

Prostatic Urethral Lift

Policy # 00480

Original Effective Date: 10/21/2015

Current Effective Date: 12/01/2025

Retired Effective Date: 03/16/2016

Returned to Active Status: 12/01/2020

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: Transurethral Water Vapor Thermal Therapy for Benign Prostatic Hyperplasia is addressed separately in medical policy 00684.

Note: Temporarily Implanted Nitinol Device (iTind) for Benign Prostatic Hyperplasia is addressed separately in medical policy 00825.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider the use of prostatic urethral lift in individuals with moderate-to-severe lower urinary tract obstruction due to benign prostatic hyperplasia when all of the following criteria are met to be **eligible for coverage:****

Patient Selection Criteria

Coverage eligibility for prostatic urethral lift will be considered when all of the following criteria are met:

- The individual has persistent or progressive lower urinary tract symptoms despite medical therapy (α_1 -adrenergic antagonists maximally titrated, 5 α -reductase inhibitors, or combination medication therapy maximally titrated) over a trial period of no less than 12 weeks, or is unable to tolerate medical therapy; AND,
- Prostate gland volume is ≤ 80 mL; AND,
- Prostate anatomy demonstrates normal bladder neck without an obstructive or protruding median lobe; AND,
- Individual does not have active urinary tract infection or recent prostatitis (within past year); AND,
- Individual has had appropriate testing to exclude diagnosis of prostate cancer; AND,
- Individual does not have a known allergy to nickel, titanium or stainless steel; AND,
- The individual is 45 years of age or older.

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When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of prostatic urethral lift in other situations, including repeat procedures, to be **investigational**.*

The use of prostatic urethral lift when patient selection criteria are not met is considered to be **investigational**.*

Background/Overview

Benign Prostatic Hyperplasia

Benign prostatic hyperplasia (BPH) is a common disorder among older individuals that results from hyperplastic nodules in the periurethral or transitional zone of the prostate. The clinical manifestations of BPH include increased urinary frequency, nocturia, urgency or hesitancy to urinate, and a weak stream when urinating. The urinary tract symptoms often progress with worsening hypertrophy and may lead to acute urinary retention, incontinence, renal insufficiency, and/or urinary tract infection. Benign prostatic hyperplasia prevalence increases with age and is present in more than 80% of individuals ages 70 to 79 years.

Two scores are widely used to evaluate BPH-related symptoms: the American Urological Association Symptom Index (AUASI) and the International Prostate Symptom Score (IPSS). The AUASI is a self-administered 7-item questionnaire assessing the severity of various urinary symptoms. Total AUASI scores range from 0 to 35, with overall severity categorized as mild (≤ 7), moderate (8-19), or severe (20-35). The IPSS incorporates questions from the AUASI and a quality of life question or a "Bother score."

Evaluation and management of BPH include assessment for other causes of lower urinary tract dysfunction (eg, prostate cancer), symptom severity, and the degree that symptoms are bothersome to determine the therapeutic approach.

For patients with moderate-to-severe symptoms (eg, an AUASI score of ≥ 8), bothersome symptoms, or both, a discussion about medical therapy is reasonable. Benign prostatic hyperplasia should generally be treated medically first. Available medical therapies for BPH-related lower urinary tract dysfunction include α -adrenergic blockers (eg, alfuzosin, doxazosin, tamsulosin, terazosin, silodosin), 5 α -reductase inhibitors (eg, finasteride, dutasteride), combination α -adrenergic blockers and 5 α -reductase inhibitors, anti-muscarinic agents (eg, darifenacin, solifenacin, oxybutynin), and phosphodiesterase-5 inhibitors (eg, tadalafil). In a meta-analysis of both indirect comparisons from

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placebo-controlled studies (including 6,333 patients) and direct comparative studies (including 507 patients), Djavan et al (1999) found that the IPSS improved by 30% to 40% and the Qmax score (mean peak urinary flow rate) improved by 16% to 25% in individuals assigned to α -adrenergic blockers. Combination therapy using an α -adrenergic blocker and 5 α -reductase inhibitor has been shown to be more effective for improving IPSS than either treatment alone, with median scores improving by more than 40% over 1 year and by more than 45% over 4 years.

Patients who do not have sufficient response to medical therapy, or who are experiencing significant side effects with medical therapy, may be referred for surgical or ablative therapies. Various surgical and ablative procedures are used to treat BPH. Transurethral resection of the prostate (TURP) is generally considered the reference standard for comparisons of BPH procedures. In the perioperative period, TURP is associated with risks of any operative procedure (eg, anesthesia risks, blood loss). Although short-term mortality risks are generally low, a large prospective study with 10,654 patients by Reich et al (2008) reported the following short-term complications: "failure to void (5.8%), surgical revision (5.6%), significant urinary tract infection (3.6%), bleeding requiring transfusions (2.9%), and transurethral resection syndrome (1.4%)." Incidental carcinoma of the prostate was diagnosed by histologic examination in 9.8% of patients. In the longer term, TURP is associated with an increased risk of sexual dysfunction and incontinence.

