Sentara Health Plans

Commercial

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

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Effective Date	6/1/2026
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

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. Addintional 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

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

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. 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.

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 Commercial products.
  - Use MCG Prostatectomy, Transurethral Resection (TURP) (S-970) for simple prosctectomy and TURP codes
- Authorization requirements
  - Pre-certification by the Plan is required.
- Special Notes:
  - Commercial
    - 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.
    - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered

Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

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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LCD: Transurethral Waterjet Ablation of the Prostate (L38549). (2025, Dec 14). Retrieved Feb 06, 2026, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38549&ver=17&keyword=Benign%20prostate&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

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NCD: Cryosurgery of Prostate (230.9). (2001, Jul 01). Retrieved Feb 06, 2026, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=123&ncdver=1&keyword=cryosurgery&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

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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, 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