DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. 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 (i.e., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this Molina Clinical Policy (MCP) document and provide the directive for all Medicare members.

DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL

The prostatic urethral lift (PUL) or UroLift System is a minimally invasive technology for treating lower urinary tract symptoms due to benign prostatic hyperplasia (BPH). The UroLift is a permanent implant that is inserted during a minimally invasive transurethral outpatient procedure proposed to relieve prostate obstruction and open the urethra directly leaving the prostate intact. The PUL procedure consists of small permanent transprostatic implants placed cystoscopically to compress the prostate tissue, therefore increasing the urethral lumen and reducing obstruction to urine flow. Subsequently, 4 or 5 implants are delivered into the prostatic urethra to maintain urethral patency. A final cystoscopy confirms that the implants were appropriately positioned. Most common adverse events reported include hematuria, dysuria, micturition urgency, pelvic pain, and urge incontinence.

On September 13, 2013, the FDA approved the UroLift for marketing through a de novo classification as a class II device used as a permanent implant to relieve low or blocked urine flow in men aged 50 and older with BPH. According to the FDA The UroLift® System should not be used if the patient has any of the following conditions: 2

- Prostate volume of >80 cc
- An obstructive or protruding median lobe of the prostate
- A urinary tract infection
- Urethra conditions that may prevent insertion of delivery system into bladder
- Urinary incontinence
- Current gross hematuria
- A known allergy to nickel
RECOMMENDATION

Prostatic urethral lift or UroLift for Benign Prostatic Hyperplasia (BPH) is considered experimental, investigational and unproven due to insufficient evidence in the peer reviewed medical literature that that have not established safety, efficacy and effect on net health outcomes.

SUMMARY OF MEDICAL EVIDENCE

There is insufficient published evidence to assess the role of the Prostatic urethral lift (PUL) or UroLift for the treatment of patients with for benign prostatic hyperplasia including the safety and/or impact on health outcomes or patient management. The Prostatic Urethral Lift or UroLift is being investigated as a minimally invasive alternative to drug therapy and/or surgery. While the available evidence on the efficacy and safety of the UroLift system for treatment of symptomatic BPH is promising and consistent across the studies, the overall quality of the evidence is low. The pivotal L.I.F.T. Study is limited by a high attrition rate and inadequate follow-up to determine long-term safety and durability of the device. In addition, after 3 months, this RCT was unblinded, which may have affected later results. Several studies were performed by the same group of investigators and no study was completely independent of the manufacturer. Although most outcome measures were subjective, most studies were unblinded so that patient responses may have been influenced by knowledge of assigned treatment. All of the studies were relatively small in size or lost patients over time. The UroLift may be a viable alternative for men who require surgical therapy for BPH due to medically refractory symptoms, but additional data are needed from long-term RCTs to confirm these promising results. Direct comparisons of the UroLift procedure with other surgical or medical treatments for BPH are needed.

A summary of the most relevant studies are outlined below.

The best available published evidence is limited to the randomized sham-controlled FDA pivotal LIFT trial reported by Roehrborn et al. (2013) of a PUL device for treatment of lower urinary tract symptoms (LUTS) secondary to BPH. The patient and questionnaire administrator were blinded to the randomization. Men aged > 50 years with an American Urological Association Symptom Index (AUASI) of > 13, a maximum flow rate of 12 ml/second or less, and a prostate of 30 to 80 cc were randomized 2:1 to PUL or sham. The sham consisted of rigid cystoscopy with sounds mimicking those heard with the PUL placement. At three months, the AUASI reduction was assessed; the primary end point of the study was to have an AUASI reduction of 25% greater than the sham. The PUL patients had an AUASI reduction of 11.1 + 7.67 whereas the sham patients change was 5.9 + 7.66 (P = 0.003) at three months. The PUL reduction remained at 12 months. Peak urinary flow was increased 4.4 ml at 3 months and remained at 4.0 ml/second at 12 months (p <0.001). There was no new ejaculatory or erectile dysfunction. Adverse events were described as mild and transient. There was a 5% retreatment rate at one year. A follow up to this study by Roehrborn et al. (2015) reported that at 2 years, 106 men treated with the UroLift were evaluable for the per-protocol analysis. In these patients, the AUASI score (−9.2 ± 7.57), QOL (−2.2 ± 1.71), and Qmax (mean 4.2 mL per second) remained improved by 42%, 48%, and 58%, respectively (P<0.0001 for all) (Roehrborn et al., 2014). The reduction in the BPHII score was also sustained compared with baseline (−55.6 ± 3.4) (P<0.0001).
McVary et al. (2013) analyzed the sexual function of the men in the Roehrborn et al. study immediately above. Men ≥50 years with prostates 30-80 cc, International Prostate Symptom Score (IPSS) >12, and peak urinary flow rate (Qmax) ≤12 ml/s were randomized 2:1 between PUL and sham. Blinded groups were compared at 3 months and active arm then followed to 12 months for LUTS with IPSS and for sexual function with sexual health inventory for men (SHIM) and Male Sexual Health Questionnaire for Ejaculatory Dysfunction (MSHQ-EjD). No evidence of degradation in erectile or ejaculatory function after PUL was found. SHIM and MSHQ-EjD scores were not different from control at 3 months but were modestly improved and statistically different from baseline at 1 year. 7

