



Louisiana

Saturation Biopsy for Diagnosis, Staging, and Management of Prostate Cancer

Policy # 00639

Original Effective Date: 01/01/2019

Current Effective Date: 11/09/2020

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.

Note: Gland Cryoablation of Prostate Cancer is addressed separately in medical policy 00022.

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 saturation biopsy in the diagnosis, staging, and management of prostate cancer to be **investigational**.*

Policy Guidelines

Saturation biopsy is generally considered obtaining more than 20 biopsy tissue cores from the prostate in a systematic manner; it is occasionally defined as obtaining more than 18 biopsy tissue cores.

Background/Overview

Prostate Cancer

Prostate cancer is common and is the second leading cause of cancer-related deaths in men in the U.S.

Diagnosis

The diagnosis of prostate cancer is made by biopsy of the prostate gland. The approach to biopsy has changed over time, especially with the advent of prostate-specific antigen screening programs that identify cancer in prostates that are normal to palpation and to transrectal ultrasound. For patients with an elevated prostate-specific antigen level but with a normal biopsy, questions exist about subsequent evaluation, because repeat biopsy specimens may be positive for cancer in a substantial percentage of patients.

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In the early 1990s, use of sextant biopsies involving 6 random, evenly distributed biopsies became the standard approach to diagnose prostate cancer. In the late 1990s, as studies showed high false-negative rates for this strategy (missed cancers), approaches were developed to increase the total number of biopsies and to change the location of the biopsies. While there is disagreement about the optimal strategy, most would agree that initial prostate biopsy strategies should include at least 10 to 14 cores. Additional concerns have been raised about drawing conclusions about the stage (grade) of prostate cancer based on limited biopsy specimens. Use of multiple biopsies has also been discussed as an approach to identify tumors that may be eligible for subtotal cryoablation therapy.

At present, many practitioners use a 12- to 14-core "extended" biopsy strategy for patients undergoing initial biopsy. This extended biopsy is done in an office setting and allows for more extensive sampling of the lateral peripheral zone; a sampling of the lateral horn might increase the cancer detection rate by approximately 25%.

Another approach to increasing the number of biopsy tissue cores is "saturation" biopsy. In general, saturation biopsy is considered as more than 20 cores taken from the prostate, with an improved sampling of the anterior zones of the gland, which may be undersampled in standard peripheral zone biopsy strategies and might lead to missed cancers. Saturation biopsy might be performed transrectally or transperineally; the transperineal approach is generally performed as a stereotactic template-guided procedure with general anesthesia.

Surveillance

In addition to the diagnosis of prostate cancer, some have suggested that saturation biopsy could be a part of active surveillance (a treatment approach that involves surveillance with prostate-specific antigen, digital rectal exam, and routine prostate biopsies in men whose cancers are small and expected to behave indolently). Saturation biopsy has the potential to identify tumor grade more accurately than standard biopsy.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Saturation biopsy is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

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Rationale/Source

Description

Saturation biopsy of the prostate, in which more cores are obtained than by standard biopsy protocol, has been proposed in the diagnosis (for initial or repeat biopsy), staging, and management of patients with prostate cancer.

Summary of Evidence

For individuals who have suspected prostate cancer who receive initial saturation biopsy, the evidence includes randomized controlled trials, observational studies, and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, test accuracy, and treatment-related morbidity. A 2013 systematic review found higher rates of cancer detection with saturation biopsy than with extended biopsy overall, but, in the subgroup of men with prostate-specific antigen levels less than 10 ng/mL, the degree of difference was small and possibly not clinically significant. Health outcomes (eg, survival rate) were not reported. Although several studies were published after the systematic review, none showed that initial saturation biopsy improved the detection of clinically significant cancers and none reported progression or survival outcomes. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have suspected prostate cancer who receive repeat saturation biopsy, the evidence includes observational studies and a systematic review. Relevant outcomes are overall survival, disease-specific survival, test accuracy, and treatment-related morbidity. Several studies have compared saturation with standard prostate biopsies in the repeat biopsy setting and have found significantly higher detection rates with saturation biopsy. However, at least 1 study found that about one-third of the positive findings with saturation biopsy were clinically insignificant cancers. Moreover, studies of saturation biopsy as the repeat prostate biopsy strategy focused on cancer detection rates and did not report health outcomes (eg, progression or survival). Evidence is lacking as to whether saturation biopsy leads to improved health outcomes, including the possibility of detecting clinically insignificant cancers, which could lead to unnecessary treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have prostate cancer and are candidates for active surveillance who receive saturation biopsy, the evidence includes 2 nonrandomized comparative studies. Relevant outcomes are overall survival, disease-specific survival, test accuracy, and treatment-related morbidity. Both

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studies retrospectively compared standard biopsy with saturation biopsy for selecting patients for active surveillance; neither found that saturation biopsy improved the ability to select patients. In 1 study, biopsy method was not a significant predictor of upstaging and, in the other study, biopsy method was not significantly associated with selecting patients with a high Gleason score. The evidence is insufficient to determine the effects of the technology on health outcomes.

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 3 physician specialty societies and 3 academic medical centers while this policy was under review in 2014. There were 5 responses from 1 specialty society, 4 responses from another, and 1 response from the third, for a total of 10 specialty society responses. Most reviewers stated that saturation biopsy is considered investigational and did not think that saturation biopsy in patients with 2 prior negative biopsies and persistently rising prostate-specific antigen level is considered medically necessary. Clinicians proposed various options that could be used in the situation of prior negative biopsies and rising prostate-specific antigen level: there was no consensus on the best approach. Suggestions included magnetic resonance imaging with transrectal ultrasound, multiparametric magnetic resonance imaging, and 3T pelvic magnetic resonance imaging. There was near consensus that there is insufficient evidence to support the use of any of these techniques for the indications being considered.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines

The National Comprehensive Cancer Network guidelines (v.2.2019) on early detection of prostate cancer state that routine use of advanced biopsy techniques, including saturation biopsy, is not recommended for initial biopsy. However, based on emerging evidence the guidelines state that saturation biopsy can be considered for "very high-risk" men with previous negative biopsies. The guidelines do not specify a definition of "very high-risk", but state that men with persistently elevated

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or rising PSA after 1 or more negative TRUS biopsies are considered at "high risk". The guidelines also note that alternative strategies using MRI or biomarkers may avoid the use of biopsy altogether. The emerging evidence cited in the guidelines included 1 prospective nonrandomized study (Zaytoun et al 2011) and uncontrolled observational studies published between 2006 and 2013.

NCCN guidelines on prostate cancer treatment (v.2.2020) do not mention saturation biopsy.

U.S. Preventive Services Task Force Recommendations

The U.S. Preventive Services Task Force (2018) recommendations on prostate cancer screening did not address saturation biopsy.

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 search of [ClinicalTrials.gov](https://clinicaltrials.gov) in June 2020 did not identify any ongoing or unpublished trials that would likely influence this review.

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10/04/2018 Medical Policy Committee review
10/17/2018 Medical Policy Implementation Committee approval. New policy.
10/03/2019 Medical Policy Committee review
10/09/2019 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
10/01/2020 Medical Policy Committee review
10/07/2020 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 10/2021

Coding

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

Code Type	Code
CPT	55706
HCPCS	No codes
ICD-10 Diagnosis	C61, D07.5, D40.0

*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 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 the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated 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.

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