

Benign Prostatic Hypertrophy Treatments as an Alternative to Transurethral Resection of the Prostate (TURP), Surgical 83

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Benign Prostatic Hypertrophy BPH Treatments are drug therapy or surgical intervention procedures that decrease the size of the prostate used as an Alternative to Transurethral Resection of the Prostate (TURP).

Criteria:

Benign Prostatic Hypertrophy treatments (surgical alternatives to Transurethral Resection of the Prostate (TURP)) is considered medically necessary for individuals with **ALL** of the following:

- Failure, contraindication, or intolerance to at least 3 months of conventional medical therapy for LUTS/BPH (eg, alpha blocker, PDE5 inhibitor, finasteride/dutasteride)
- International Prostate Symptom Score of 8 or greater
- Individual wants an alternative to transurethral resection of the prostate (TURP)
- Severe symptoms that cause discomfort, interfere with daily activities, or threaten health with **1 or more** of the following:
 - Lower urinary tract symptoms (eg, Urinary retention) secondary to enlarged prostate
 - Renal insufficiency secondary to enlarged prostate
 - Recurrent or persistent urinary tract infections secondary to enlarged prostate
 - Recurrent gross hematuria secondary to enlarged prostate
 - Recurrent bladder stones secondary to enlarged prostate
- Treatment to include **1 or more** of the following:
 - Contact laser ablation of the prostate (CLAP)
 - Robotic Waterjet Treatment (RWT) (eg, AquaBeam, Aquablation, Waterjet system) with **ALL** of the following:
 - Age ≤ 80 years
 - International Prostate Symptom Score (IPSS) ≥ 12
 - LUTS/BPH not previously treated with fluid jet system
 - Maximum urinary flow rate (Qmax) of ≤ 15 mL/s (voided volume greater than 125 cc)

- Prostate volume of 30 cc to 150 cc by transrectal ultrasound
- Transurethral Ultrasound Ablation (TULSA)

Benign Prostatic Hypertrophy treatments are considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Endoscopic balloon dilation of the prostate
- Cellular Therapy Injections
- Drug-coated Balloon (e.g. Optilume BPH) 52443
- Transperineal laser ablation of the prostate (TLAP)
- Transrectal thermal therapy (including transrectal microwave hyperthermia, transrectal radiofrequency hyperthermia, transrectal electrothermal hyperthermia, and transrectal high-intensity focused ultrasound)

Document History:

Revised Dates:

- 2025: March – Implementation date of June 1, 2026. Procedure codes updated to align with changes to service authorization. Additional criteria, exclusions and housekeeping.
- 2024: April
- 2021: March
- 2020: April
- 2019: October
- 2016: January
- 2015: March, April, July, October
- 2013: March, June
- 2012: February
- 2011: February
- 2010: February

Reviewed Dates:

- 2023: March
- 2022: March
- 2019: February
- 2018: November
- 2017: December
- 2016: March
- 2014: April
- 2009: February

Origination Date:

- March 2008

Coding:

Medically necessary with criteria:

Coding	Description
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume less than 50 mL
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction
52597	Transurethral robotic-assisted waterjet resection of prostate, including intraoperative planning, ultrasound guidance, control of postoperative bleeding, complete, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy, when performed

Considered Not Medically Necessary:

Coding	Description
0867T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL
52443	Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed
53899	Unlisted procedure, urinary system

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage
 - See the appropriate benefit document for specific coverage determination. Individual specific benefits take precedence over medical policy.
- Application to products
 - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
 - Use MCG Prostatectomy, Transurethral Resection (TURP) (S-970) for simple prostatectomy and TURP codes
- Authorization requirements
 - Pre-certification by the Plan is required.
- Special Notes:
 - This medical policy express Sentara Health Plan’s determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
 - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to “correct or ameliorate” (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member’s condition. [EPSDT Supplement B \(updated 5.19.22\) Final.pdf](#)
- Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider within 60 days of the date of service requested.

References:

References used include but are not limited to the following: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; Uptodate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Benign, prostate, prostatic, hypertrophy, cystourethroscopy, vaporization, enucleation, transurethral, ablation, prosthesis, SHP Benign Prostatic Hypertrophy Treatments, SHP Surgical 83, enlarged prostate, Hormonal manipulation, finasteride, Alpha adrenergic blockers, Ultrasonic aspiration, Transurethral incision, Laser prostatectomy, Transurethral microwave thermotherapy, TUMT, benign prostatic hyperplasia, BPH, transurethral resection of the prostate, TURP, Transurethral needle ablation, TUNA, Transurethral electrovaporization, TUVF, UroLume endourethral prosthesis, bulbar urethral stenosis, bulbar urethral, dilation, urethrotomy, urethroplasty, Photo selective laser vaporization of the prostate, PVP, Contact laser ablation of the prostate, CLAP, Holmium laser procedures of the prostate, HoLAP, HoLEP, HoLRP,

Transurethral ultrasound guided laser induced prostatectomy, TULIP, Visually guided laser ablation of the prostate, VLAP, Prostatic urethral lift, UroLift