

**To:** AmeriHealth Caritas Louisiana Providers

**Date:** April 1, 2026

**Subject:** LDH Approved Clinical Policies

**Summary:** Five LDH Approved Clinical Policies.

AmeriHealth Caritas Louisiana would like to inform you of five updated clinical policies that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guidelines are effective **May 1, 2026**, and will be located at the following link on our website under Clinical Policies: <https://www.amerihealthcaritasla.com/provider/resources/index.aspx>.

1. Cochlear Implants
2. Microwave Thermotherapy for Lung and Kidney Tumors
3. Opioid Treatment
4. Prostatic Urethral Lift/UroLift for Benign Prostatic Hyperplasia
5. Prosthetic Devices

Reminder: If your practice is not registered with our website portal, NaviNet, we highly recommend registering. To register, please visit [www.navinet.net](http://www.navinet.net) to sign up or contact your Provider Account Executive for details.

**Questions:**

Thank you for your continued support and commitment to our patients' care. If you have questions about this communication, please get in touch with AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your [Provider Network Management Account Executive](#).

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**Need to update your provider information?** Send full details to [network@amerihealthcaritasla.com](mailto:network@amerihealthcaritasla.com)

# Cochlear implants

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4006

Recent review date: 9/2025

Next review date: 1/2027

Policy contains: Unilateral or bilateral cochlear implants.

*AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered by AmeriHealth Caritas Louisiana, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.*

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## Policy statement

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AmeriHealth Caritas Louisiana covers unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in members younger than 21 years of age. Implants must be used in accordance with Food and Drug Administration (FDA) guidelines.

AmeriHealth Caritas Louisiana requires a multi-disciplinary implant team to collaborate on determining eligibility and providing care that includes, at minimum: a fellowship-trained pediatric otolaryngologist or fellowship-trained otologist, an audiologist, and a speech-language pathologist.

An audiological evaluation must find:

- Severe-to-profound hearing loss determined using an age-appropriate combination of behavioral and physiological measures; and
- Limited or no functional benefit achieved after a sufficient trial of hearing aid amplification.

A medical evaluation must include:

- Medical history;
- Physical examination verifying the candidate has intact tympanic membrane(s), is free of active ear disease, and has no contraindication for surgery under general anesthesia;

- Verification of receipt of all recommended immunizations;
- Verification of accessible cochlear anatomy that is suitable to implantation, as confirmed by imaging studies (computed tomography (CT) and/or magnetic resonance imagery (MRI)), when necessary; and
- Verification of auditory nerve integrity, as confirmed by electrical promontory stimulation, when necessary.

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the member.

Non-audiological evaluations must include:

- Speech and language evaluation to member's level of communicative ability; and
- Psychological and/or social work evaluation, as needed.

Pre-operative counseling shall be provided to the member, if age appropriate, and the member's caregiver and will provide:

- Information on implant components and function; risks, limitations, and potential benefits of implantation; the surgical procedure; and postoperative follow-up schedule;
- Appropriate post-implant expectations, including being prepared and willing to participate in pre- and postimplant assessment and rehabilitation programs; and
- Information about alternative communication methods to cochlear implants.

#### Prior Authorization and Reimbursement

All aspects of cochlear implant care (preoperative evaluation, implantation, implants, repairs, supplies, therapy) must be prior authorized.

If prior authorized, AmeriHealth Caritas Louisiana reimburses for preoperative evaluation services (i.e., evaluation of speech, language, voice, communication, auditory processing, and/or audiologic/aural rehabilitation) even when the member may not subsequently receive an implant.

At the time of surgery, AmeriHealth Caritas Louisiana reimburses the hospital for both the implant and the per diem.

AmeriHealth Caritas Louisiana shall cover other necessary equipment, repairs, and replacements according to the Durable Medical Equipment fee schedule.

Only one cochlear implant per lifetime, per ear, per eligible member shall be reimbursed unless the implant fails or is damaged beyond repair, in which case reimbursement for another implant and re-implantation will be considered.

AmeriHealth Caritas Louisiana shall cover the cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language, and hearing therapy.

AmeriHealth Caritas Louisiana shall cover cochlear implant post-operative programming and diagnostic analysis services.

The following expenses related to the maintenance of each cochlear implant device will be covered if prior authorized:

1. All costs for upgrades and repairs to the component parts of the implant; and
2. All costs for cords and batteries.

#### Non-Covered Expenses of Cochlear Device(s)

The following items are non-covered expenses:

1. Service contracts and/or extended warranties; and
2. Insurance to protect against loss and theft.

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## References

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Louisiana Department of Health. Medicaid Services Manual. Chapter 5. Professional Services. Cochlear implants. <https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf> Last updated 08/12/2024.

Louisiana Department of Health. Medicaid Services Manual. Chapter 25. Hospital Services. Section 25.6 Prior authorization. Cochlear implants. <https://www.lamedicaid.com/provweb1/providermanuals/manuals/Hosp/Hosp.pdf>. Last updated 05/12/2025.

Louisiana Department of Health. Medicaid Services Manual. Chapter 18. Durable Medical Equipment. Section 18.2.16 Cochlear Implant (Early and Periodic Screening, Diagnostic and Treatment - Only) coverage criteria. <https://www.lamedicaid.com/provweb1/providermanuals/manuals/DME/DME.pdf>. Last updated 06/25/2025.

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## Policy updates

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Initial review date: 3/2/2021

2/2023: Policy references updated.

9/2023: Policy references updated, to reflect AmeriHealth Caritas Louisiana manual.

9/2024: Policy references updated.

9/2025: Policy references updated. Coverage modified.

# Microwave Thermotherapy for Lung and Kidney Tumors

Clinical Policy ID: CCP.1528

Recent review date: 7/2025

Next review date: 11/2026

Policy contains: Image-guided thermal ablation, microwave ablation, non-small cell lung cancer, percutaneous ablation, renal cell carcinoma

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## Coverage policy

See also CCP.1397 Microwave thermotherapy for breast cancer.

Microwave thermotherapy (ablation) of a primary or metastatic lung tumor is clinically proven and, therefore, may be medically necessary when all of the following criteria are met (National Comprehensive Cancer Network, 2025):

- The member is either:
- Is deemed medically inoperable due to the location or extent of the lesion or due to comorbid conditions.
- Will not receive stereotactic ablative radiotherapy or definitive radiation therapy.
- A single tumor is less than or equal to 3 centimeters in size.

Microwave ablation of malignant kidney tumors is clinically proven and, therefore, may be medically necessary when all of the following are met (National Comprehensive Cancer Network, 2025a):

- The member either is not a candidate for surgery due to other medical conditions or presents a significant risk of illness or death from the procedure.
- The tumor is a clinical stage one renal lesion that is 3 centimeters or less in diameter.

#### Limitations

No limitations were identified during the writing of this policy.

#### Alternative covered services

- Radiofrequency ablation.
- Cryoablation.
- Surgical resection.
- Stereotactic radiosurgery.
- Definitive radiation therapy.

## Background

Tumor ablation is a minimally invasive technique that applies chemical or thermal methods under image guidance to induce cellular necrosis and destroy solid tumors while sparing adjacent tissue. Thermal ablation is accomplished by cooling or heating the targeted tissue to less than minus 40 degrees Celsius or more than 60 degrees Celsius, which will achieve cytotoxicity in most tissues. Depending on the technique, targeted tissues may be accessed percutaneously, laparoscopically, intraoperatively, endoscopically, or, in the case of high-intensity focused ultrasound, extracorporeally, to achieve locoregional tumor control (Gala, 2020).

Several minimally invasive thermal ablative modalities are available: radiofrequency, laser, cryoablation, high-intensity focused ultrasound, and microwave. Irreversible electroporation is a nonthermal option that applies short pulses of a strong electrical current to form permanent nanopores within the cell membrane to induce cell death. Radiofrequency is the most commonly used ablative modality for locoregional tumor eradication, but microwave ablation has emerged as an alternative (Gala, 2020).

Microwave systems comprise a microwave generator, a coaxial cable, and a 14 to 17-gauge antenna to transmit the waves to the tissue. Antenna (needle) placement is achieved using ultrasound, computed tomography, or fluoroscopic guidance, depending on lesion location. Total tumor necrosis can be achieved when temperature remains at 54 degrees Celsius for at least three minutes, or reaches 60 degrees Celsius instantly (Gala, 2020).

