Nerve Graft With Radical Prostatectomy

Policy # 00113
Original Effective Date: 06/05/2002
Current Effective Date: 06/12/2023

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

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

Based on review of available data, the Company considers unilateral or bilateral nerve grafts in individuals who have had resection of one or both neurovascular bundles as part of a radical prostatectomy to be investigational.*

Background/Overview
Erectile Dysfunction
Erectile dysfunction is a common problem after radical prostatectomy. In particular, spontaneous erections are usually absent in men whose prostate cancer required bilateral resection of the neurovascular bundles as part of the radical prostatectomy procedure.

Treatment
A variety of noninvasive treatments are available, including vacuum constriction devices and intracavernosal injection therapy. However, spontaneous erectile activity is preferred by individuals. Studies have reported results from bilateral and unilateral nerve grafts, the latter involving resection of 1 neurovascular bundle.

There has been interest in sural nerve grafting to replace cavernous nerves resection during prostatectomy. The sural nerve is considered expendable and has been extensively used in other nerve grafting procedures, such as brachial plexus and peripheral nerve injuries. As applied to prostatectomy, a portion of the sural nerve is harvested from 1 leg and then anastomosed to the divided ends of the cavernous nerve. Reports also indicate the use of other nerves (eg, genitofemoral nerve) for grafting.
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FDA or Other Governmental Regulatory Approval
U.S. Food and Drug Administration (FDA)
A nerve graft with radical prostatectomy is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration (FDA).

Several nerve cuff products have been cleared for marketing by FDA through the 510(k) process. FDA product code: JXI. An example of a human tissue nerve graft product, the Avance®† nerve graft (AxoGen), is regulated by FDA under 21 CFR, Part 1271 regulations for Human Cellular and Tissue-based Products (HCT/P).

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

Nerve grafting at the time of radical prostatectomy, most commonly using the sural nerve, has been proposed to reduce the risk of postoperative erectile dysfunction.

Summary of Evidence
For individuals who have radical prostatectomy with resection of neurovascular bundles who receive nerve grafting, the evidence includes a randomized controlled trial (RCT), cohort studies, and case series. Relevant outcomes are functional outcomes, quality of life, and treatment-related morbidity. The RCT did not find that unilateral nerve grafting was associated with a statistically significant improvement in potency rates at 2 years postsurgery. Cohort studies also did not result in better outcomes with nerve grafting. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.
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Supplemental Information
Clinical Input From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 4 academic medical centers while this policy was under review in 2008; no input was received from physician specialty societies. Input from the 4 centers agreed that this procedure is considered investigational.

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

National Comprehensive Cancer Network
The National Comprehensive Cancer Network guidelines on the treatment of prostate cancer (v. 3.2022) states: “Replacement of resected nerves with nerve grafts has not been shown to be beneficial” for recovery of erectile function after radical prostatectomy.

U.S. Preventive Services Task Force Recommendations
Not applicable.

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

Ongoing and Unpublished Clinical Trials
A currently unpublished trial that might influence this review is shown in Table 1.
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Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01770340</td>
<td>Nerve Grafting With an Allograft During Radical Prostatectomy - Extended Follow-up in a Prospective Randomized Trial</td>
<td>30</td>
<td>Jul 2020 (terminated)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

References
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**Policy History**
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05/16/2002  Medical Policy Committee review
06/05/2002  Managed Care Advisory Council approval
06/01/2004  Medical Director Review
06/15/2004  Medical Policy Committee review. Format revision.
06/28/2004  Managed Care Advisory Council approval
08/02/2006  Medical Director Review
06/13/2007  Medical Director Review
06/20/2007  Medical Policy Committee approval. Policy updated with literature search. No change to policy statement. Sural removed from title.
06/04/2009  Medical Director Review
06/17/2009  Medical Policy Committee approval. No change to coverage.
06/03/2010  Medical Policy Committee approval
06/16/2010  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/02/2011  Medical Policy Committee review
06/14/2012  Medical Policy Committee review
06/20/2012  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/06/2013  Medical Policy Committee review
04/02/2015  Medical Policy Committee review
04/20/2015  Medical Policy Implementation Committee approval. Updated rationale /source. Coverage eligibility unchanged.
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08/03/2015  Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
04/07/2016  Medical Policy Committee review
04/20/2016  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2017  Coding update: Removing ICD-9 Diagnosis Codes
05/04/2017  Medical Policy Committee review
05/17/2017  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/03/2018  Medical Policy Committee review
05/16/2018  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/02/2019  Medical Policy Committee review
05/15/2019  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/07/2020  Medical Policy Committee review
05/13/2020  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/06/2021  Medical Policy Committee review
05/12/2021  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/05/2022  Medical Policy Committee review
05/11/2022  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/04/2023  Medical Policy Committee review
05/10/2023  Medical Policy Implementation Committee approval. Replaced “patients” with “individuals” in the investigational statement. Coverage eligibility unchanged.

Next Scheduled Review Date: 05/2024

Coding
The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®), copyright 2022 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of
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descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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CPT is a registered trademark of the American Medical Association.

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

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>64912, 64913, 64999</td>
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<tr>
<td></td>
<td>Add codes effective 06/01/2023: 64910, 64911</td>
</tr>
<tr>
<td>HCPCS</td>
<td>No codes</td>
</tr>
<tr>
<td>ICD-10 Diagnosis</td>
<td>All related diagnoses</td>
</tr>
</tbody>
</table>

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

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and
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whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Consultation with technology evaluation center(s);
2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

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

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

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