Sentara® Health Plans

Commercial

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	3/15/2024
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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 *.

Purpose:

This policy addresses the medical necessity of 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 individuals with **All** 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 considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- 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: *

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.

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