Both microwave and radiofrequency methods convert heat energy into coagulative necrosis of tumor cells. Unlike radiofrequency ablation, which uses electrical energy at a frequency of 3 hertz to 300 gigahertz, microwave ablation applies short-duration, high-voltage electromagnetic pulses with frequencies between 900 and 2,450 megahertz. Because of its larger electromagnetic field and rapid heating capabilities, microwave ablation creates a larger, homogenous ablative field and avoids the “heat sink” effect that commonly occurs with radiofrequency ablation of highly vascular solid organs. As a result, higher intratumoral temperatures and larger and predictable ablation zones can be created in a shorter time period. In addition, microwave ablation is not limited by the poor electrical conductivity and thermal conduction of charred or desiccated lung tissue, which can reduce the effectiveness of radiofrequency ablation (Gala, 2020).

For assessing response to locoregional treatment, computed tomography and magnetic resonance imaging are used at regular intervals. The optimal imaging modality for follow-up and imaging interpretation will depend on the therapy used and planned future treatments (American College of Radiology, 2018).

The U.S. Food and Drug Administration (2023) has issued 510(k) premarket approval to several microwave ablation devices as electrosurgical cutting and coagulation devices and accessories for soft tissue ablation.

## Findings

### Lung tumors

#### Overall efficacy and professional recommendations

Microwave ablation is a safe and effective treatment for malignant lung tumors in appropriately selected individuals, a conclusion supported by a substantial body of evidence and professional guidance. The National Comprehensive Cancer Network (2025b) recommends image-guided thermal ablation for primary or secondary lung tumors smaller than 3 centimeters in non-surgical candidates, with the choice of modality depending on tumor characteristics, complication risks, and operator expertise. Generally, microwave ablation is most effective for individuals with tumors smaller than 3 centimeters who are not ideal candidates for surgery. An expert consensus panel from the American Association for Thoracic Surgery identifies microwave ablation, as a form of image-guided thermal ablation, as a reasonable treatment option for high-risk patients with stage I non-small cell lung cancer who are not candidates for standard surgical resection. Surgical resection is generally favored when deemed safe, while stereotactic ablative radiotherapy is recommended as the preferred non-surgical modality. Image-guided thermal ablation techniques, including microwave ablation, are considered subsequent alternatives for patients who are ineligible for, or decline, both surgery and stereotactic ablative radiotherapy. The guideline emphasizes a tiered, individualized approach to treatment selection based on patient risk, tumor characteristics, and patient preferences (Pennathur, 2025).

#### Comparison with surgery and other ablative modalities

Compared to surgery, microwave ablation offers faster recovery and lower morbidity, and it demonstrates comparable or superior outcomes to other modalities in specific contexts. For stage 1 disease, one meta-analysis found no significant difference in overall survival between lobectomy and microwave ablation (Chan, 2021), while another large review found survival rates comparable to stereotactic body radiation therapy and superior to radiofrequency ablation (Laeseke, 2023). Direct comparisons with radiofrequency ablation highlight specific benefits, including less intraprocedural pain ( $P = .0043$ ), greater tumor mass reduction ( $P = .0215$ ), and a significantly shorter ablation duration (Macchi, 2017; Liu, 2025). Evidence on long-term survival is conflicting; while one meta-analysis found no difference in survival (Sun, 2019), another reported higher one- through five-year survival rates for radiofrequency ablation (all  $P < .05$ ) (Yuan, 2019).

#### Combination therapy and specific patient populations

The role of microwave ablation has also been explored in combination with systemic treatments and for specific metastatic disease. For participants with stage 3B and 4 non-small cell lung cancer, adding microwave ablation ( $n = 148$ ) to chemotherapy alone ( $n = 145$ ) significantly improved both progression-free survival (10.3 vs. 4.9 months;  $P < .0001$ ) and overall survival (median not reached vs. 12.6 months;  $P < .0001$ ) (Wei, 2020). In participants with pulmonary metastases from colorectal cancer, a systematic review reported complete remission in 37.0%, local control in 44.8%, and a three-year disease-free survival of 43.2% following microwave ablation (Tan, 2023).

#### Complications, recurrence, and evidence gaps

While generally safe, microwave ablation is associated with known complications, and its effectiveness is limited by variable local recurrence rates and gaps in the evidence. The most common complication is pneumothorax requiring chest tube placement (10% to 52%), with other risks including pleural effusion (7% to 17.22%), pulmonary hemorrhage (10%), and pulmonary infection (7%) (Liu, 2025; Nelson, 2019; Tan, 2023; Wei, 2020).

Furthermore, a key limitation is the highly variable local recurrence rate (9% to 37%), which likely reflects the retrospective nature and heterogeneity of existing studies (Nelson, 2019). The efficacy of ablation also diminishes for tumors exceeding 3 centimeters, underscoring the need for prospective, comparative trials to clarify its role (Lanuti, 2025).

## Kidney tumors

### Evidence and guideline support

For small, localized kidney tumors, microwave ablation is a viable, tissue-sparing option for non-surgical candidates, supported by key professional guidelines and emerging evidence. While partial nephrectomy remains the standard of care for T1a renal cell carcinoma, guidelines from the National Comprehensive Cancer Network (2025a) and the Society of Interventional Radiology (Morris, 2020) now include microwave ablation as an appropriate technique for small renal masses, typically those 3 centimeters or smaller. This support exists even as the evidence base for microwave ablation remains less robust than for radiofrequency ablation or cryoablation, with no randomized controlled trials published to date. The American Urological Association recommends thermal ablation as an alternative to surgery for treatment of clinical T1a solid renal masses smaller than 3 centimeters in size. For patients who elect thermal ablation, the percutaneous technique is preferred over a surgical approach, whenever feasible, to minimize morbidity (Moderate Recommendation; Evidence Level: Grade C). Either radiofrequency ablation or cryoablation may be offered for thermal ablation (Conditional Recommendation; Evidence Level: Grade C). Microwave ablation was not mentioned specifically (Campbell, 2021).

### Comparative efficacy and safety

Systematic reviews find that microwave ablation offers favorable oncologic outcomes. A 2025 meta-analysis reported a 5-year cancer-specific survival rate of 98% and a five-year local control rate of 92% for tumors smaller than 4 centimeters (Huang, 2025). Other reviews suggest microwave ablation provides comparable technical efficacy and survival to radiofrequency ablation and cryoablation, with a potentially lower rate of local recurrence (Castellana, 2023; McClure, 2023). When compared to partial nephrectomy, thermal ablation techniques generally show lower overall survival and local control but offer superior preservation of renal function and lower complication rates (Uhlig, 2019).

### Complications and evidence limitations

Microwave ablation is a technical procedure with known risks. Major post-procedural complications occur in up to six percent of participants, with an overall complication rate of up to 21% (Gunn, 2020). Common complications include hemorrhage, abscess, and damage to adjacent structures (e.g., bowel, ureter). The primary limitation in the field remains the lack of high-quality, long-term data from prospective, randomized trials. Therefore, while microwave ablation is a recommended treatment option for appropriately selected individuals, further research is needed to solidify its long-term comparative effectiveness (Castellana, 2023; Huang, 2025).

In 2025, we updated the coverage policy to include microwave ablation for kidney tumors as a covered service for appropriately selected patients, reorganized the discussion section with clearer thematic headings, and updated references. We added four new 2025 publications: one systematic review/meta-analysis (Huang), one systematic review (Lanuti), one meta-analysis (Liu), and one expert consensus guideline (Pennathur). We also updated the National Comprehensive Cancer Network guidelines for kidney and lung cancers to their 2025 versions.

## References

On June 6, 2025, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “microwave ablation,” “lung neoplasm” (MeSH), “lung cancer,” and “renal cell carcinoma.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

American College of Radiology. LI-RADS® CT/MRI manual. Chapter 9. LI-RADS® Treatment Response. <https://www.acr.org/-/media/ACR/Files/Clinical-Resources/LIRADS/Chapter-9-Treatment-response.pdf>. Published 2018.

Campbell SC, Clark PE, Chang SS, Karam JA, Souter L, Uzzo RG. Renal mass and localized renal cancer: Evaluation, management, and follow-up: AUA guideline: Part I. *J Urol*. 2021;206(2):199-208. Doi: 10.1097/JU.0000000000001911.

Castellana R, Natrella M, Fanelli G, et al. Efficacy and safety of MWA versus RFA and CA for renal tumors: A systematic review and meta-analysis of comparison studies. *Eur J Radiol*. 2023;165:110943. Doi: 10.1016/j.ejrad.2023.110943.

