

7.01.102 Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux

Original Policy Date:	March 30, 2015	Effective Date:	October 1, 2024
Section:	7.0 Surgery	Page:	Page 1 of 13

Policy Statement

- I. Periureteral bulking agents may be considered **medically necessary** as a treatment of vesicoureteral reflux grades II, III, or IV when medical therapy has failed and surgical intervention is otherwise indicated.
- II. The use of bulking agents as a treatment of vesicoureteral reflux in other clinical situations is considered **investigational**.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

The use of bulking agents is contraindicated in individuals with nonfunctioning kidney(s), Hutch diverticuli, active voiding dysfunction, and ongoing urinary tract infection.

Coding

See the [Codes table](#) for details.

Description

Most commonly seen in children, vesicoureteral reflux (VUR) is the retrograde flow of urine from the bladder upward toward the kidney. The primary management strategies have been prophylactic antibiotics to reduce urinary tract infections and, for higher grade disease, surgical correction of the underlying reflux. Injection of periureteral bulking agents is proposed as an alternative to surgical intervention.

Related Policies

- [Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence](#)

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

In 2001, Deflux was approved by the U.S. Food and Drug Administration (FDA) through the premarket application process for the "treatment of children with vesicoureteral reflux (VUR) grades II-IV" and

remains the only FDA-approved bulking agent for VUR.¹¹ Contraindications include patients with nonfunctioning kidney(s), Hutch diverticulum, ureterocele, active voiding dysfunction, and ongoing UTI. Duplicated ureters were initially considered a contraindication to Deflux treatment, but this was changed to a precaution in 2007.

FDA product code: LNM.

Rationale

Background

Vesicoureteral Reflux

Vesicoureteral reflux (VUR) predisposes patients to urinary tract infections (UTIs) and renal infection (pyelonephritis) by facilitating the transport of bacteria from the bladder to the upper urinary tract. Pyelonephritis causes renal scarring in as many as 40% of children, and extensive scarring may lead to renal insufficiency and hypertension. The period between first renal scarring from pyelonephritis and the development of hypertension or end-stage renal disease can be 30 to 40 years.¹ Although the exact prevalence of VUR in the general population is unknown, a meta-analysis of more than 250 articles revealed its occurrence in 31.1% of children who were evaluated for a UTI and 17.2% in those with normal kidneys who underwent a voiding cystourethrogram for other indications, such as hydronephrosis.²

Diagnosis

In most cases, VUR is diagnosed after a febrile UTI episode or abnormality seen on ultrasound imaging.³ Approximately one-third of children with UTIs are found to have VUR.⁴ The average age for UTI onset is 2 to 3 years, corresponding to the age when toilet training occurs. There also appears to be a genetic predisposition to VUR; therefore, siblings may also be examined.

The criterion standard for diagnosis is voiding cystourethrography, a procedure that involves catheterization of the bladder. According to the 2011 American Academy of Pediatrics guideline on the diagnosis and management of the initial UTI in febrile infants and children 2 to 24 months of age (reaffirmed in 2016), voiding cystourethrography should not be performed routinely after the first febrile UTI.⁵ Voiding cystourethrography is indicated if renal and bladder ultrasonography reveals hydronephrosis, scarring, or other findings that would suggest either high-grade VUR or obstructive uropathy, as well as in other atypical or complex clinical circumstances. The severity of reflux is described by a grade, typically with the International Reflux Study Group grading system, which grades severity from I (reflux partway up the ureter) to V (massive reflux of urine up the ureter with marked tortuosity and dilation of the ureter and calyces). Determination of VUR grade is not exact, however, due to factors such as bladder pressure, which may vary at the time of measurement. In general, more severe reflux is associated with higher rates of renal injury, and less severe reflux (i.e., grade I and II) is associated with higher rates of spontaneous resolution and treatment success.^{6,7} Other factors found to be associated with the likelihood of spontaneous resolution of VUR and/or renal injury include age, sex, laterality, the presence of renal scars, the presence of voiding dysfunction, and history of UTI.¹

Treatment

Treatment strategies for VUR include bladder training, antibiotic prophylaxis, and surgical modification of the ureter to correct the underlying reflux. Vesicoureteral reflux is likely to resolve spontaneously over 1 to 5 years; lower grades of reflux (i.e., grades I and II) are associated with a higher probability of spontaneous resolution.^{6,7,3} The decision to administer prophylactic antibiotic treatment includes consideration of potential adverse events of long-term antibiotic therapy, which can include allergic reactions and development of treatment-resistant bacteria resulting in breakthrough UTIs.

