

MEDICAL POLICY

POLICY TITLE	PROSTATIC URETHRAL LIFT
POLICY NUMBER	MP 1.147

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective date:	8/1/2026

POLICY

Use of prostatic urethral lift in individuals with moderate-to-severe lower urinary tract obstruction due to benign prostatic hyperplasia may be considered **medically necessary** 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 6 months, 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 urinary retention related to conditions other than benign prostatic hyperplasia, 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.

Use of prostatic urethral lift in other situations, including repeat procedures, is considered **investigational**. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

Policy Guidelines

Use of temporarily implanted nitinol devices for benign prostatic hyperplasia is addressed separately in **MP 1.164**.

Cross-References:

MP 1.164 Temporarily Implanted Nitinol Device (iTind) for Benign Prostatic Hyperplasia

MP 4.043 Focal Treatments for Prostate Cancer

MP 4.053 Transurethral Water Vapor Thermal Therapy and Transurethral Water Jet Ablation (Aquablation) for Benign Prostatic Hypertrophy

MP 4.054 Hydrogel Spacer Use During Radiotherapy for Prostate Cancer

MP 5.053 Magnetic Resonance–Guided Focused Ultrasound

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PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:

<https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies>.

DESCRIPTION/BACKGROUND

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 (e.g., prostate cancer), symptom severity, and the degree that symptoms are bothersome to determine the therapeutic approach.

For patients with moderate-to-severe symptoms (e.g., 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 (e.g., alfuzosin, doxazosin, tamsulosin, terazosin, silodosin), 5 α -reductase inhibitors (e.g., finasteride, dutasteride), combination α -adrenergic blockers and 5 α -reductase inhibitors, anti-muscarinic agents (e.g., darifenacin, solifenacin, oxybutynin), and phosphodiesterase-5 inhibitors (e.g., tadalafil). In a meta-analysis of both indirect comparisons from 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.

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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 (e.g., 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."

Regulatory Status

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 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

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

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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 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.

Additional Information

2017 Input

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 PUL 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.

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DEFINITIONS

N/A

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when Medically Necessary:

Procedure Codes								
52441	52442	C9739	C9740					

ICD-10-CM Diagnosis Code	Description
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms

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POLICY HISTORY

MP 1.147	05/25/2018 Retirement Review. Rationale condensed to summary of evidence only. Policy criteria moved to MP 4.043 Treatments of the Prostate. Retirement effective 12/01/2018.
	06/27/2025 Minor Review. Policy brought out of retirement with revised criteria. Updated all sections of the policy.
	04/08/2026 Consensus Review. No changes to coding. References updated.

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