Policy

The Medical Management Department reviews referral requests for prior authorization of prostate artery embolization for treatment of benign prostatic hypertrophy and refractory hematuria of prostate origin.

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, referral requests must include the following supporting materials:

1. History and physical exam, laboratory results (urinalysis, PSA) and radiology imaging (usually transrectal prostate ultrasound, possibly MRI) results supporting the diagnosis of benign prostatic hypertrophy without evidence of cancer.
2. Patient history of any pelvic surgery, pelvic radiation therapy, bleeding diastheses or immune compromising conditions.
3. A physician order from a Urology specialist for the prostate artery embolization procedure with a statement that this procedure is the only procedural alternative to control BPH symptoms or unremitting hematuria.
4. The embolization procedure will be performed by an Interventional Radiologist physician(s) who have received appropriate interventional embolization training in the prostate region to perform highly selective embolization.
5. The embolization procedure uses Embosphere microspheres.
6. The ordering physician has documented that the patient is not planning to father children in the future or has discussed with the patient that the effects of the procedure on fertility have not been determined and they agree to proceed.

B. Criteria for Medical Necessity:

1. Prostate Artery Embolization is considered medically necessary in men for treatment of benign prostatic hypertrophy who meet ALL the following criteria:
   a. Aged 40 years or older, AND
   b. Have a diagnosis of symptomatic benign prostatic hypertrophy (BPH) that is refractory to medical therapy consistent with ALL of the following:
      i. Patient score of 13 or higher on the IPSS scale, AND
      ii. Prostate size > 80grams, AND
iii. Trial of at least two drugs to treat BPH symptoms without significant improvement of IPSS score, e.g., alpha blockers (alfuzosin, doxazosin, silodosin, tamulosin, terazosin), 5-alpha-reductase inhibitors (dutasteride, finasteride) or tadalafil, OR contraindication to medication therapy; AND

C. Indications Considered Experimental/Investigational or not of Medical Necessity:

2. Prostate artery embolization is considered medically necessary in men for treatment of refractory hematuria of prostate origin in whom other conservative therapy and medical procedures have been unsuccessful at controlling the hematuria.

CPT/HCPCS Codes

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<th>Code</th>
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<tr>
<td>37243</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraproducral road mapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction</td>
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REFERENCES


UpToDate.