Open surgical treatment is typically reserved for patients with high-grade reflux (grades III and IV) or as salvage therapy for those who are noncompliant with antibiotic therapy or have breakthrough UTIs while receiving prophylactic therapy. Surgical management involves lengthening the intramural ureter by modification of the ureterovesical attachment with reimplantation of the ureter. Success rates for open surgery are reported to be greater than 95% and nearly 100% for patients with lower grades of reflux. Advances in surgical technique, including the use of a lower abdominal transverse incision, have led to smaller scars. Combined with a reduction in the use of ureteral stents and prolonged catheterization, the changes have led to shorter hospital stays and reduced surgery-related morbidity. Moreover, surgeries can now be done on an outpatient basis. Surgery, however, still involves risks associated with anesthesia and potential complications, such as ureteral obstruction, infection, and bleeding.¹ Some centers have reported using laparoscopic antireflux surgery, but this is technically difficult and not widespread. Robotic-assisted laparoscopic methods are being developed to overcome some of the technical difficulties.⁸

Treatment of VUR remains controversial. There is a lack of good evidence that VUR actually increases the risk of pyelonephritis and renal scarring, and the long period of time before renal scarring, hypertension, and end-stage renal disease makes these serious conditions difficult to study. Moreover, VUR has a relatively high rate of spontaneous resolution (>60% over 5 years), so many children may not benefit from treatment.⁹ An important challenge is to identify the subset of children most likely to benefit from VUR treatment.³ At present, in the absence of definitive answers on the utility of treating VUR or the best treatment option, antibiotic prophylaxis to prevent recurrent UTIs and surgery to treat the underlying reflux remain accepted management strategies.

Bulking Agents

The use of bulking agents in the treatment of VUR has been reported for more than 20 years and is suggested as an alternative to antibiotic and surgical therapy. Bulking agents can be injected into tissue around the ureteral orifices to minimize reflux. The STING procedure (subureteral transurethral injection) involves the endoscopic injection of a bulking agent into the submucosal bladder wall just below the ureteral opening. In the modified STING procedure, the needle is placed in the ureteral tunnel, and the bulking agent is injected into the submucosal intraureteral space. When successfully injected, the compound tracks along the length of the detrusor tunnel and establishes a coated ureteral tunnel. More recently, the HIT (hydrodistension of the ureteric orifice and injection of bulking agents in the mid to distal submucosal tunnel at the 6 o'clock position) and double HIT (modified HIT with proximal and distal intraluminal submucosal injections) techniques have gained favor; a meta-analysis revealed that overall VUR resolution was 82.5% with HIT as compared to 71.4% with STING ($p < .00001$).^{3,10} These endoscopic procedures can be performed in an outpatient setting.

A variety of bulking agents have been tested for biocompatibility and absence of migration. Some compounds used in clinical studies are collagen (Contigen[®] [Allergan, Coolock; note: this product is no longer commercially available], Zyderm[®] and Zyplast[®] [use discontinued due to immune reaction concerns]¹¹, polytetrafluoroethylene paste (Teflon) [use discontinued due to concerns regarding particle migration]¹¹, polydimethylsiloxane (Macropastique[®]) [use discontinued due to concerns of malignant potential]¹¹, calcium hydroxyapatite (Coaptite[®]), dextranomer/hyaluronic acid copolymer (Deflux[®], Dexell[®], or Dx/HA), polyacrylamide hydrogel (Bulkamid[®] [Axonics]), and polyacrylate-polyalcohol copolymer (Vantris[®] [Promedon]).

Adverse Events

According to case series data, injection of periureteral bulking agents is associated with low morbidity rates. Temporary postoperative ureteral obstruction may occur in less than 0.7% of patients following injection of bulking agents; this can be treated with ureteral stenting until the problem resolves.¹² In comparison, on average, a 2% (range, 0% to 9%) ureteral obstruction and reoperation rate has been reported following ureteral reimplantation.¹³ In 2019, Friedmacher and Puri estimated the incidence of ureteral obstruction following endoscopic injections of various substances (i.e., Dx/HA, polyacrylate polyalcohol, polydimethylsiloxane, calcium hydroxyapatite,

polytetrafluoroethylene, or collagen) in 25 publications.¹⁴ Results revealed ureteral obstruction to be a rare complication after endoscopic correction of VUR, generally occurring in less than 1% of treated cases independent of the injected substance, volume, and technique.