Several minimally invasive prostate ablation procedures are available, including transurethral microwave thermotherapy, transurethral needle ablation of the prostate, urethromicroablation phototherapy, and photoselective vaporization of the prostate. The minimally invasive procedures were individually compared with TURP at the time they were developed, which provided a general benchmark for evaluating those procedures. The American Urological Association (AUA) recommends surgical intervention for patients who have "renal insufficiency secondary to BPH, refractory urinary retention secondary to BPH, recurrent urinary tract infections (UTIs), recurrent bladder stones or gross hematuria due to BPH, and/or with lower urinary tract symptoms (LUTS) attributed to BPH refractory to and/or unwilling to use other therapies."

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

One implantable transprostatic tissue retractor system has been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. In 2013, the NeoTract UroLift®[†] System UL400 (NeoTract) was cleared (after receiving clearance through the FDA's de novo classification process in March 2013; K130651/DEN130023). In 2016, the FDA determined that the UL500 was substantially equivalent to existing devices (UL400) for the treatment of symptoms of urinary flow obstruction secondary to BPH in individuals ages 50 years and older. In 2017, the FDA expanded the indication for the UL400 and UL500 to include *lateral and median* lobe hyperplasia

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in men 45 years or older. An additional clearance in 2019 (K193269) modified an existing contraindication for use from men with a prostate volume of >80 cc to men with a prostate volume of >100 cc. FDA product code: PEW.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Benign prostatic hyperplasia (BPH) is a common condition in older individuals that can lead to increased urinary frequency, an urgency to urinate, a hesitancy to urinate, nocturia, and a weak stream when urinating. The prostatic urethral lift (PUL) procedure involves the insertion of 1 or more permanent implants into the prostate, which retracts prostatic tissue and maintains an expanded urethral lumen.

Summary of Evidence

For individuals who have lower urinary tract obstruction symptoms due to benign prostatic hyperplasia (BPH) who do not have sufficient response to medical therapy or are experiencing significant side effects with medical therapy and receive a prostatic urethral lift (PUL), the evidence includes systematic reviews, randomized controlled trials (RCTs), and nonrandomized studies. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. One RCT, the BPH6 study, compared the PUL procedure with transurethral resection of the prostate (TURP) and reported that the PUL procedure was noninferior for the study's composite endpoint, which required concurrent fulfillment of 6 independently validated measures of symptoms, safety, and sexual health. While TURP was superior to PUL in managing lower urinary tract symptoms, PUL did provide significant symptom improvement over 2 years. PUL was further superior to TURP in preserving ejaculatory function. These findings were corroborated by another RCT (the LIFT study), which compared PUL with sham control. Patients underwent washout of BPH medications before enrollment. LIFT reported that patients with the PUL procedure, compared with patients who had sham surgery and no BPH medication, had greater improvements in lower urinary tract symptoms without worsened sexual function at 3 months. After 3 months, patients were given the option to have PUL surgery; 80% of the patients with sham procedures chose that option. Publications from this trial reported these findings were preserved in a subset of patients over 3 to 5 years; however, a high number of patients were either excluded or lost to follow-up during this time. The BPH6 and LIFT RCTs included men with a prostate volume

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up to 80 cm³ and excluded men with median lobe obstruction. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have lower urinary tract obstruction symptoms due to BPH who have had a prior PUL procedure who are treated with a repeat PUL, the evidence includes long-term follow-up data from the LIFT study, systematic reviews, and reports on care setting real world experience. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. Clinical data on the occurrence of repeat PUL, and consensus on clinically relevant definitions of retreatment/reintervention and subsequent outcomes are lacking. The 5 year surgical reintervention rate in the LIFT study was reported as 13.6%, while a meta-analysis concluded that the surgical reintervention rate following PUL is 6% per year. An analysis of clinical care setting real world experience reported the overall retreatment rate at 1 and 2 years to be 5.2% (95% confidence interval [CI], 4.2 to 6.1) and 11.9% (95% CI, 10.1 to 13.6), respectively, following an initial PUL. A retrospective healthcare system database analysis of endoscopic procedures for BPH found that patients treated with PUL were almost twice as likely to be retreated at 2-year follow-up compared to those receiving TURP (odds ratio [OR], 1.78; p<.01). The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2017

Clinical input was sought to help determine whether the use of PUL for individuals with lower urinary tract obstruction symptoms due to BPH who do not have sufficient response to medical therapy or are experiencing significant side effects with medical therapy would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, while this policy was under review in 2017, clinical input on the use of a prostatic urethral lift for 3 indications were received from 4 respondents, including 2 physician-level responses identified through a specialty society and 2 physician-level responses identified through an academic medical center. Input consistently supported that the use of PUL for individuals with moderate-to-severe lower urinary tract obstruction symptoms due to BPH provides a clinically meaningful improvement in net health outcome and indicates this use is consistent with generally accepted medical practice. See Appendices 1 and 2 for details of the clinical input.

