

Evidence Based Guideline

Transurethral Microwave Thermotherapy for Benign Prostatic Hyperplasia

File Name: transurethral_microwave_thermotherapy_for_benign_prostatic_hyperplasia
Guideline Number: EBG.RAD5210
Origination: 1/1997
Last Review: 7/2003

Active guideline, no longer scheduled for routine literature review.

Description of Procedure or Service

Transurethral microwave thermotherapy (TUMT) is an alternative to transurethral resection of the prostate for patients who have benign prostatic hyperplasia (BPH). The prostate gland often enlarges as men age. This is called benign (not malignant) prostatic hyperplasia (a type of overgrowth of tissues in the body). Since the prostate gland surrounds the urethra (the tube-like structure that carries urine from the bladder out through the penis), it may block the flow of urine. Symptoms include the need to frequently empty the bladder, especially at night, difficulty in starting the urine flow or dribbling after urination ends. Also, size and strength of the urine stream may decrease. TUMT is a non surgical procedure performed with the goal of releasing the partial blockage caused by an enlarged prostate gland. The procedure is performed with a specially designed catheter that creates heat to destroy the enlarged prostate tissue. The catheter system has a built in cooling system that protects adjacent tissue such as the urethra. As the treated prostate tissue heals, it shrinks, reducing the blockage of urine, thus achieving improvement in symptoms and voiding.

Prostatron is the most recent device with FDA (Food and Drug Administration) approval for this type of treatment.

Microwave thermotherapy is not to be confused with an earlier technique of microwave treatment, microwave hyperthermia, which has largely been abandoned.

Evidence Based Guideline for Transurethral Microwave Thermotherapy (TUMT)

TUMT may be appropriate for patients with severe benign prostatic hyperplasia who would be candidates for transurethral resection of the prostate and who have prostatic lengths of 35-50 mm.

Medical Evidence regarding Transurethral Microwave Thermotherapy (TUMT) indicates it is not recommended in the following situations:

For any criteria other than shown above.

This procedure is contraindicated for patients with cardiac pacemakers or implanted defibrillators.

For technical reasons, transurethral microwave thermotherapy is not recommended for patients who have large prostate glands (greater than 5 cm in length or larger than 70 g in volume), median lobe enlargement, or bladder neck stenosis.

Policy: Transurethral Microwave Thermotherapy for Benign Prostatic Hyperplasia

Benefits Application

Please refer to certificate for availability of benefit. This guideline relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore certificate language should be reviewed before applying the terms of the policy.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 53850

Medical Term Definitions

N/A

Scientific Background and Reference Sources

TEC Evaluation - 9/11/96

BCBSA Medical Policy Reference Manual - Policy 7.01.52 - 11/30/96

Medical Policy Advisory Group 10/99

Specialty Matched Consultant Review 7/18/2001

BCBSA Medical Policy Reference Manual - Review date: 4/15/02 - Policy 7.01.52

Specialty Matched Consultant Review 5/2003

Policy Implementation/Update Information

1/97 Original policy issued - National Association reviewed 11/30/96

1/98 Reaffirmed. Added CPT4 code and Policy Guidelines and Benefit Application.

8/99 Reformatted, Medical Term Definitions added.

10/99 Medical Policy Advisory Group - Statement added that this procedure was contraindicated for patients with cardiac pacemakers or implanted defibrillators.

4/01 System changes.

9/01 Specialty Matched Consultant Review. No change to criteria.

7/03 Specialty Matched Consultant Advisory Panel review 5/2003. No changes to criteria. Description section revised for clarity. Statement re: "Microwave thermography" under Benefits Application moved to Description section and "thermography" corrected to "thermotherapy". Benefits Application statement revised. Policy status changed to "Active policy, no longer scheduled for routine literature review."

9/18/06 Medical Policy changed to Evidence Based Guideline.

Policy: Transurethral Microwave Thermotherapy for Benign Prostatic Hyperplasia

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.