurrence and/or confirmatory biopsy or imaging, with disease remaining localized and amenable to salvage therapy.

TNM System - Staging system to stage prostate cancer that separates tumor (T), lymph nodes (N) and metastases (M) as shown below:

Tumor (T) Staging:

T1 - Clinically inapparent tumor not detectable on exam or imaging

T2 - Tumor confined within the prostate

T3 - Tumor extends through the prostate capsule (may include seminal vesicles)

T4 - Tumor invades adjacent structures (e.g., bladder, rectum)

Regional Lymph Node (N) Staging:

N0 - No regional lymph node involvement

N1 – Regional lymph node metastasis present

Distant **Metastasis (M) Staging:**

M0 - No distant metastasis

M1 – Distant metastasis present

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MCG. Proton Beam Therapy, A-0389 (AC)

MCG. Stereotactic Body Radiotherapy, A-0694 (AC)

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Related Policies

Clinical Criteria Used in UM Decisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Unlisted and Unspecified Procedure Codes

Appendix

Policy Number:

Effective: 12/9/2021 **Next review:** 9/1/2027

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): ORS 743A.130; Oregon Administrative Rules (OARs) 410-120-1200, 410-141-3820, 410-141-3825, 410-151-0001, 410-151-0002, 410-151-0003

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