Prostatic Urethral Lift (PUL) — MEDICARE

Last Review Date: August 12, 2016  Number: MG.MM.ME.62

Medical Guideline Disclaimer

Property of EmblemHealth. All rights reserved. The treating physician or primary care provider must submit to EmblemHealth the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary. If there is a discrepancy between this guideline and a member’s benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication. EmblemHealth Services Company LLC, (“EmblemHealth”) has adopted the herein policy in providing management, administrative and other services to HIP Health Plan of New York, HIP Insurance Company of New York, Group Health Incorporated and GHI HMO Select, related to health benefit plans offered by these entities. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definitions

The UroLift® system is a minimally invasive implant developed to treat lower urinary tract symptoms (LUTS) related to urinary outflow obstruction secondary to benign prostatic hypertrophy (BPH) in men 50 years of age or older. In this procedure, permanent implants (made from common implantable materials: nitinol, stainless steel and polyethylene terephthalate) are delivered trans-prostatically to retract the enlarged lateral lobes of the prostate. This procedure dilates the prostatic urethra in leading to improvement in LUTS symptoms without the need for surgical resection or the application of thermal energy to the prostate.

Guideline

Prostatic urethral lift procedures are considered medically necessary for Medicare members when all of the following criteria are met:

1. Symptomatic BPH in male members ≥ 50 years of age with well documented voiding symptoms consistent with prostatic hypertrophy
2. AUA symptom index (AUASI) score ≥ 13
3. Peak urine flow rate (Qmax) ≤ 12 cc/sec on a voided volume of > 125 cc
4. Member has had an adequate trial of, but is refractory to or intolerant of, usual BPH medication
5. Prostate volume ≤ 80 cc without an obstructive median lobe
6. No signs, symptoms or diagnostic evidence of active urinary infection and no history of bacterial prostatitis within prior 12-month period
7. Normal renal function
8. Member is a poor candidate for alternate surgical BPH interventions due to any of the following:
• Presence of underlying disease (e.g. cardiac, pulmonary, etc.)
• High risk for bleeding
• Member chooses PUL based on likelihood of preserving erectile function and/or another documented reason

Limitations/Exclusions
Coverage is for surgical intervention with up to a total of six implants. Implants in excess of six will deny but may be reconsidered on an exception basis with a formal redetermination.

Applicable Procedure Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52441</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant</td>
</tr>
<tr>
<td>52442</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>C9739</td>
<td>Cystourethroscopy, with insertion of transprostatic implant; 1 to 3</td>
</tr>
<tr>
<td>C9740</td>
<td>Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants</td>
</tr>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>

Applicable Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N40.1</td>
<td>Enlarged prostate with lower urinary tract symptoms</td>
</tr>
</tbody>
</table>

References


National Institute for Health and Care Excellence (NICE). Insertion of prostatic urethral lift implants to treat lower urinary


