Prostate Treatment

MP9361

Covered Service: Yes—as shown below.

Prior Authorization Required: Yes—as shown below

Additional Information: None

Prevea360 Health Plan Medical Policy:

1.0 The following interventions do not require prior authorization and are considered medically necessary for the treatment of benign prostate hypertrophy (BPH) for members as an alternative to transurethral resection of the prostate:

1.1 Medical management

1.2 Ultrasonic aspiration

1.3 Transurethral Microwave Thermotherapy (TUMT)

1.3.1 TUMT does not require prior authorization and is considered medically necessary for the treatment of symptomatic BPH.

1.3.2 TUMT is not considered medically necessary and therefore not covered for members with:

1.3.2.1 History of a previous TUMT; OR
1.3.2.2 Medication, neurological disorder, or renal or urinary tract disease which influences urinary tract function; OR
1.3.2.3 Microwave-sensitive implants; prostate or bladder cancer; isolated and asymptomatic enlargement of the median lobe of the prostate; hip or femoral bone dysfunction; previous surgery or radiation of the prostate, rectum, urethra, or bladder neck.

1.4 Transurethral needle ablation (TUNA) also known as radiofrequency needle ablation (RFNA).

1.5 Transurethral incision of the prostate (TUIP)

1.6 Transurethral electrovaporization of the prostate (TUVP)

1.7 Laser prostatectomy

1.8 Laser based procedures including contact laser ablation of the prostate (CLAP), holmium laser procedures of the prostate (HoLAP, HoLEP, HoLRP)
Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

1.9 Cystoscopic procedure using small implants to separate encroaching prostatic lobes. Prostatic urethral lift (e.g. UroLift) is considered medically necessary for the treatment of symptomatic BPH when ALL of the following criteria are met:

1.9.1 Age 50 or above; AND
1.9.2 Estimated prostate volume <80 cc; AND
1.9.3 No obstructive median lobe of the prostate identified on cystoscopy; AND
1.9.4 Failure, contraindication, or intolerance to at least 3 months of conventional medical therapy for BPH.

2.0 Endourethral prosthesis (urtheral stent) (e.g. UroLume) does not require a prior authorization and is considered medically necessary to relieve prostatic obstruction secondary to BPH:

2.1 Men at least 60 years of age; OR
2.2 Men under 60 who are poor surgical candidates, AND
2.3 Prostates are at least 2.5 cm in length.

2.4 Endourethral prosthesis is also considered medically necessary for the treatment of recurrent bulbar urethral stenosis/stricture when previous therapeutic approaches such as dilation, urethrotomy, or urethroplasty have failed.

2.5 The endourethral prosthesis is considered experimental and investigational for other indications, and therefore is not medically necessary.

3.0 Prevea360 Health Plan considers the following medically necessary for the treatment of prostate cancer and prior authorization is not required: prostate brachytherapy, seed implantation and transperineal implantation of radioisotopes.

4.0 The following interventions require prior authorization through the Health Services Division:

4.1 Cryosurgery as salvage therapy for local recurrence after primary treatment for prostate cancer for members who have undergone a radical prostatectomy or radiation therapy during treatment.

4.2 Cryoablation of the prostate as a primary treatment for prostate cancer with clinically localized prostate cancer stages:

4.2.1 T1-clinically unapparent tumors and neither palpable nor visible by imaging; OR
4.2.2 T2-are palpable and appear confined with the prostate; OR
4.2.3 T-3 tumors extend through the prostatic capsule or into the seminal vesicles; AND
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4.2.4 Who are not suitable candidates for primary therapy with standard treatment or surgery.

5.0 The following interventions do not require prior authorization through the Health Services Division:

5.1 Intensity-Modulated Radiotherapy (IMRT). Please refer to MP9426 Intensity Modulated Radiation Therapy (IMRT) for criteria.

5.2 Stereotactic Radiosurgery. Please refer to MP9459 Stereotactic Body Radiotherapy for criteria.

6.0 The prostate cancer vaccine sipuleucel-T (PROVENGE) requires prior authorization through the Health Services Division and is considered medically necessary for the treatment of adults with metastatic castrate-resistant prostate cancer who:

6.1 Are asymptomatic or minimally symptomatic with Eastern Cooperative Oncology Group (ECOG) performance status 0-1; AND

6.2 Have no visceral metastases; AND

6.3 Have testosterone levels < 50 ng/dL or below lowest level of normal; AND

6.4 Have a life expectancy of greater than six months.

6.5 The prostate cancer vaccine is considered experimental and investigational for all other indications (e.g. prevention of prostate cancer and treatment of localized prostate cancer) and is therefore not medically necessary.

7.0 Sural nerve graft during radical prostatectomy for the treatment of erectile dysfunction is considered not medically necessary.

8.0 MRI-TRUS Fusion-Guided Prostate Biopsy for the diagnosis of prostate cancer requires prior authorization through the Health Services Division. MRI-TRUS is considered medically necessary after one (1) or more negative TRUS biopsies and the member is considered at high risk due to:

8.1 Persistently elevated PSA;

8.2 Rising PSA;

8.3 All other indications for MRI-TRUS Fusion-Guided Biopsy are considered experimental and investigational, and therefore are not medically necessary.

9.0 Prevea360 Health Plan considers the following approaches for the treatment of BPH to be experimental and investigational, and therefore not medically necessary:

9.1 Endoscopic balloon dilation of the prostate

9.2 Transrectal thermal therapy (including transrectal microwave hyperthermia, transrectal radiofrequency hyperthermia, transrectal electrothermal hyperthermia and transrectal high-intensity focused ultrasound).

9.3 Interstitial laser coagulation of prostate (ILCP)
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9.4 Water induced thermotherapy (also known as hot-water balloon thermoablation and thermourethral hot-water therapy)
9.5 Plasma kinetic vaporization (e.g. PlasmaKinetic™ Tissue Management System)
9.6 Temporary implantable nitinol device (TIND)
9.7 Absolute ethanol injection (transurethral)
9.8 Aquablation (water jet-hydrodissection)
9.9 Bipolar plasma enucleation
9.10 Phytotherapy
9.11 Water vapor thermal therapy (e.g. Rezum System)
9.12 High-intensity, focused ultrasound (HIFU)
9.13 Histotripsy
9.14 Prostatic arterial embolization (transcatheter embolization)
9.15 MRI-guided laser focal ablation
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