A large series published by Puri et al (2012) retrospectively reported on 1551 children injected with Dx/HA for high-grade VUR.¹⁵ The only reported procedure-related complication was hematuria lasting up to 12 hours in 3 patients. There was no evidence of delayed vesicoureteral junction obstruction. Febrile UTIs occurred in 69 (5%) patients during follow-up; median follow-up was 5.6 years. Dwyer et al (2013) compared the rate of febrile UTIs in 2 cohorts of patients with VUR.¹⁶ The incidence of febrile UTI did not differ significantly between patients who had ureter reimplantation (8% [16/210 cases]) and those who had endoscopic injections of Dx/HA (4% [4/106 patients]) ($p=.24$). Lightfoot et al (2019) evaluated long-term outcomes after Dx/HA injection for primary VUR in 99 patients (median follow-up: 8.4 years).¹⁷ Results revealed that a secondary surgery was performed in 13 (13.1%) patients, which was most commonly a repeat Dx/HA injection. Only 3 (3%) patients required open or laparoscopic surgery after Dx/HA injection. Additionally, of the 83 (84.7%) patients reporting ≥ 1 febrile UTIs preoperatively, only 9 (10.8%) reported postoperative occurrence of febrile UTIs.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trials are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Efficacy of Bulking Agents for Vesicoureteral Reflux

Treatment of vesicoureteral reflux (VUR) with periurethral bulking agents is proposed for 2 indications: (1) an alternative to other types of surgery for individuals with high-grade VUR (predominantly grades III and IV) who have failed or are noncompliant with prophylactic antibiotics; and (2) an alternative to prophylactic antibiotics for individuals with low-grade or high-grade VUR (i.e., those who have not failed medical treatment and may be ineligible for surgery).

Clinical Context and Therapy Purpose

The purpose of endoscopic treatment with periureteral bulking agents in individuals with VUR who have either failed medical therapy and are eligible for surgery or not failed medical therapy and may be ineligible for surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant populations of interest are individuals with VUR who have either failed medical therapy and are eligible for surgery or have not failed medical therapy and may be ineligible for surgery.

Primary VUR is the most common type of VUR and occurs as a result of a congenitally incompetent ureterovesical junction. Children younger than 2 years of age, white ethnicity, and female sex are risk factors for VUR. Children with partial or complete duplicated ureters are also at an increased risk of VUR.

Interventions

The therapy being considered is endoscopic treatment with periureteral bulking agents.

Comparators

The following therapies and practices are currently being used to make decisions about VUR: ureteral reimplantation surgery for individuals who have either failed medical therapy and are eligible for surgery or antibiotic prophylaxis, ureteral reimplantation surgery, and surveillance only for those who have not failed medical therapy and may be ineligible for surgery.

Outcomes

The general outcomes of interest are a reduction in urinary tract infections (UTIs), reduction in the incidence of pyelonephritis, and treatment-related adverse events.

Appropriate outcomes for the comparison of bulking agents and other types of surgery are the resolution of reflux and reduction in the rate of UTIs and pyelonephritis. Because prophylactic antibiotic use does not treat the underlying reflux, reduction in the rate of UTIs and pyelonephritis are reasonable outcomes for studies comparing antibiotics with bulking agents. Differences in morbidity are also important outcomes for both proposed uses. Bulking agents may or may not be curative, and follow-up injection may be necessary within 6 months. Beneficial effects may last between 3 and 12 months.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Systematic Reviews

A Cochrane review by Williams et al (2019) included RCTs evaluating treatments for VUR.¹⁸ Reviewers addressed a variety of interventions including long-term antibiotic prophylaxis, open surgery, and the use of bulking agents. The reviewers' decision to combine studies on open surgery and bulking agents limited the ability to analyze the efficacy of bulking agents. This Cochrane review selected 34 trials (N=4001 children). Four studies compared endoscopic injection with antibiotics alone and 3 studies

assessed the outcome of febrile UTI. There was little or no difference in the risk of febrile UTI with endoscopic injection as compared to antibiotic therapy (relative risk [RR], 0.74; 95% confidence interval [CI], 0.31 to 1.78; low certainty evidence). Four studies comparing 2 different materials for endoscopic injection (n=425 children) reported VUR resolution rates and the 2 studies that compared Macroplastique to Deflux found Macroplastique to be probably superior to Deflux (3 months: RR, 0.50; 95% CI, 0.33 to 0.78; 12 months: RR, 0.54; 95% CI, 0.35 to 0.83; low certainty evidence).