McNicholas et al. (2013) described the outcomes of 102 men with symptomatic BPH treated at seven centers in five countries. The study was had a single arm and was not blinded. Average age was 68 years, average prostate size was 48 cm3, and average IPPS was 23. Patients were followed at 2 and 6 weeks, and 3, 6, and 12 months postoperatively. The mean IPPS improved 36%, the mean QOL improved 39%, and the maximum flow rate (Qmax) improved by 38% by two weeks. At 12 months observation, these rates of improvement were 52%, 53% and 51% respectively. These results were statistically significant although the postvoid residual volume (PVR) did not show a statistically significant change. There were no reports of retrograde ejaculation. Transurethral resection of the prostate (TURP) occurred in four patients (6.5%). Adverse events were short duration of dysuria (25%), hematuria (16%), and urgency (10%). 6

Cantwell et al. (2014) conducted a prospective crossover trial of PUL in patients with LUTS due to BPH. Men > 50 years old with an IPPS > 13, a Qmax of <12 mL/s, and a prostate of 30-80 mL were enrolled. The study was prospective, randomized, controlled, “blinded,” and conducted in 19 centers in the USA, Canada, and Australia. Patients underwent a sham procedure with rigid cystoscopy, inability to see the operator or endoscopy imaging, and hearing sounds associated with an operative procedure. Three to six months later the patients were re-assessed and a PUL was placed. At entry, there were 66 men; 53 (80%) elected to have the PUL. There was a similar change in the IPPS for both sham and crossover PUL patients at two weeks, but the change continued to increase in the latter group and reached statistical significance at three months. In contrast, the urinary flow rate change was more durable three months after the sham rigid cystoscopy showing a 2.4 mL/s increase in Qmax at 3 months. There was further improvement at 3 months post-PUL which was maintained at 12 months. Improvements in IPPS 3 months post-PUL was 11.1 points or 122% greater than the 3 month post-sham improvement of 5.0 points (P < 0.001). Improvements were similar to those noted in the study by Roehrborn et al. (2013) described above. Clinically and statistically significant improvement in Health Related Quality of Life (HRQL) scores and BPHII post-PUL also occurred. Sexual function was maintained. Adverse events were primarily mild except for two patients who developed urinary retention. One patient progressed to TURP. 3

Chin et al. (2012) evaluated a prostatic urethral lift (PUL) device placed in 64 men, > 55 years old, with moderate to severe symptomatic benign prostatic hyperplasia treated in six (6) Australian facilities. Effectiveness was evaluated at 2 weeks and 3, 6, 12, and 24 months. The International Prostate Symptom Score (IPPS) decreased 42% in 2 weeks, 49% at 6 months, and 42% at two years. Patients treated early in the study had a 34% decrease at three years. The quality of life score (QOL) score improved from an average of 4.9 at baseline to 2.7 at 2 weeks, and 2.5 at one and two years. The BPH Impact Index (BPHII) decreased 39% at 2
weeks with a 60% reduction at 2 years; these results were statistically significant at each measurement period. Peak flow increased an average amount of > 30% at all intervals. There were no findings of degraded erectile function. Numbers of evaluable patients were not clear although it was noted that the sample size was reduced at 24 months because not all of the patients had reached that point of follow-up. There was no active or sham control group. Twenty percent (20%) (13/64) of the initially treated patients required repeat treatment.  

**CODING INFORMATION**  
THE CODES LISTED IN THIS POLICY ARE FOR REFERENCE PURPOSES ONLY. LISTING OF A SERVICE OR DEVICE CODE IN THIS POLICY DOES NOT IMPLY THAT THE SERVICE DESCRIBED BY THIS CODE IS COVERED OR NON-COVERED. COVERAGE IS DETERMINED BY THE BENEFIT DOCUMENT. THIS LIST OF CODES MAY NOT BE ALL INCLUSIVE.

<table>
<thead>
<tr>
<th>CPT</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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9739</td>
<td>Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants</td>
</tr>
<tr>
<td>C9740</td>
<td>Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description: [For dates of service prior to 10/01/2015]</th>
</tr>
</thead>
<tbody>
<tr>
<td>600-0.0.1</td>
<td>Hypertrophy (benign) of prostate range of codes</td>
</tr>
<tr>
<td>600.2-600.21</td>
<td>Benign localized hyperplasia of prostate range of codes</td>
</tr>
<tr>
<td>600.9-600.91</td>
<td>Hyperplasia of prostate, unspecified range of codes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description: [For dates of service on or after 10/01/2015]</th>
</tr>
</thead>
<tbody>
<tr>
<td>N40.0-N40.3</td>
<td>Enlarged prostate range of codes</td>
</tr>
</tbody>
</table>

**REFERENCES**

**Government Agency**


**Peer Reviewed Publications**

3. Cantwell AL, Bogache WK, Richardson SF, Tutrone RF, Barkin J, Fagelson JE, Chin PT, Woo HH.


Professional Organization Guidelines


Hayes


Other Resources