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

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Effective Date	3/2008
Next Review Date	3/1/2024
Coverage Policy	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.*.

Purpose:

This policy addresses Benign Prostatic Hypertrophy Treatments as an **Alternative** to Transurethral Resection of the Prostate (TURP).

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 are considered medically necessary for **1 or more** of the following:

- Severe symptoms that cause discomfort, interfere with daily activities, or threaten health with **1 or more** of the following**:**
  - Individual has failed or has contraindications to medical therapy
  - Individual wants an alternative to transurethral resection of the prostate
- Treatment to include **1 or more** of the following**:**
  - Alpha adrenergic blockers
  - Contact laser ablation of the prostate (CLAP)
  - Cryosurgical Ablation
  - Holmium laser procedures of the prostate (HoLAP, HoLEP, HoLRP)
  - Hormonal manipulation (including finasteride)
  - Laser prostatectomy
  - Photo selective laser vaporization of the prostate(PVP)
  - Prostatic urethral lift (UroLift)

- Salvage Cryosurgery of Prostate after Radiation Failure for all of the following:
  - Individual has failed a trial of radiation therapy as their primary treatment
  - Individual with 1 or more of the following:
    - Stage T2B or below
    - Gleason score <9
    - PSA <8 ng/mL
- Transurethral electrovaporization (TUVP)
- Transurethral incision (TUIP)
- Transurethral microwave thermotherapy (TUMT) for **all of the following**:
  - Individual has symptomatic benign prostatic hyperplasia (BPH)
  - Individual has failed or is not a candidate for medical therapy
  - Individual wishes to avoid more invasive therapies such as transurethral resection of the prostate (TURP)
- Transurethral needle ablation (TUNA)
- Transurethral ultrasound guided laser induced prostatectomy (TULIP)
- Transurethral Waterjet Ablation of the Prostate may be covered for ALL of the following:
  - Lower urinary tract symptoms attributable to benign prostatic hyperplasia (LUTS/BPH)
  - LUTS/BPH not previously treated with fluid jet system
  - Age ≤ 80 years
  - Prostate volume of 30 cc to 150 cc by transrectal ultrasound
  - Persistent moderate to severe symptoms despite maximal medical management, including ALL of the following:
    - International Prostate Symptom Score (IPSS) ≥ 12
    - Maximum urinary flow rate (Qmax) of ≤ 15 mL/s (voided volume greater than 125 cc)
    - Failure, contraindication, or intolerance to at least 3 months of conventional medical therapy for LUTS/BPH (eg, alpha blocker, PDE5 inhibitor, finasteride/dutasteride)
  - Waterjet system is FDA approved/cleared
- Ultrasonic aspiration
- UroLume endourethral prosthesis for permanent use with **1 or more** of the following**:**
  - Individuals 60 years of age or older
  - Individuals under 60 years of age who are poor surgical candidates with a prostate at least 2.5 centimeters in length
  - Individuals with recurrent bulbar urethral stenoses/strictures when previous therapeutic approaches such as dilation, urethrotomy, or urethroplasty have failed
- Visually guided laser ablation of the prostate (VLAP)
- Water vapor thermal therapy (e.g., Rezūm System)

Benign Prostatic Hypertrophy Treatments is not medically necessary for any other indication other than the uses listed in clinical criteria including the but not limited to the following:

- Absolute ethanol injection (transurethral)
- Botulinum toxin
- Endoscopic balloon dilation of the prostate
- Plasma kinetic vaporization (PlasmaKinetic Tissue Management System, Gyrus,)
- Prostate artery embolization
- Repeat Transurethral microwave thermotherapy (TUMT)
- Water-induced thermotherapy (hot-water balloon thermoablation)

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)

52282	Cystourethroscopy, with insertion of permanent urethral stent
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)
52450	Transurethral incision of prostate
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

Considered Not Medically Necessary:

Coding	Description
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
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement
53899	Unlisted procedure, urinary system

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 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

Effective Date:

- March 2008

References:

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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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 by 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.*

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, TUVP, 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