In a systematic review and network meta-analysis, Mina-Riascos et al (2021) evaluated the effectiveness and safety of endoscopic management versus ureteral reimplantation in pediatric patients (1 month to 15 years of age) with primary high-grade VUR.¹⁹ The authors evaluated clinical experiments, quasi-experiments, and cohort studies for this review; bulking agents used in the studies included polytetrafluoroethylene, hyaluronic acid, collagen, dextranomer/hyaluronic acid (Dx/HA), and polyacrylate-polyalcohol copolymer. Overall 9 studies met the inclusion criteria - 7 observational and 2 clinical experiments. The primary outcome was the occurrence of post-treatment UTI. When comparing endoscopic management (Dx/HA and polyacrylate-polyalcohol copolymer) to ureteral reimplantation, no significant differences were found in mixed comparisons. Only 3 studies assessed complications with no statistically significant differences observed. Limitations of this systematic review include a lack of stratification by grade and patient age. Only 3 studies reported UTI diagnostic criteria, which may potentially lead to information bias.

A systematic review by Routh et al (2010) identified randomized trials and observational studies evaluating Dx/HA copolymer treatment for pediatric VUR.²⁰ A total of 47 studies, mainly retrospective case series, met eligibility criteria. A key inclusion criterion was that studies report the postoperative success rate after a single injection of Dx/HA. Success was defined as resolution of VUR and could also include downgrading to grade I VUR. Of 7303 ureters injected with Dx/HA, 5633 (77%) were considered treatment successes. There were higher rates of success in children with low-grade reflux than in those with high-grade reflux. For example, the 164 children whose preoperative VUR was grade I had an 89% success rate compared with a 59% success rate among the 1109 children with initial grade IV VUR.

Randomized Controlled Trials Periureteral Bulking Agents versus Surgery

The first RCT comparing periureteral bulking agents with ureteral reimplantation was published by Garcia-Aparicio et al (2013). The authors randomized 41 children older than 1 year of age with VUR grades I to IV to endoscopic treatment with Dx/HA (n=22) or ureteral reimplantation (n=19).²¹ Indications for surgery included recurrent UTIs, persistent VUR after 2 years of antibiotic prophylaxis, impairment of renal function, or another type of impairment due to VUR. Thirty-five refluxing ureters were treated with bulking agents, and 32 refluxing ureters were treated with ureteral reimplantation. One year after treatment, 32 (91.4%) of 35 ureters in the Dx/HA group and 32 (100%) of 32 ureters in the surgical reimplantation group were cured; the difference between groups was not statistically significant (p=.23). Findings were similar at final follow-up. At 5 years, 30 (85.7%) of 35 ureters in the Dx/HA group and 100% in the ureteral reimplantation group were free of VUR (p=.48). One patient in the Dx/HA group and 2 patients in the ureteral reimplantation group experienced treatment complications. Two patients in the Dx/HA group and none in the ureteral reimplantation group experienced fevers posttreatment. Rates of complications and adverse events did not differ significantly between groups. Trial results supported a finding of no large differences between the 2 treatments, but the study was not powered to detect smaller differences in outcomes and was also likely too small to detect differences in complications and adverse events.

Salih et al (2021) randomly assigned 60 pediatric patients older than 1 year of age with primary VUR grades III and IV to endoscopic injection of Dx/HA (n=30) or extravesical ureteral reimplantation utilizing an open Lich-Gregoir technique (n=30).²² Indications for the intervention included recurrent UTI, impairment of renal function due to reflux, persistence of reflux after continuous antibiotic prophylaxis, and renal scarring, with the majority of cases operated on for breakthrough infections.

Endoscopic Dx/HA was performed in 45 refluxing ureters and open ureteral reimplantation was conducted in 48 refluxing ureters. The mean follow-up for all patients was 17.7 ± 7.1 months. Overall reflux resolution was 80% (36/45) of the ureters in the Dx/HA group after a single injection and 93.75% (45/48) of the ureters in the ureteral reimplantation group ($p=.007$). Endoscopic injection failed in 9 ureters; therefore, another Dx/HA injection was given with improvement in 4 cases. The failed 5 cases after the second injection underwent salvage ureteral reimplantation. The mean operative time was longer for the ureteral reimplantation group versus the endoscopic group (110.3 ± 18.9 minutes vs. 28.6 ± 7.4 minutes; $p<.001$) and the median hospital stay was significantly shorter in the endoscopic injection group (1 vs. 4 days; $p<.001$). Trial results supported a finding of an increased success rate with ureteral reimplantation in comparison to endoscopic injection of Dx/HA; however, the minimally invasive endoscopic injection was superior in terms of operative time and hospital stay.