Chan MV, Huo YR, Cao C, Ridley L. Survival outcomes for surgical resection versus CT-guided percutaneous ablation for stage I non-small cell lung cancer (NSCLC): A systematic review and meta-analysis. *Eur Radiol*. 2021;31(7):5421-5433. Doi: 10.1007/s00330-020-07634-7.

Gala KB, Shetty NS, Patel P, Kulkarni SS. Microwave ablation: How we do it? *Indian J Radiol Imaging*. 2020;30(2):206-213. Doi: 10.4103/ijri.IJRI\_240\_19.

Gunn AJ, Parikh NS, Bhatia S. Society of interventional radiology quality improvement standards on percutaneous ablation in renal cell carcinoma. *J Vasc Interv Radiol*. 2020;31(2):195-201.e3. Doi: 10.1016/j.jvir.2019.11.004.

Huang RS, Chow R, Benour A, et al. Comparative efficacy and safety of ablative therapies in the management of primary localised renal cell carcinoma: a systematic review and meta-analysis. *Lancet Oncol*. 2025;26(3):387-398. doi:10.1016/S1470-2045(24)00731-9.

Laeseke P, Ng C, Ferko N, et al. Stereotactic body radiation therapy and thermal ablation for treatment of NSCLC: A systematic literature review and meta-analysis. *Lung Cancer*. 2023;182:107259. Doi: 10.1016/j.lungcan.2023.107259.

Lanuti M, Suh RD, Criner GJ, et al. Systematic review of image-guided thermal ablation for treatment of high-risk patients with stage I non-small cell lung cancer. *Semin Thorac Cardiovasc Surg*. 2025;37(1):82-88. Doi:10.1053/j.semtcvs.2024.11.001.

Liu X, Zhan Y, Wang H, Tang X, Cheng Y, et al. Radiofrequency ablation versus microwave ablation for lung cancer/lung metastases: a meta-analysis. *ANZ J Surg*. 2025;95(1):56-65. Doi:10.1111/ans.19376.

Macchi M, Belfiore MP, Floridi C, et al. Radiofrequency versus microwave ablation for treatment of the lung tumours: Lumira (lung microwave radiofrequency) randomized trial. *Med Oncol*. 2017;34(5):96. Doi: 10.1007/s12032-017-0946-x.

McClure T, Lansing A, Ferko N, et al. A comparison of microwave ablation and cryoablation for the treatment of renal cell carcinoma: A systematic literature review and meta-analysis. *Urology*. 2023;180:1-8. Doi: 10.1016/j.urology.2023.06.001.

Morris CS, Baerlocher MO, Dariushnia SR, et al. Society of interventional radiology position statement on the role of percutaneous ablation in renal cell carcinoma: Endorsed by the Canadian Association for Interventional Radiology and the Society of Interventional Oncology. *J Vasc Interv Radiol*. 2020;31(2):189-194.e3. Doi: 10.1016/j.jvir.2019.11.001.

National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Kidney cancer. Version 3.2025. [www.nccn.org](http://www.nccn.org). Published January 9, 2025.(a)

National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Non-small cell lung cancer. Version 4.2025. [www.nccn.org](http://www.nccn.org). Published May 23, 2025.(b)

Nelson DB, Tam AL, Mitchell KG, et al. Local recurrence after microwave ablation of lung malignancies: A systematic review. *Ann Thorac Surg*. 2019;107(6):1876-1883. Doi: 10.1016/j.athoracsur.2018.10.049.

Pennathur A, Lanuti M, Merritt RE, et al. Treatment selection for the high-risk patient with stage i non-small cell lung cancer: sublobar resection, stereotactic ablative radiotherapy or image-guided thermal ablation? *Semin Thorac Cardiovasc Surg*. 2025;37(1):114-121. Doi:10.1053/j.semtcvs.2024.10.004.

Sun YD, Zhang H, Liu JZ, et al. Efficacy of radiofrequency ablation and microwave ablation in the treatment of thoracic cancer: A systematic review and meta-analysis. *Thorac Cancer*. 2019;10(3):543-550. Doi: 10.1111/1759-7714.12973.

Tan CQY, Ho A, Robinson HA, et al. A systematic review of microwave ablation for colorectal pulmonary metastases. *Anticancer Res*. 2023;43(7):2899-2907. Doi: 10.21873/anticancer.16461.

Uhlig J, Strauss A, Rücker G, et al. Partial nephrectomy versus ablative techniques for small renal masses: A systematic review and network meta-analysis. *Eur Radiol*. 2019;29(3):1293-1307. Doi: 10.1007/s00330-018-5660-3.

U.S. Food and Drug Administration. 510(k) Premarket Notification database. Searched using product code NEY. <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. Page last updated June 6, 2025.

Wei Z, Yang X, Ye X, et al. Microwave ablation plus chemotherapy versus chemotherapy in advanced non-small cell lung cancer: A multicenter, randomized, controlled, phase 3 clinical trial. *Eur Radiol*. 2020;30(5):2692-2702. Doi: 10.1007/s00330-019-06613-x.

Yuan Z, Wang Y, Zhang J, Zheng J, Li W. A meta-analysis of clinical outcomes after radiofrequency ablation and microwave ablation for lung cancer and pulmonary metastases. *J Am Coll Radiol*. 2019;16(3):302-314. Doi: 10.1016/j.jacr.2018.10.012.

## Policy updates

7/2023: initial review date and clinical policy effective date: 8/2023

7/2024: Policy references updated.

7/2025: Policy references updated. Coverage updated.

# Opioid Treatment

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4039

Recent review date: 10/2025

Next review date: 2/2027

Policy contains: Opioid treatment; medication-assisted treatment; opioid use disorder; substance use disorder.

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## Policy statement

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AmeriHealth Caritas Louisiana provides coverage for medically necessary medications for Opioid Use Disorder (MOUD) delivered in opioid treatment programs, including methadone treatment, to all Medicaid-eligible adults and adolescents with OUDs.

### Components

#### Screening

A screening is conducted to determine eligibility and appropriateness for admission and referral.

#### Opioid Treatment Program (OTP) practitioner examination

A complete physical examination, including a drug screening test, by the OTP's practitioner must be conducted before admission to the OTP. A full medical exam, including results of serology and other tests, must be completed within 14 days of admission. The OTP practitioner must ensure members have a Substance Use or Opioid Use Disorder. The member must have been addicted to opiates for at least one year before admission for treatment, or meet exception criteria as outlined in 42 Code of Federal Regulations §8.12, as set in federal regulations, as determined by an OTO practitioner .

## **Alcohol and Drug Assessment and Referrals**

A comprehensive bio-psychosocial assessment must be completed within the first seven (7) days of admission, which substantiates treatment. For new admissions, the American Society of Addiction Medicine (ASAM) 6 Dimensional risk evaluation must be included in the assessment. The assessment must be reviewed and signed by a licensed mental health professional (LMHP). The comprehensive bio-psychosocial assessment shall contain the following:

- Circumstances leading to admission;
- Past and present behavioral health concerns;
- Past and present psychiatric and addictive disorders treatment;
- Significant medical history and current health status;
- Family and social history;
- Current living situation;
- Relationships with family of origin, nuclear;
- Family and significant others;
- Education and vocational training;
- Employment history and current status;
- Military service history and current status;
- Legal history and current legal status;
- Emotional state and behavioral functioning, past and present; and
- Strengths, weaknesses, and needs.

Ongoing assessment and referral services for individuals presenting a current or past use pattern of alcohol or other drug use is essential in the treatment of substance use disorders. The assessment is designed to gather and analyze information regarding a member's biopsychosocial, substance use and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance use-related treatment or referral. A licensed provider shall comply with licensing standards and any further LDH standards outlined below in regard to assessment practices. Once an individual receives an assessment, a staff member shall provide the individual with the identified clinical recommendations, including referral to alternative level of care or services. Assessments shall include the consideration of appropriate psychopharmacotherapy. There shall be evidence that the member was assessed to determine if MOUD was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis, and an appropriate assignment to level of care was determined, with referral to other appropriate services as indicated.

OTP providers, when clinically appropriate, shall address the following during the assessment and referral process:

- Educate members on the proven effectiveness, benefits and risks of Food and Drug Administration approved MOUD options for their SUD;
- Refer to other MOUD offsite as applicable; and
- Document member education, access to MOUD and member response in the progress notes.

