I. POLICY/Criteria

A. The Urolift/Prostatic Urethral Lift System is a covered benefit for the treatment of symptomatic benign prostatic hypertrophy (BPH) when both of the following are met:
   1. Men age 50 and older, and
   2. Prostate up to 80 cc

Coverage is limited to a maximum of six (6) implants.

B. Urolift is not a covered benefit if any of the following are present:
   1. Obstructive median lobe
   2. Urinary retention
   3. Post-void residual volume greater than 250 ml
   4. Active infection
   5. Gross hematuria
   6. Cystolithiasis within 3 months
   7. Prostate specific antigen greater than 10 ng/ml (unless biopsy was negative)
   8. Bacterial prostatitis within 1 year

II. MEDICAL NECESSITY REVIEW

☐ Required  ☒ Not Required  ☐ Not Applicable

III. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
INDIVIDUAL: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.

MEDICARE: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.

MEDICAID/HEALTHY MICHIGAN PLAN: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945-42542-42543-42546-42551-159815--00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945-5100-87572--00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IV. BACKGROUND

The UroLift System (NeoTract Inc.) is a minimally invasive, prostatic urethral lift (PUL) system that provides anterolateral mechanical traction of the lateral lobes of the prostate, opening the urethral lumen and reducing obstruction. Implants are delivered bilaterally to separate the encroaching lobes, beginning approximately 1.5 centimeters distal to the bladder neck. Cystoscopic inspection after each implant determines whether additional implants are required. Four to 5 implants are typically placed but this varies with the size and shape of the prostate. The device may avoid some of the morbidities and complications associated with other surgical approaches.

The UroLift System is intended for the treatment of symptoms due to urinary outflow obstruction secondary to BPH in men ≥ 50 years of age with a prostate size up to 80 milliliters (mL) in size whose symptoms are refractory to medical therapy, and/or who are inappropriate candidates for more invasive procedures or who do not wish to undergo these procedures. The procedure is typically performed by a urologist in the office or other outpatient setting with the use of local anesthesia and oral sedation.

The L.I.F.T. Study randomized 206 patients with BPH to implantation of the UroLift device versus a sham procedure and met its primary endpoint finding that patients treated with the device had a ≥ 25% reduction in the American Urological Association Symptom Index (AUASI) (P<0.0001) at 3 months compared with the sham controls, which was sustained at 1 year. Other endpoints that were improved at 3 months and at 1 year in the UroLift group compared with the controls included the Benign Prostatic Hyperplasia Impact Index (BPHII) (P<0.001 for both time points and maximum urinary flow rate (Qmax) (P<0.0001 for both time points). Changes in scores on the Male Sexual Health Questionnaire for
Ejaculatory Dysfunction (MSHQ-EjD), MSHQ-bother, and International Index of Erectile Function (IIEF-5) were similar between the UroLift group and the controls at 3 months and at 1 year. These clinical benefits were sustained through 2 years as shown by follow-up of 106 patients available for analysis.

V. CODING INFORMATION

ICD-10 Codes that may apply:
N40.1 Enlarged prostate with lower urinary tract symptoms

CPT/HCPCS Codes:
52441 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
52442 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

Outpatient Facility Codes:
C9739 Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants
C9740 Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
L8699 Prosthetic implant, not otherwise specified

VI. REFERENCES

Hayes, Inc. UroLift System (NeoTract Inc.) for Treatment of Benign Prostatic Hypertrophy, April 23, 2015
Benign Prostatic Hyperplasia (BPH) Treatments. Cigna Medical Coverage Policy 0159.
Prostatic Urethral Lift Procedure for the Treatment of BPH. Blue Cross Blue Shield Blue Care Network of Michigan Joint Medical Policy.
AMA CPT Copyright Statement:
All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member’s plan in effect as of the date services are rendered. Priority Health’s medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health’s medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan’s ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name “Priority Health” and the term “plan” mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.