Periureteral Bulking Agents versus Antibiotic Prophylaxis

Findings from the Swedish Reflux Trial in children were published by Brandstrom et al (2010).^{23,24,25,26} This nonblinded multicenter study included 203 children (128 girls, 75 boys) between the ages of 1 and 2 years with grade II, III, or IV reflux. Participants were not required to have failed antibiotic prophylaxis; thus, the trial evaluated injection of a bulking agent as an alternative to antibiotic therapy. Most participants (194 [96%]) were identified after a symptomatic UTI. Recruitment was more difficult than expected, and enrollment was stopped after 6 years. Participants were randomized to 1 of 3 groups: antibiotic prophylaxis ($n=69$), endoscopic treatment with Deflux ($n=66$), or surveillance only ($n=68$).

The trial aimed to simulate clinical practice (i.e., prophylactic antibiotics were prescribed without monitoring compliance) rather than ensuring that study participants took a known dose of antibiotics. Primary study outcomes included VUR status, and rates of febrile UTI and kidney damage after 2 years. Sixty-four of 66 patients randomized to endoscopy received treatment. Fourteen of 19 patients with ongoing dilating VUR after 1 injection received a second injection; 2 patients received a third injection. Complications occurred in 6 (9%) of the 64 individuals who received endoscopic treatment. Overall, 187 (92%) participants completed at least 6 of the 8 follow-up visits; analysis was intention to treat. Two-year cystourethrography was done in 185 (91%) of the 203 patients. Voiding cystourethrography findings indicated that VUR had resolved in 9 (13%) of 68 patients in the prophylaxis group, in 20 (38%) of 52 in the endoscopy group, and in 10 (15%) of 65 in the surveillance group. The proportion of patients in the 3 groups whose VUR was downgraded to grade I or II was 18 (26%) of 68, 17 (33%) of 52, and 21 (32%) of 65, respectively. There was a significantly greater proportion of patients whose VUR had resolved or had been downgraded in the endoscopy group than in the prophylaxis ($p<.001$) and the surveillance groups ($p=.003$). Thirteen (20%) of the 66 patients randomized to endoscopy whose VUR had initially resolved or been downgraded experienced recurrences and had stage III or IV VUR at 2 years.

Febrile UTI rates by treatment group in girls were 8 (19%) of 43, 10 (23%) of 43, and 24 (57%) of 42, respectively, in the prophylaxis, endoscopic, and surveillance groups. Rates were significantly higher in the surveillance group than either the prophylaxis group ($p=.002$) or the endoscopic group ($p=.14$); rates did not differ significantly between the prophylaxis and endoscopic groups. Rates of febrile UTI recurrence during follow-up were dramatically higher in girls (42/128 [33%]) than in boys (7/75 [9%]). The rate of new renal damage did not differ significantly among groups.

After stratifying findings by sex, the sample sizes in reported analyses were relatively small. For this reason, the study might have been insufficiently powered to evaluate some of the outcomes of interest (e.g., kidney damage, febrile UTIs). Moreover, findings might not be applicable to children outside of the restricted age range evaluated or to those with lower grade VUR. Larger studies with a more representative sample of children with VUR are needed to evaluate the effectiveness of this treatment further.

Capozza and Caione (2002) reported on the results of 61 children with VUR (grades II to IV) who were randomized to an endoscopic subureteral implantation (n=40) of Deflux or 12 months of antibiotic prophylaxis (n=21).²⁷ Entry criteria included grades II, III, or IV reflux present for at least 6 months. The antibiotic therapy was not specified and presumably varied. It was not reported whether patients had been receiving antibiotic therapy during the preceding 6 months and experienced breakthrough UTIs, were noncompliant, or showed no evidence of spontaneous resolution of VUR. Therefore, it is unknown whether the Deflux treatment was primarily considered an alternative to medical therapy or to surgical therapy. Partly due to the small numbers in the antibiotic control group, the distribution of the different grades of VUR differed between groups. Outcomes included improvement in reflux grade and measures of renal function; incidence of UTIs was not reported. The only statistically significant outcome reported was an improvement in reflux grade at month 12, with 69% of those in the Deflux group reporting a reflux grade of I or less compared with only 38% in the antibiotic group. However, these results should not be surprising, because antibiotic therapy is not intended to improve reflux grade but simply to sterilize the urine while awaiting the spontaneous resolution of VUR. Therefore, the only conclusion is that Deflux results in a higher incidence of VUR resolution than spontaneous resolution.