## **Treatment Planning Process**

Treatment plans must be based on the assessments to include person-centered goals and objectives. The treatment plan must be developed within seven days of admission by the treatment team.

The treatment plan must:

- Identify the services intended to reduce the identified condition, as well as the anticipated outcomes of the individual;
- Include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA);
- Specify the frequency, amount and duration of services;
- Be signed by the licensed mental health professional or the OTP practitioner responsible for developing the plan; and
- Specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.

The re-evaluation must involve the individual, family, and providers and must determine whether services have contributed to meeting the stated goals. The treatment plan must be updated and revised if there is no measurable reduction of disability or restoration of functional level. The updated plan must identify different rehabilitation strategies with revised goals and services. If the services are being provided to a youth enrolled in the Coordinated System of Care (CSoc) program, the wrap-around agency (WAA) must be notified, and the substance use treatment provider must either be on the Child Family Team (CFT) or will work closely with the CFT. Substance use service provision will be part of the youth's plan of care (POC) developed by the team.

## **Treatment Services**

Treatment services include:

- The administration and dispensing of medications;
- Treatment phases 1 through 4;
  - Initial treatment phase lasts from three to seven days. During this phase, the provider conducts orientation, provides individual counseling and develops the initial treatment plan for treatment of critical health or social issues.
  - Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider:
    - Conducts weekly monitoring of the member's response to medication;
    - Provides at least four individual counseling sessions;
    - Revises the treatment plan within 30 days to include input by all disciplines, the member and significant others; and
    - Conducts random monthly drug screen tests.
- Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider must:
  - Perform random monthly drug screen tests until the member has negative drug screen tests for 90 consecutive days as well as random testing for alcohol when indicated;
  - Thereafter, monthly testing to members who are allowed six days of take-home doses, as well as random testing for alcohol when indicated;
  - Continuous evaluation by the nurse of the member's use of medication and treatment from the program and from other sources;
  - Documented reviews of the treatment plan every 90 days in the first two years of treatment by the treatment team;
  - Documentation of response to treatment in a progress note at least every 30 days;
  - Medically supervised withdrawal from synthetic narcotic with continuing care (only when the member requests withdrawal). The provider must:

- Decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by member;
  - Provide counseling of the type and quantity based on medical necessity; and
  - Conduct discharge planning as appropriate.
- Take Home Dosing
  - Participants may receive take-home doses in accordance with state and federal regulations and the member's treatment plan phase. Take Home Dosing is a privilege contingent upon the member's progress in treatment and surroundings, absence of known diversion activity and based upon the probability of the member's risk of diversion, which is determined by assessment and clinical judgement.
    - In determining eligibility for unsupervised take-home doses, the OTP practitioner must consider whether benefits outweigh risks and the following criteria, among other pertinent factors:
    - Absence of active substance use disorders or other physical or behavioral health conditions that increase risk of harm, including overdose risk, or that impair the ability to function safely.
    - Regular clinic attendance.
    - Absence of serious behavioral problems that endanger the member, the public, or others;
    - Absence of known diversion activity.
    - Stability of home environment and social relationships.
    - Assurance that take-home medication can be safely stored (lock boxes provided by the member); and
    - Any other criteria the OTP practitioner considers relevant to member safety and public health.
  - Dispensing limits
    - During the first 14 days, the take-home supply is limited to 7 days.
    - From day 15 of treatment, the take-home supply is limited to 14 days.
    - From day 31 of treatment, the take-home supply must not exceed 28 days at a time.
- Exceptions
  - The provider must request and obtain approval for any federally identified exception to the take-home dispensing restrictions from the State Opioid Treatment Authority. Confirmation of approval must be included in the medical record.
- Loss of take-home privilege
  - If a urine drug screen is positive for substances other than methadone or methadone metabolites, or includes a medication without a valid prescription, the OTP practitioner, operating within scope of practice, must determine the actual number of take-home doses and whether the member may maintain take-home medication.
- Care coordination
  - Services must include communication and coordination with other health providers as it relates to the member's Opioid Use Disorder treatment.
  - Dates and recommended take-home dosages ordered by the OTP practitioner must be documented in both the member's treatment record and the Methadone Central Registry to prevent simultaneous enrollment in more than one OTP and to ensure accurate dispensing.

## Eligibility Criteria

The medical necessity for substance use services must be determined by and recommended by an OTP practitioner. Members who meet clinical criteria must be at least 18 years old, unless the member has consent

from a parent or legal guardian, if applicable, and the State Opioid Treatment Authority. Members must also meet member admission criteria for federal opioid treatment standards in accordance with 42 CFR §8.12, as determined by an OTP practitioner.

## **Member Records**

In addition to the general requirements for record keeping, each member's record shall contain the following:

- Recording of medication administration and dispensing in both the member's treatment record and the Methadone Central Registry in accordance with federal and state requirements;
- Results of five most recent drug screen tests with action taken for positive results;
- Physical status and use of additional prescription medication;
- Contact notes and progress notes (monthly, or more frequently, as indicated by needs of client) that include employment/vocational needs, legal and social status, and overall individual stability;
- Documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate;
- Documentation of approval by the State Opioid Treatment Authority for any exception to take-home dispensing restrictions and the opioid treatment program practitioner's clinical justification; and
- Any other pertinent information.

## **Additional Provider Responsibilities**

OTPs must maintain an up-to-date disaster and emergency plan, which has been approved by the SOTA. In the event of an emergency leading to temporary closure of a program, an up-to-date plan for emergency administration of medications must be addressed. OTPs should have the capability to respond to emergencies on a 24-hour basis. The plan should include a contracted opioid treatment program practitioner with whom the provider can contact during emergencies. The plan should also include a mechanism for informing members of emergency arrangements and alternative dosing locations and a procedure for notifying SAMHSA, DEA, and state authorities of the event.

OTPs must coordinate access to the Methadone Central Registry for employees who provide direct member care. Access should be coordinated through an email request to the State Opioid Treatment Authority. The OTP should assign access to more than one person to update the Methadone Central Registry. Updates should occur on a daily basis and/or as changes in prescribed doses occur.

Monthly census and capacity reports must be submitted by the fifth of each month and must include quarterly staff training documentation and the number of pregnant women, using the format approved by the State Opioid Treatment Authority.

Upon the death of a member, the OTP must:

- Report the death of a member enrolled in their clinic to the SOTA within 24 hours of the discovery of the member's death;
- Report the death of a member to the Health Standards Section (HSS) within 24 hours of discovery if the death is related to program activity;
- Submit documentation on the cause and/or circumstances to SOTA and to HSS, if applicable, within 24 hours of the provider's receipt of the documentation; and
- Adhere to all protocols established by LDH on the death of a member.

Guest dosing occurs when a member receives Methadone dosing at another OTP other than their primary/home-based OTP clinic. Guest dosing can be coordinated with the State Opioid Treatment Authority during natural disasters if the prescriber is unable to contact the provider with whom the member is affiliated. The providers involved in a temporary transfer or guest dosing must ensure the following:

- The receiving provider shall verify dosage prior to dispensing and administering medication;
- The sending provider shall verify dosage and obtain approval and acceptance from the receiving provider prior to member's transfer; and
- Documentation to support all temporary transfers and guest dosing is maintained.

**NOTE:** Non-preferred forms of buprenorphine and buprenorphine/naloxone require prior authorization.

Services provided to adolescents must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. All substance use treatment services must offer the family component. Adolescent substance use programs shall include family involvement, parent education and family therapy.

Staffing for the facility must be consistent with State licensure regulations on a full-time employee (FTE) basis.

## **Provider Qualifications**

### **Agency**

To provide services, OTPs must meet the following requirements:

- Licensed by the Louisiana Department of Health (LDH) per La. R.S. 40:2151 et seq.;
- OTPs must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to AmeriHealth Caritas Louisiana, with whom the agency contracts or is being reimbursed;
- Services must be provided under the supervision of a licensed mental health professional (LMHP) or OTP practitioner who is acting within the scope of his/her professional license and applicable state law. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards;
- Arrange for and maintain documentation that prior to employment (or contracting, volunteering, or as required by law) individuals pass criminal background checks, including sexual offender registry checks, in accordance with all of the below:
  - The Behavioral Health Service Provider (BHSP) licensing regulations established by the Louisiana Administrative Code (LAC) 48:I.Chapter 56, which includes those for owners, managers, and administrators; any individual treating children and/or adolescents; and any unlicensed direct care staff;
  - La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing member care;
  - La. R.S. 15:587, as applicable; and
  - Any other applicable state or federal law.

- Providers must not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over 90 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. Results of criminal background checks are to be maintained in the individual's personnel record;
- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting with any employee or contractor that performs services that are compensated with AmeriHealth Caritas Louisiana funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in AmeriHealth Caritas Louisiana or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in AmeriHealth Caritas Louisiana or the Department of Health and Human Services' Office of Inspector General;
- Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (<https://exclusions.oig.hhs.gov>) and the LDH Adverse Action website is located at <https://adverseactions.ldh.la.gov/SelSearch>;
- Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
- Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use;
- Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which must be renewed within a time period recommended by the AHA;
- Maintain documentation of verification of staff meeting educational and professional requirements, licensure (where applicable), as well as completion of required trainings for all staff. Quarterly trainings must be documented and submitted to the SOTA on a quarterly basis; and
- Ensure and maintain documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention (CI) curriculum prior to handling or managing crisis calls, which must be updated annually.

## **Staff**

To provide services, staff must meet the following requirements:

- Licensed and unlicensed professional staff must be at least 18 years of age, with a high school diploma or equivalent according to their areas of competence as determined by degree, required levels of experience as defined by State law and regulations and departmentally approved guidelines and certifications;
- Effective six (6) months after publication date, staff must be at least three years older than any member served under 18 years of age. Licensed individual practitioners with no documentation of having provided

substance use services prior to December 1, 2015, are required to demonstrate competency via the Alcohol and Drug Counselor (ADC) exam, the Advanced Alcohol and Drug Counselor (AADC) exam, or the Examination for Master Addictions Counselor (EMAC). Any licensed individual practitioner, who has documentation of providing substance use services prior to December 1, 2015, and within their scope of practice is exempt from (ADC, AADC, EMAC) testing requirements. Organizational agencies are required to obtain verification of competency (passing of accepted examinations) or exemption (prior work history/resume, employer letter);

- Staff can include the Office of Behavioral Health (OBH) credentialed peer support specialists who meet all other qualifications. A peer specialist is a recommended position at all ASAM levels of care. A peer specialist is a person with lived experience with behavioral health challenges, who is in active recovery and is trained to assist others in their own recovery. The peer specialist uses their own unique, life-altering experience in order to guide and support others who are in recovery. This refers to individuals recovering from substance use disorders. Peer specialist work in conjunction with highly trained and educated professionals. They fill a gap by providing support from the perspective of someone who has first-hand experience;
- The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a member of the direct care staff who has an alcohol or drug offense, unless the employee or contractor has completed his/her court-ordered sentence, including community service, probation and/or parole and been sober per personal attestation for at least the last two years;
- Satisfactory completion of criminal background checks pursuant to the BHSP licensing regulations (LAC 48:I.Chapter 56), La R.S. 40:1203.1 et seq., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation;
- Pass a TB test prior to employment;
- Pass drug screening tests as required by agency's policies and procedures;
- Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;
- Direct care staff must not have a finding on the Louisiana State Adverse Action List;
- Complete AHA recognized First Aid, CPR and seizure assessment training. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training;
- All direct care staff shall receive orientation and training for and demonstrate knowledge of the following, including, but not limited to:
  - Symptoms of opiate withdrawal;
  - Drug screen testing and collections;
  - Current standards of practice regarding opiate addiction treatment;
  - Pelly-drug addiction; and
  - Information necessary to ensure care is provided within accepted standards of practice; and
- Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service.

## **Staffing Requirements**

Personnel must consist of professional and other support staff that are adequate to meet the needs of the individuals admitted to the facility.

The OTP shall have the following staff:

## **Medical Director**

The provider must ensure that its medical director is a licensed physician with a current, valid unrestricted license to practice in the state of Louisiana with two years of qualifying experience in treating psychiatric disorders.

The medical director must provide the following services:

- Decrease the dose to accomplish gradual, but complete withdrawal, only when requested by the member;
- Provide medically approved and medically supervised assistance for withdrawal, only when requested by the member;
- Participate in the documentation of reviews of treatment plan every 90 days in the first two years of treatment;
- Participate in discharge planning.

## **Pharmacist or Dispensing Physician**

The OTP must employ or contract with a pharmacist or dispensing physician to assure that any prescription medication dispensed on-site meets the requirements of applicable state statutes and regulations. The pharmacist or dispensing physician shall have a current, valid unrestricted license to practice in the state of Louisiana and provide the following services:

- Dispense all medications;
- Work collaboratively with the Medical Director to decrease the dose to accomplish gradual, but complete withdrawal, only when requested by the member;
- Contribute to the development of the initial treatment plan;
- Contribute to the documentation for the treatment plan review every 90 days in the first two years of treatment; and
- Document response to treatment in progress notes at least every 30 days.

## **Clinical Supervisor**

The opioid treatment program must employ or contract with a clinical supervisor who:

- Is an LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;
- Must be on duty and on call as needed;
- Has two years of qualifying clinical experience; and
- Provides supervision of unlicensed professionals, plus the listed responsibilities,
- Shall have the following responsibilities:
  - Provide supervision utilizing evidenced-based techniques related to the practice of behavioral health counseling;
  - Serve as resource person for other professionals counseling persons with behavioral health disorders;
  - Attend and participate in care conferences, treatment planning activities, and discharge planning;
  - Provide oversight and supervision of such activities as recreation, art/music or vocational education;
  - Function as member advocate in treatment decisions;

- Ensure the provider adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload, and referrals;
- Provide only those services that are within the person's scope of practice; and
- Assist the clinical director and/or medical director and governing body with the development and implementation of policies and procedures.

### **OTP Practitioner**

An OTP Practitioner is defined as a physician, APRN, NP, or physician assistant who is currently licensed in Louisiana and in good standing with their respective Louisiana professional licensing board to prescribe and/or dispense medications for opioid use disorders, and who is acting within the scope of all applicable state and federal laws and the individual's professional license.

The OTP practitioner must provide the following services:

- Conduct the initial practitioner examination for admission.
- Prescribe and/or administer medications.
- Monitor the member's response to medications.
- Determine the number of take-home doses a member is authorized to receive.
- Contribute to the development of and sign the initial treatment plan.
- Participate in discharge planning.

### **Nursing Staff**

Nursing staff shall have a current, valid and unrestricted nursing license in the State of Louisiana and provide the following services. The following services must be provided under the direction of a registered nurse (RN):

- Administer medications;
- Monitor the member's response to medications;
- Evaluate of member's use of medication and treatment from the program and other sources;
- Document response to treatment in progress notes at least every 30 days;
- Contribute to documentation for the treatment plan review every 90 days in the first two years of treatment;
- Conduct drug screens; and
- Participate in discharge planning.

### **Licensed Mental Health Professional (LMHP)**

The OTP must employ or contract with an LMHP. LMHPs must have a current, valid, and unrestricted license in the State of Louisiana, and must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards. The LMHP providing substance use treatment services must have documented credentials, experience and/or training in working with members who have substance use disorders, which must be maintained in the individual's personnel record.

Licensed Mental Health Professionals provide the following services:

- Conduct orientation;
- Develop the initial plan for treatment;

- Revise treatment to include input by all disciplines, members and significant others;
- Provide individual counseling;
- Contribute to the development as well as document the initial treatment plan;
- Document response to treatment in progress notes at least every 30 days;
- Contribute to the development as well as document reviews of treatment plan every 90 days in the first two years of treatment by the treatment team; and
- Conduct in discharge planning as appropriate.

### **Unlicensed professionals (UPs)**

UPs of substance use services must be registered with the Addictive Disorders Regulatory Authority (ADRA) and meet regulations and requirements in accordance with La. RS 37:3387 et seq. Written verification of ADRA registration and documentation of supervision when applicable must be maintained in the individual's personnel record. Unlicensed staff who fall under a professional scope of behavioral health practice with formal board approved clinical supervision and whose scope includes the provision of substance use services will not need to register with ADRA. Unlicensed substance use providers must meet at least one of the following qualifications:

- Be a master's-prepared behavioral health professional that has not obtained full licensure privileges and is participating in ongoing professional supervision. When working in substance use treatment settings, the master's-prepared UP must be supervised by an LMHP, who meets the requirements of this Section;
- Be a registered addiction counselor;
- Be a certified addiction counselor; or
- Be a counselor-in-training (CIT) that is registered with ADRA and is currently participating in a supervision required by the Addictive Disorders practice act.

### **Unlicensed professionals perform the following services under the supervision of a physician or LMHP:**

- Participate in conducting orientation,
- Participate in discharge planning as appropriate; and
- Provide support to the treatment team where applicable, while only providing assistance allowable under the auspices of and pursuant to the scope of the individual's license.

### **Staff Ratios**

OTPs must maintain a sufficient level of staffing to meet the needs of the members. The caseload of each LMHP or UP must not exceed 75 active members.

### **Allowed Provider Types and Specialties**

- PT 68 Substance Use and Alcohol Use Center PS 70 Clinic/Group with Subspecialty 8V Methadone Clinic.

### **Allowed Modes of Delivery**

- Individual;
- Group;
- On-site; and
- Tele-video (LMHPs only).

- Mobile Dosing Unit means a mobile unit that is established as part of, but geographically separate from, the opioid treatment program's parent facility, from which appropriately licensed practitioners may dispense or administer MOUD or collect samples for drug testing or analysis.

### **Telehealth**

Telehealth services must be delivered using HIPAA compliant audio and visual communication technology. LMHPs providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services offered within Opioid treatment programs may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face services.

### **Exclusions**

Methadone admission visits conducted by the admitting physician within OTPs are not allowed via telecommunication technology.

### **Reimbursement**

Reimbursement for Methadone for OUD treatment will only be made to OTPs, which are federally approved by SAMHSA and the DEA, and regulated by LDH, which includes OBH and HSS. A provider subspecialty code 8V has been established for the OTPs/Methadone clinics as sole source providers.

The 8V subspecialty has two bundled rate options. H0020 will be used for a bundled rate reimbursement for Methadone treatment. H0047 will be used for a bundled rate for Buprenorphine treatment, but excludes the ingredient cost of the medication. Buprenorphine medication will be billed separately using the applicable J-codes (J0571-J0575) depending on dosage amounts.

Bundled rates for the OTPs will facilitate the practical needs of member-centered treatment in the administration of MOUD to integrate the provision of counseling and medical services. It strengthens recovery and decreases recidivism in members diagnosed within the substance use disorder spectrum.

The section below provides an explanation of available codes for the OTPs/Methadone clinics.

### **H0020 Methadone Bundled Rate**

Bundled rate includes all state and federal regulatory mandated components of treatment. Services include but are not limited to the following:

- Medication: This includes the administration, dosing, and dispensing of Methadone as per the member's treatment plan;
- Counseling: Members are required to participate in group or individual sessions as part of the member's treatment plan;
- Urine Drug Testing: This includes the urine drug testing or other laboratory tests deemed medically necessary;
- Physical examinations by a physician or advanced practice registered nurse;
- Evaluation and management visits;
- Evaluation and management visits;
- Case management; and
- Laboratory Services.

The OTP may be reimbursed for the bundled rate for participants receiving take home doses in accordance with state and federal regulations and the member's treatment plan phase.

Guest dosing occurs when a member receives Methadone dosing at another OTP other than their primary/home-based OTP clinic. The guest dosing provider will bill for the bundled rate and provide clinical care, if appropriate, that is coordinated with the "home" provider and Methadone Central Registry (MCR) to ensure correct dosing.

#### **H0047 Buprenorphine Bundled Rate**

Bundled rate includes all components of treatment, except for the Buprenorphine medication. Services include but are not limited to the following:

- Assessment and individualized treatment plan;
- Individual and group counseling;
- Urine Drug Testing or laboratory testing; and
- Coordination of medically necessary services.

Buprenorphine medication will be billed separately using the applicable J-codes (J0571-J0575) depending on dosage amounts.

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## **References**

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Louisiana Department of Health. 2017. Behavioral Health Services Provider Manual. Addiction Services. Opioid Treatment. Chapter 2, Section 2.4. Issued August 22, 2025.

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## **Policy updates**

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Initial review date: 3/2/2021

11/2023: Policy references updated.

11/2024: Policy references updated.

10/2025: Policy references updated.

# Prostatic urethral lift/UroLift for benign prostatic hyperplasia

Clinical Policy ID: CCP.1529

Recent review date: 8/2025

Next review date: 12/2026

Policy contains: benign prostatic hyperplasia; prostatic urethral lift; UroLift.

*AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered by AmeriHealth Caritas Louisiana, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.*

## Coverage policy

Prostatic urethral lift (UroLift<sup>®</sup>, Teleflex, Inc., Pleasanton, California) is clinically proven and, therefore, may be medically necessary for treatment of lower urinary tract symptoms due to benign prostatic hyperplasia when all of the following criteria are met (American Urological Association [Lerner, 2023]):

- Member has a prostate volume between 30 and 80 cc.
- There is verified absence of an obstructive median lobe of the prostate.

### Limitations

For members with a prostate volume greater than 80 cc and up to 100 cc or with an obstructive median lobe, the decision to proceed with a prostatic urethral lift procedure should be made on a case-by-case basis, understanding the limited evidence supporting improved patient outcomes in these populations.

Contraindications to UroLift include the following (U.S. Food and Drug Administration, 2025):

- Prostate volume of >100 cc.
- A urinary tract infection.
- Urethral conditions that may prevent insertion of delivery system into bladder.
- Urinary incontinence.
- Current gross hematuria.
- A known allergy to nickel
- Alternative covered services
- Medications, including alpha blockers, 5-alpha reductase inhibitors, or a combination.
- Transurethral resection of the prostate.
- Guideline-directed minimally invasive surgery, including:
  - Convective radiofrequency water vapor thermal therapy
  - Prostatic arterial embolization
  - Temporary implantable nitinol device
  - Transurethral microwave thermotherapy

## Background

Benign prostatic hyperplasia, also known as benign prostatic hypertrophy, is a nonmalignant growth of prostate tissue and relatively common in older people with a prostate. The condition is marked by symptoms of the lower urinary tract, urinary retention, or infections due to incomplete bladder emptying. Some cases will not require treatment but can be addressed by watchful waiting to ensure worsening of symptoms is limited. Other cases can be treated conservatively with alpha blockers, 5-alpha reductase inhibitors, phosphodiesterase-5 inhibitors (tadalafil), antimuscarinics, or a combination. However, these medications are not always effective and are associated with elevated risk of ejaculatory and erectile dysfunction (Ng, 2024).

For cases requiring surgery, transurethral approaches and enucleation procedures have largely replaced open prostatectomy as preferred surgical options. Minimally invasive surgical options such as paclitaxel-coated prostatic balloon dilation, transurethral microwave thermotherapy, water vapor or steam infusion therapy, and prostatic urethral internal lateral suturing (prostatic urethral lift) have emerged, offering shorter operating room time, faster recovery, and fewer side effects (Ng, 2024).

The prostatic urethral lift is an endoscopic procedure that retracts obstructing prostatic lobes using small metal implants to secure the retracted position of the enlarged prostate tissue away from the urethra. A disposable cartridge delivers an implant consisting of a capsular nitinol tab and a urethral stainless steel tab held together by a non-absorbable suture, which draws the prostatic urethra to the capsule. The procedure creates an open channel from the bladder neck to the verumontanum. It requires three to four tabs per implantation and either local or general anesthesia, and it can be performed in inpatient or outpatient settings (Rahman, 2024).

In 2013, the U.S. Food and Drug Administration approved the UroLift System UL400 for the treatment of benign prostatic hyperplasia in patients age 50 years and older with no obstructive median or lateral lobe hyperplasia and prostate volumes between 30 and 80 cc (U.S. Food and Drug Administration, 2013). In 2017, approval was expanded to include the UL500 model for lateral and median lobe prostate hyperplasia (U.S. Food and Drug Administration, 2017).

In 2019, approval for recent models expanded based on substantial equivalence to predicate devices and unpublished data presented to the U.S. Food and Drug Administration. Approval includes individuals with prostate volumes up to 100 cc and patients aged 45 years and older. Lowering the age criterion was based on an early American Urological Association guideline defining the index patient > 45 years of age with lower urinary

tract symptoms and multiple studies demonstrating minimal differences between the populations age 45 and age 50 in terms of histopathology, volume, and symptomatology (U.S. Food and Drug Administration, 2025).

## Findings

### Guidelines

The American Board of Urology reports that prostatic urethral lift procedures increased significantly since its introduction in 2015, and currently account for one-third of all procedures for benign prostatic hyperplasia (Zhang, 2023).

According to the American Urological Association, the overwhelming majority of patients with lower urinary tract symptoms/ benign prostatic hyperplasia who desire treatment will choose some form of medical therapy, but medical therapy failure is not an absolute requirement for interventional procedures. The Association recommends surgery for patients who have: renal insufficiency, refractory urinary retention, or gross hematuria secondary to benign prostatic hyperplasia; recurrent urinary tract infections; recurrent bladder stones; lower urinary tract symptoms/ benign prostatic hyperplasia refractory to other therapies; or an unwillingness to use other therapies. While it is appropriate to discuss medical therapy with patients for whom additional therapy is warranted, proceeding to a procedural intervention without trialing medications may also be discussed as part of the informed decision-making process (Lerner, 2023).

The American Urological Association guideline recommends prostatic urethral lift for patients with lower urinary tract symptoms from benign prostatic hyperplasia who meet the following criteria (Lerner, 2023):

- Prostate volume is 30 to 80 cc and verified absence of an obstructive median lobe. For men with prostate sizes ranging from 81 to 100 cc or with obstructive median lobes, there was insufficient evidence to make formal recommendations.
- The patient desires preservation of erectile and ejaculatory function.

The American Urological Association's recommendations were based on the inclusion criteria and results of the L.I.F.T. study (ClinicalTrials.gov identifier NCT01294150). The inclusion criteria were participants aged 50 years and older with an International Prostate Symptom Score > 12, a peak flow rate (Q<sub>max</sub>) ≤ 12 mL/s, and a prostate volume 30 to 80 cc. Participants were randomized to the Lift procedure or sham control and followed for five years. Prostatic urethral lift offered rapid improvement in symptoms, quality of life, and flow rate durable to five years with a higher likelihood of preserving sexual function compared to many other surgical interventions (Roehrborn, 2017).

A National Institute for Health and Care Excellence guideline on UroLift is similar to that of the American Urological Association, and recommends the procedure be reserved for patients 50 years and older (National Institute for Health and Care Excellence, 2021).

A European Association of Urology guideline resembles the American Urological Association in its recommendations for urethral lift for lower urinary tract symptoms in those with a prostate volume of < 70 cc and no middle lobe who are interested in preserving ejaculatory function (Cornu, 2024).

A Canadian Urological Association guideline recommends prostatic urethral lift for patients with lower urinary tract symptoms interested in preserving ejaculatory function with prostate volume < 80 cc, or for patients with a small to moderate median lobe and bothersome lower urinary tract symptoms (Elterman, 2022).

### Evidence review

Recent systematic reviews/meta-analyses produced the following findings on the effectiveness outcomes of prostatic urethral lift/UroLift. While the prostatic urethral lift improves symptoms from a risk-benefit perspective, it is generally not as effective as transurethral resection of the prostate (Cornu, 2023). Similarly, Franco (2021, 2022), in a Cochrane review of 27 studies (n = 3,017), concluded that prostatic urethral lift showed little to no difference in urological symptom improvement compared to transurethral resection of the prostate, although it was the most efficacious among five minimally invasive procedures.

Current evidence supports prostatic urethral lift/UroLift for patients with small prostate volumes ranging from 30 to 80 cc without obstructive median lobes based on the L.I.F.T. randomized, sham-controlled trial. The evidence for those with larger prostate volumes (81 to 100 cc) and with obstructive median lobes is very limited in the published literature. Results of the MedLift prospective, nonrandomized study (n = 45) were promising but insufficient to support prostatic urethral lift as a safe and effective treatment for patients with benign prostatic hyperplasia and obstructive median lobes (Rukstalis, 2019; ClinicalTrials.gov identifier: NCT02625545).

#### *Long-term effectiveness and safety*

The long-term effectiveness and safety of prostatic urethral lift have been highlighted in several studies. Jing (2020) observed that the effects of prostatic urethral lift weaken over time, with patients tracked up to 24 months, and that while it was not as effective as transurethral resection of the prostate, prostatic urethral lift remained safe and effective in selected patients. Tanneru (2020) supported these findings, reporting that prostatic urethral lift was well-tolerated and provided favorable outcomes in symptoms and sexual health over a 24-month period. Sajjan (2022) noted that prostatic urethral lift had similar symptom improvement and adverse event rates compared to other minimally invasive procedures at three, six, and 12 months, but transurethral resection of the prostate consistently yielded superior outcomes during these periods.

A meta-analysis by Xiang (2020) consolidated data from 19 articles, covering 11 independent patient series and a total of 304 to 605 patients. The study found significant improvements in the International Prostate Symptom Score by 9.73 to 12.16 points, the Benign Prostatic Hyperplasia Impact Index by 3.74 to 4.50 points, and the maximum flow rate by 3.44 to 4.26 milliliters per second over 24 months. Quality of life scores also improved by 2.20 to 2.55 points, with stable or slightly improved sexual function. Complications were minimal and typically mild, with no significant changes in postvoid residual volume, supporting prostatic urethral lift as an effective and safe procedure that preserves sexual function.

#### *Re-intervention rates and cost effectiveness*

Re-intervention rates and cost effectiveness are critical factors in evaluating the overall utility of prostatic urethral lift. Miller (2020) analyzed data from 11 studies involving 2,016 patients and found a pooled annual surgical re-intervention rate of 6.0%, with variations depending on follow-up duration. This highlights a higher re-intervention rate than commonly cited in the literature, emphasizing the need for long-term follow-up data. Chughtai (2022) noted that prostatic urethral lift had lower improvements in prostate scores than other procedures and the highest five-year cost, approximately \$9,580 compared to \$6,328 for transurethral resection of the prostate. Despite these costs, Light (2021) found that prostatic urethral lift had the highest rate of erectile function preservation at one, six, 12, and 24 months compared with other minimally invasive procedures.

#### *Comparative effectiveness of prostatic urethral lift and other treatments*

Several studies have compared the effectiveness of prostatic urethral lift with other treatments over varying periods. Baboudjian (2023) reported that after five years, the effectiveness of surgical or minimally invasive retreatment was 13% for prostatic urethral lift versus 4% for water vapor thermal therapy. Lucas-Cava (2023) found that prostatic urethral lift had a significantly higher rate of re-interventions but a significantly lower rate of major adverse events compared to transurethral resection of the prostate. Minimally invasive procedures such as prostatic urethral lift did not result in significant changes in ejaculatory or erectile function and was associated

with a lower risk of retrograde ejaculation compared to transurethral resection of the prostate, other electrosurgical procedures, and laser treatment (Busetto, 2025; Gemma, 2024; Manfredi, 2022). Page (2021) noted that after prostatic urethral lift, the in-hospital complication rate was 3.4%, with 93% of patients being catheter-free within 30 days, and re-treatment rates at one and two years were 5.2% and 11.9%, respectively.

In 2024, we revised the coverage section based on updated clinical guidelines from American Urological Association. We also revised the findings section to group studies thematically. We also added new systematic reviews (Miller, 2020; van Kollenburg, 2023; Xiang, 2020).

In 2025, we updated the references and revised the medical necessity criteria to align with current American Urological Association guideline recommendations for prostatic urethral lift procedures. These changes include deleting the age criterion and the requirement of medication failure.

## References

On April 21, 2025, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “benign prostatic hyperplasia,” “benign prostatic hypertrophy,” “prostatic urethral lift,” and “UroLift.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

Baboudjian M, Cornu J-N, Gondran-Tellier B, et al. Pharmacologic and surgical retreatment after office-based treatments for benign prostatic hyperplasia: A systematic review. *Eur Urol Focus*. 2023;9(5):727-733. Doi: 10.1016/j.euf.2023.03.004.

Busetto GM, Lombardo R, De Nunzio C, et al. Ejaculation sparing of classic and minimally invasive surgical treatments of LUTS/BPH. *Prostate Cancer Prostatic Dis*. 2025;28(1):37-44. Doi: 10.1038/s41391-024-00834-y.

Chughtai B, Rojanasart S, Neeser K, et al. A comprehensive analysis of clinical, quality of life, and cost-effectiveness outcomes of key treatment options for benign prostatic hyperplasia. *PLoS One*. 2022;17(4):e0266824. Doi: 10.1371/journal.pone.0266824.

ClinicalTrials.gov. The safety and effectiveness of UroLift: LIFT Pivotal Study (LIFT). ClinicalTrials.gov identifier NCT01294150.

<https://www.clinicaltrials.gov/study/NCT01294150?term=NCT01294150&rank=1>. Last update posted September 5, 2018.

