Prostate Cancer Treatment

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

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, extent of the cancer, and site of recurrence.

Perirectal spacers may be utilized during treatment prostate cancer. These products increase the distance between the rectum and the prostate to reduce radiation of the rectum from the external beam radiation therapy (EBRT) field and brachytherapy (internal radiation implant).

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) to be medically necessary for recurrent prostate cancer when the **ALL** of the following criteria is met:

1. Radiation therapy has been completed
2. Positive digital rectal exam **OR** Prostate-Specific Antigen (PSA) has been confirmed to be increasing
3. Patient is a candidate for local therapy as evidenced by both of the following:
   - **a.** Original clinical stage T1-T2, NX or N0 (see Definitions)
   - **b.** PSA now less than 10 ng/mL
4. Biopsy is positive or suspicious of recurrence of prostate cancer
5. Absence of metastatic disease

II. Radiation for Prostate Cancer Therapy

A. Stereotactic Body Radiotherapy

PacificSource follows MCG A-0694 (AC) for Stereotactic Body Radiotherapy

B. Proton Beam

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

NOTE: Coverable diagnosis:

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 documentation supports **ALL** of the following criteria

1. Diagnosis of clinically localized prostate cancer (without posterior extraprostatic extension)
2. Stereotactic body radiotherapy is planned
3. Tumor has not invaded the rectum

Medicaid

PacificSource Community Solutions follows the hierarchical process detailed in the "Clinical Criteria Used in UM Decisions" policy when determining coverage for treatment of prostate cancer. PCS evaluates services based on the relevant coverage guidelines, limitations, and restrictions specified in

the OHP Prioritized List of Health Services and its guidelines, as well as any applicable Oregon Administrative Rules (OARs).

PacificSource follows the “Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)” criteria for members under 21 and Young Adults with Special Health Care Needs (YSHCN).

PCS follows the “Unlisted and Unspecified Procedure Codes” policy for requests for unlisted codes.

Medicare

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

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 indication, including as an initial treatment for localized prostate cancer.

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.

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

Definitions

Prostate-Specific Antigen (PSA) – laboratory test that measures the amount of protein made by the prostate gland found in the blood.

Prostate-Specific Antigen (PSA) nadir – the absolute lowest level the PSA drops after treatment, which is a value of 2 ng/ml greater than their lowest value.

Prostate Cancer Staging - method of evaluating cancer by detailing size of tumor, if lymph nodes are affected, and if the tumor has metastasized as detailed below:

Stage I - Prostate cancer cannot be felt by digital rectal examination, causes no symptoms, and is only in the prostate, usually found incidentally in a prostatectomy specimen when surgery is done for benign prostatic hyperplasia

Stage II - Cancer confined to the prostate gland found by needle biopsy done for an elevated prostate-specific antigen (PSA) level or after rectal examination reveals a mass in the prostate

Stage III - Cancer cells have spread outside the capsule of the prostate to tissues around the prostate (e.g., seminal vesicles)

Stage IV - Cancer cells have metastasized to lymph nodes or to organs and tissues (e.g., the bone, liver, or lungs)

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

Tumor (T) Staging:

T1 - The tumor is too small to be seen on scans or felt during examination of the prostate

T2 - The tumor is completely inside the prostate gland

T3 - The tumor has broken through the capsule of the prostate gland

T4 - The tumor has spread into other body organs

Lymph Node (N) Staging:

NX - Cancer in nearby lymph nodes cannot be measured, unable to be assessed

N0 - No cancer cells found in any lymph nodes

N1 - One positive lymph node smaller than 2 cm across

N2 - More than 1 positive lymph node; or one that is between 2 cm and 5 cm across

N3 - Any positive lymph node that is bigger than 5 cm across

Metastases (M) Staging:

M0 - No cancer spread outside the pelvis

M1 - Cancer has spread outside the pelvis

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The Health Evidence Review Commission (HERC) Prioritized List of Health Services https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

Oregon Administrative Rules (OARs). Oregon Health Authority. Health Systems: Medical Assistance Programs – Chapter 410 https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87

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:** 6/1/2026

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): Guideline Note 173, Oregon Administrative Rules (OAR) 410-120-1200 and 410-141-3820 to 3830, Oregon Administrative Rules (OARs) 410-120-1200, 410-141-3820, 410-141-3825, 410-151-0001, 410-151-0002, 410-151-0003; Oregon Administrative Rules (OAR) 410-120-1200 and 410-141-3820 to 3830Oregon Administrative Rules (OAR) 410-120-1200 and 410-141-3820 to 3830OR SB 463, ORS 743A.130.

Commercial Ops: 5/2025

Government Ops: 5/2025