Children With Duplicated Ureters

No controlled studies have been published comparing bulking agents with other treatments in children with duplicated ureters. However, several case series are available, and these uncontrolled studies suggest reasonable response rates without high complication rates in this population. Hunziker et al (2013) published a case series of 123 children with complete duplex systems who were treated with Dx/HA for grade II, III, IV, or V VUR.²⁸ The mean age of participants was 3 years (range, 1 month to 12 years). Complete duplicated ureters were unilateral in 100 (81%) patients and bilateral in the remaining 13. A total of 136 refluxing ureteral units were treated with endoscopic injections of Dx/HA. Three months after treatment, children were evaluated using voiding cystourethrography and bladder ultrasound. The rate of VUR resolution after 1 injection was 68.4% (93/136 ureters). Vesicoureteral reflux resolved in an additional 35 (25.7%) ureters after a second injection and in the remaining 8 (5.9%) ureters after a third injection. There was 1 complication associated with the endoscopic injections, which was a case of frank hematuria. No patients needed ureteral reimplantation, and there was no evidence on ultrasound of delayed vesicoureteral junction obstruction. Five (4%) patients developed febrile UTIs during follow-up.

Molitierno et al (2008) included 52 children with duplex ureters who had grade II, III, IV, or V VUR.²⁹ Overall, VUR was cured in 44 (85%) of 52 patients after 1 or 2 treatments with Dx/HA. Lackgren et al (2003) evaluated 68 children with duplex ureters and VUR.³⁰ Forty-three (63%) children had a positive response to treatment, defined as having their reflux resolve to grade 0 or I. There were no complications associated with treatment. Seventeen (25%) children required open surgery.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

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.

American Urological Association

In 2017, the American Urological Association reviewed and confirmed the validity of its 2010 published guideline on the management of primary vesicoureteral reflux (VUR) in children.³¹ The Association

recommended that patients older than 1 year of age who have a febrile breakthrough urinary tract infection while receiving continuous antibiotic prophylaxis be considered for open surgery or endoscopic injection of bulking agents. Specific bulking agents mentioned were Deflux and Macroplastique. The guideline was based on a review of the evidence, but its authors acknowledged the lack of robust randomized controlled trial data.

U.S. Preventive Services Task Force Recommendations

The U.S. Preventive Services Task Force has not addressed the use of injectable bulking agents to treat VUR.

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 did not reveal any relevant ongoing clinical trials as of June 12, 2024.

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Clinical findings and duration of urinary tract infections (UTIs)
 - Comorbidities
 - International Reflux Study Group grading system
 - Pertinent past procedural and surgical history
 - Prior diagnostic testing and results
 - Prior conservative treatments, duration, and response
- If significant comorbidities, consultation and medical clearance report(s) (if indicated)
- Radiology report(s) and interpretation (i.e., renal ultrasound, voiding cystourethrogram)

Post Service (in addition to the above, please include the following):

- Procedure report (s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material
HCPCS	L8604	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, urinary tract, 1 ml, includes shipping and necessary supplies

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
03/30/2015	BCBSA Medical Policy Adoption
07/01/2016	Policy revision without position change
10/01/2017	Policy revision without position change
10/01/2018	Policy revision without position change
10/01/2019	Policy revision without position change
10/01/2023	Policy reactivated. Previously archived from 08/01/2020 to 09/30/2023.
10/01/2024	Annual review. No change to policy statement. Policy guidelines and literature review updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) 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 Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux 7.01.102</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Periureteral bulking agents may be considered medically necessary as a treatment of vesicoureteral reflux grades II, III, or IV when medical therapy has failed and surgical intervention is otherwise indicated. II. The use of bulking agents as a treatment of vesicoureteral reflux in other clinical situations is considered investigational. 	<p>Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux 7.01.102</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Periureteral bulking agents may be considered medically necessary as a treatment of vesicoureteral reflux grades II, III, or IV when medical therapy has failed and surgical intervention is otherwise indicated. II. The use of bulking agents as a treatment of vesicoureteral reflux in other clinical situations is considered investigational.