Cornu J-N, Gacci M, Hashim H, et al. EUA Guidelines on Non-Neurogenic (Male) Lower Urinary Tract Symptoms (LUTS). 5.3.5.1 Prostatic urethral lift. <https://d56bochluxqgz.cloudfront.net/documents/full-guideline/EAU-Guidelines-on-Non-Neurogenic-Male-LUTS-2025.pdf>. Last updated April 2024.

Cornu J-N, Zantek P, Burt G, et al. Minimally invasive treatments for benign prostatic obstruction: A systematic review and network meta-analysis. *Eur Urol*. 2023;83(6):534-547. Doi: 10.1016/j.eururo.2023.02.028.

Elterman D, Aube-Peterkin M, Evans H, et al. UPDATE – Canadian Urological Association guideline: Male lower urinary tract symptoms/benign prostatic hyperplasia. *Can Urol Assoc J*. 2022;16(8):245-256. Doi: 10.5489/cuaj.7906.

Franco JV, Jung JH, Imamura M, et al. Minimally invasive treatments for lower urinary tract symptoms in men with benign prostatic hyperplasia: A network meta-analysis. *Cochrane Database Syst Rev*. 2021;7(7):CD013656. Doi: 10.1002/14651858.CD013656.pub2.

Franco JVA, Jung JH, Imamura M, et al. Minimally invasive treatments for benign prostatic hyperplasia: A Cochrane network meta-analysis. *BJU Int.* 2022;130(2):142-156. Doi: 10.1111/bju.15653.

Gemma L, Pecoraro A, Sebastianelli A, et al. Impact of minimally invasive surgical procedures for male lower urinary tract symptoms due to benign prostatic hyperplasia on ejaculatory function: A systematic review. *Prostate Cancer Prostatic Dis.* 2024;27(3):404-421. Doi: 10.1038/s41391-024-00795-2.

Jing J, Wu Y, Du M, et al. Urethral lift as a safe and effective procedure for prostatic hyperplasia population: A systematic review and meta-analysis. *Front Surg.* 2020;7:598728. Doi: 10.3389/fsurg.2020.598728.

Lerner LB, Barry MJ, Das AK, et al. Management of lower urinary tract symptoms attributed to benign prostatic hyperplasia: AUA guideline. Unabridged version. American Urological Association website. <https://www.auanet.org/documents/Guidelines/PDF/2023%20Guidelines/BPH%20Unabridged%2002-20-24%20Final.pdf>. Last updated 2023.

Light A, Jabarkhyl D, Gilling P, et al. Erectile function following surgery for benign prostatic obstruction: A systematic review and network meta-analysis of randomized controlled trials. *Eur Urol.* 2021;80(2):174-187. Doi: 10.1016/j.eururo.2021.04.012.

Lucas-Cava V, Sanchez-Margallo FM, Gorbea II, Sun F. Comparative efficacy and safety of prostatic urethral lift vs prostatic artery embolization for benign prostatic hyperplasia: A systematic review and network meta-analysis. *BJU Int.* 2023;131(2):139-152. Doi: 10.1111/bju.15748.

Manfredi C, Garcia-Gomez B, Arcaniolo D, et al. Impact of surgery for benign prostatic hyperplasia on sexual function: A systematic review and meta-analysis of erectile function and ejaculatory function. *Eur Urol Focus.* 2022;8(6):1711-1732. Doi: 10.1016/j.euf.2022.06.007.

Miller LE, Chughtai B, Dornbier RA, McVary KT. Surgical reintervention rate after prostatic urethral lift: systematic review and meta-analysis involving over 2,000 patients. *J Urol.* 2020;204(5):1019-1026. Doi: 10.1097/JU.0000000000001132.

National Institute for Health and Care Excellence. UroLift for treating lower urinary tract symptoms of benign prostatic hyperplasia. MTG 58. <https://www.nice.org.uk/guidance/mtg58>. Published May 4, 2021.

Ng M, Leslie SW, Baradhi KM. Benign prostatic hyperplasia. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. <https://www.ncbi.nlm.nih.gov/books/NBK558920/>. Updated October 20, 2024.

Page T, Veeratterapillay R, Keltie K, Burn J, Sims A. Prostatic urethral lift (UroLift): A real-world analysis of outcomes using hospital episodes statistics. *BMC Urol.* 2021;21(1):55. Doi: 10.1186/s12894-021-00824-5.

Rahman A, Leslie SW, Desai D. Prostatic urethral lift. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. <https://www.ncbi.nlm.nih.gov/books/NBK606089/>. Updated August 11, 2024.

Roehrborn CG, Barkin J, Gange SN, et al. Five year results of the prospective randomized controlled prostatic urethral L.I.F.T. study. *Can J Urol.* 2017;24(3):8802-8813. [https://www.canjurol.com/html/free-articles/V24I3\\_08\\_FREE\\_DrRoehrborn.pdf](https://www.canjurol.com/html/free-articles/V24I3_08_FREE_DrRoehrborn.pdf).

Rukstalis D, Grier D, Stroup SP, et al. Prostatic urethral lift (PUL) for obstructive median lobes: 12 month results of the Medlift study. *Prostate Cancer Prostatic Dis.* 2019;22(3):411-419. Doi: 10.1038/s41391-018-0118-x.

Sajan A, Mehta T, Desai P, Isaacson A, Bagla S. Minimally invasive treatments for benign prostatic hyperplasia: Systematic review and network meta-analysis. *Vasc Interv Radiol.* 2022;33(4):359-367.e8. Doi: 10.1016/j.jvir.2021.12.029.

Tanneru K, Gautam S, Norez D, et al. Meta-analysis and systematic review of intermediate-term follow-up of prostatic urethral lift for benign prostatic hyperplasia. *Int Urol Nephrol*. 2020;52(6):999-1008. Doi: 10.1007/s11255-020-02408-y.

U.S. Food and Drug Administration. De novo classification request for Neotract's UroLift System. [https://www.accessdata.fda.gov/cdrh\\_docs/reviews/k130651.pdf](https://www.accessdata.fda.gov/cdrh_docs/reviews/k130651.pdf). Published March 7, 2013.

U.S. Food and Drug Administration. 5101(k) Premarket Notification. Implantable transprostatic tissue retractor system. <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm?ID=K173087>. Published December 28, 2017.

U.S. Food and Drug Administration. 510(k) Premarket Notification database searched using product code PEW. <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. Last updated April 14, 2025.

van Kollenburg RAA, van Riel LAMJG, de Bruin DM, de Rijke TM, Oddens JR. Novel minimally invasive treatments for lower urinary tract symptoms: a systematic review and network meta-analysis. *Int Braz J Urol*. 2023;49(4):411-427. Doi:10.1590/S1677-5538.IBJU.2023.0016.

Xiang P, Wang M, Guan D, et al. A systematic review and meta-analysis of prostatic urethral lift for male lower urinary tract symptoms secondary to benign prostatic hyperplasia. *Eur Urol Open Sci*. 2020;19:3-15. Doi: 10.1016/j.euros.2020.05.001.

Zhang TR, Thorogood SL, Sze C. Current practice patterns in the surgical management of benign prostatic hyperplasia. *Urology*. 2023;175:157-162. Doi: 10.1016/j.urology.2023.02.025.

## Policy updates

7/2023: initial review date and clinical policy effective date: 8/2023

7/2024: Policy references updated.

8/2025: Policy references updated. Coverage modified.



# Prosthetic Devices

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4028

Recent review date: 2/2025

Next review date: 6/2026

Policy contains: Prosthetic devices; prosthesis; artificial body parts

*AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered, on a case by case basis, by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.*

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## Policy statement

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Prosthetic devices include artificial limbs, body parts, sockets, suspension components, attachment, alignment and finishing. A complete description of the prosthesis is required, such as whether the device is a conventional type, above the knee or a special type. The request should indicate the following:

- Whether the request is for the first prosthesis or a replacement;
- The mental and physical ability of the member to use the device; and
- Whether training is required for a replacement.

A plan of training shall always be a part of a first request for prosthesis.

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## References

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Louisiana Department of Health. 2010. Durable Medical Equipment Provider Manual. Prosthetic Devices. Chapter 18, Section 18.2.21.3. Issued. 03/08/2024

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## Policy updates

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Initial review date: 3/2/2021

3/2023: Policy references updated.

2/2024: Policy references updated.

2/2025: Policy references updated.