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Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Urological Association

In 2018, the American Urological Association published guidelines on the surgical management of LUTS attributed to BPH; the 2018 guidelines were most recently amended in 2021. The guidelines made the following recommendations and statements regarding prostatic urethral lift (PUL).

- "PUL may be offered as an option for patients with LUTS [lower urinary tract symptoms] /BPH [benign prostatic hyperplasia] provided prostate volume 30-80cc and verified absence of an obstructive middle lobe "
 - "Moderate Recommendation; Evidence Level: Grade C indicating "Benefits > Risks/Burdens (or vice versa); Net benefit (or net harm) appears moderate. Applies to most patients in most circumstances but better evidence is likely to change confidence"
- "PUL may be offered as a treatment option to eligible patients who desire preservation of erectile and ejaculatory function."
 - "Conditional Recommendation; Evidence Level: Grade C indicating "Risks/Burdens unclear; Alternative strategies may be equally reasonable. Better evidence likely to change confidence"
- "Clinicians should inform patients of the possibility of treatment failure and the need for additional or secondary treatments when considering surgical and minimally-invasive treatments for LUTS/BPH."
- "Surgery is recommended for patients who have renal insufficiency secondary to BPH, refractory urinary retention secondary to BPH, recurrent urinary tract infections (UTIs), recurrent bladder stones or gross hematuria due to BPH, and/or with LUTS/BPH refractory to or unwilling to use other therapies."

National Institute for Health and Care Excellence

In 2014, the National Institute for Health and Care Excellence published guidance on urethral lift implants to treat lower urinary tract symptoms (LUTS) secondary to benign prostatic hyperplasia (BPH). The guidance stated:

"Current evidence on the efficacy and safety of insertion of prostatic urethral lift implants to treat lower urinary tract symptoms secondary to benign prostatic hyperplasia is adequate to support the use of this procedure."

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In 2021, the National Institute for Health and Care Excellence published updated guidance on the use of UroLift for treating LUTS of BPH. The guidance stated: "the UroLift system relieves lower urinary tract symptoms, avoids risk to sexual function, and improves quality of life " and "the UroLift system should be considered as an alternative to transurethral resection of the prostate (TURP) and holmium laser enucleation of the prostate (HoLEP). It can be done as a day-case or outpatient procedure for people aged 50 and older with a prostate volume between 30 and 80 mL."

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT06037356	Prostatic Urethral Lift Versus Transurethral Resection of Prostate in Benign Prostatic Hyperplasia Patients With Urinary Retention	100	May 2032 (recruiting)
NCT04987892 ^a	Investigating Medication vs. Prostatic Urethral Lift: Assessment and Comparison of Therapies for Benign Prostatic Hyperplasia	250	Oct 2025 (recruiting)
NCT05784558 ^a	RELIEF Study: Real-world Evaluation of LUTS Interventions and Patient Experience During Follow-up	2500	Dec 2030 (not yet recruiting)
NCT04726748	Economic Evaluation of Prostatic Urethral Lift (Urolift)	1360	Dec 2025

NCT: national clinical trial.

^a Denotes industry-sponsored or cosponsored trial.

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10/08/2015 Medical Policy Committee review

10/21/2015 Medical Policy Implementation Committee approval. New Policy

03/16/2016 Medical Policy Implementation Committee approval. Retired

08/06/2020 Medical Policy Committee review

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08/12/2020	Medical Policy Implementation Committee approval. Brought back to active status. Added "The patient is 45 years of age or older" to criteria.
09/03/2020	Medical Policy Committee review
09/09/2020	Medical Policy Implementation Committee approval. Repeat procedures explicitly added to the investigational policy statement; statements otherwise unchanged.
10/07/2021	Medical Policy Committee review
10/13/2021	Medical Policy Implementation Committee approval. No change to coverage.
11/03/2022	Medical Policy Committee review
11/09/2022	Medical Policy Implementation Committee approval. Added trial period of 12 weeks of medical therapy to coverage criteria, and also added that the individual has not had an active to urinary tract infection within the last year.
11/02/2023	Medical Policy Committee review
11/08/2023	Medical Policy Implementation Committee approval. No change to coverage.
11/07/2024	Medical Policy Committee review
11/13/2024	Medical Policy Implementation Committee approval. No change to coverage.
04/16/2025	Coding update
11/06/2025	Medical Policy Committee review
11/12/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 11/2026

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)†, copyright 2024 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of Louisiana Blue Medical Policy Coverage Guidelines is with Louisiana Blue and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Louisiana Blue Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Louisiana Blue Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which

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contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	52441, 52442
HCPSC	C9739, C9740 Delete code effective 05/01/2025: L8699
ICD-10 Diagnosis	All Related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;

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- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.