Prostatic Urethral Lift (Urolift®)

Policy

The Medical Management Department reviews authorization requests for Prostatic Urethral Lift (Urolift®).

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee’s specific plan document must be referenced. The terms of an enrollee’s plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee’s specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

A. Documentation Required:
In order to facilitate the authorization process for the Prostatic Urethral Lift (Urolift®), referral requests must include ALL the following:

1. Member must be under the care of a Urologist trained to perform the Urolift® procedure.
2. Documentation of patient lower urinary tract symptoms related to benign prostatic hypertrophy (BPH).
3. Documentation of failed medication management for lower urinary tract symptoms of BPH.
4. Documentation of diagnostic testing for BPH.
5. Documentation that the Patient has opted for the procedure over other surgical treatments, (e.g., TURP), based on the likelihood of preserving erectile and ejaculatory function OR other surgical procedures are not possible due to patient comorbidities.

B. Criteria for Medical Necessity:
Prostatic Urethral Lift (Urolift®) is considered medically necessary when ALL of the following criteria are met:

a. Prostate volume of < 80 ml on ultrasound imaging; AND
b. Absence of obstructive middle lobe; AND
c. Failure of or intolerance to at least 2 months of conventional medical therapy for lower urinary tract symptoms of BPH including an adequate trial of at least 1 medication or documentation of contraindication to medication therapy; AND
d. IPSS score of 8 or greater.

C. Indications Considered Experimental, Investigational or not Medically Necessary: (Not an all-Inclusive list)

a. Repeat Prostatic Urethral Lift (Urolift®) procedure.
CPT Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>52441</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant.</td>
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<tr>
<td>52442</td>
<td>each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure).</td>
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References:


