PROVIDER POLICIES & PROCEDURES

FOCAL TREATMENT FOR PROSTATE CANCER

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for focal therapy and associated interventions related to prostate cancer. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Prostate cancer is the uncontrolled growth of cells in the prostate, a gland in the male reproductive system. There are several treatment options available for prostate cancer, as well as adjunctive treatments aimed at mitigating side effects associated with specific therapies. Treatment options are based on the size of the growth, how quickly it is growing, and personal preferences related to the goals and outcomes of treatment.

The transurethral ablation of prostate tissue using thermal ultrasound with MRI guidance (TULSA) and (TULSA-Pro) procedure is a minimally invasive, radiation-free treatment for prostate cancer that uses ultrasound to ablate cancerous tissue while preserving surrounding healthy structures.

Irreversible electroporation (IRE) (e.g., Nanoknife) is a minimally invasive treatment for prostate cancer that uses electrical pulses to destroy cancer cells while preserving surrounding healthy tissue.

CLINICAL GUIDELINE

Coverage guidelines for focal therapy and associated interventions related to prostate cancer will be made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Tulsa and TULSA-Pro

Transurethral ablation of prostate tissue using thermal ultrasound with MRI guidance (CPT codes **55881** and **55882**) for the treatment of localized prostate cancer is considered investigational and therefore not medically necessary as there is insufficient evidence in peer-reviewed, published, medical literature supporting its clinical efficacy and safety.

Irreversible Electroporation (IRE)

Irreversible Electroporation (IRE) (CPT code **55877**) for the treatment of localized prostate cancer is considered investigational and therefore not medically necessary as there is insufficient evidence in peer-reviewed, published, medical literature supporting its clinical efficacy and safety.

NOTE: EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that

requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Requests for coverage of focal treatment for prostate cancer will be reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

EFFECTIVE DATE
This Clinical Guideline is effective for prior authorization requests for individuals covered under the HUSKY A, B, C, and D programs on or after August 01, 2026.

LIMITATIONS
N/A

CODES:

Code	Description
55877	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous
55881	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation (more than one physician)
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed (one physician)

*Code 55881 is used in conjunction with code 51721 (Insertion of transducer through urethra for delivery of heat ultrasound). 51721 does not require prior authorization.

DEFINITIONS
1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.

6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

TULSA and TULSA-Pro

- Babalola O, Lee TJ, Viviano CJ. Prostate Ablation Using High Intensity Focused Ultrasound: A Literature Review of the Potential Role for Patient Preference Information. *J Urol*. 2018;200(3):512-519. doi:10.1016/j.juro.2018.04.066
- Bekelman JE, Rumble RB, Chen RC, et al. Clinically Localized Prostate Cancer: ASCO Clinical Practice Guideline Endorsement of an American Urological Association/American Society for Radiation Oncology/Society of Urologic Oncology Guideline. J Clin Oncol. 2018;36(32):3251-3258. doi:10.1200/JCO.18.00606
- Bates AS, Ayers J, Kostakopoulos N, Lumsden T, Schoots IG, Willemse PPM et al. A Systematic Review of Focal Ablative Therapy for Clinically Localized Prostate Cancer in Comparison with Standard Management Options: Limitations of the Available Evidence and Recommendations for Clinical Practice and Further Research. European urology oncology. 2021 Jun 1;4(3):405-423. doi: 10.1016/j.euo.2020.12.008
- Chin JL, Billia M, Relle J, et al. Magnetic Resonance Imaging-Guided Transurethral Ultrasound Ablation of Prostate Tissue in Patients with Localized Prostate Cancer: A Prospective Phase 1 Clinical Trial. Eur Urol. 2016;70(3):447-455. doi:10.1016/j.eururo.2015.12.029
- Ciezki JP. Overview of low- and very low-risk clinically localized prostate cancer. In: *UpToDate*, Lee WR, Richie JP (Eds.). Wolters Kluwer. Updated May 28, 2025.
- Eastham JA, Auffenberg GB, Barocas DA, et al. Clinically localized prostate cancer: AUA/ASTRO guideline, part I: introduction, risk assessment, staging, and risk-based management. J Urol. 2022;208(1):10-18.
- National Comprehensive Cancer Network (NCCN). Prostate Cancer. NCCN Clinical Practice Guidelines in Oncology, Version 5.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf.

- Pisters LL, Spiess PE. Cryotherapy and other ablative techniques for the initial treatment of prostate cancer. In: *UpToDate*, Lee WR, Richie JP, Yushak M (Eds.). Wolters Kluwer. Updated February 18, 2025.

Irreversible Electroporation (IRE)

- Eastham JA, Auffenberg GB, Barocas DA, et al. Clinically localized prostate cancer: AUA/ASTRO guideline. Part III: principles of radiation and future directions. J Urol. 2022;208(1):26-33.
- National Comprehensive Cancer Network (NCCN). Prostate Cancer. NCCN Clinical Practice Guidelines in Oncology, Version 5.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf.
- Richie JP. Localized prostate cancer: Risk stratification and choice of initial treatment. In: *UpToDate*. Lee RW, Yushak M (Eds.). Wolters Kluwer. Updated February 10, 2026.
- U.S. Food & Drug Administration. 510(k) Premarket Notification. Medical Device: NanoKnife Generator. Available at: https://www.accessdata.fda.gov/cdrh_docs/pdf24/K242687.pdf

PUBLICATION HISTORY

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