

## Procedures for the Treatment of Benign Prostatic Hypertrophy (BPH)

Effective: August 1, 2024

<p><b>Prior Authorization Required</b> If <u>REQUIRED</u>, submit supporting clinical documentation pertinent to service request.</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p><b>Notification Required</b> IF <u>REQUIRED</u>, concurrent review may apply</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>

### Applies to:

#### Commercial Products

- Harvard Pilgrim Health Care Commercial products; 800-232-0816
- Tufts Health Plan Commercial products; 617-972-9409  
CareLink<sup>SM</sup> – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

#### Public Plans Products

- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
- Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
- Tufts Health One Care – A dual-eligible product; 857-304-6304

#### Senior Products

- Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
- Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
- Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

**Note:** While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

### For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual<sup>®</sup> criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at [www.harvardpilgrim.org/providerportal](http://www.harvardpilgrim.org/providerportal). In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual<sup>®</sup> link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the [instructions here](#)). Members may access materials by logging into their online account (visit [www.harvardpilgrim.org](http://www.harvardpilgrim.org), click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

### For Tufts Health Plan Members:

To obtain InterQual<sup>®</sup> SmartSheets<sup>TM</sup>

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider [click here](#) to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual<sup>®</sup> SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

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## Overview

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. For **Tufts Health One Care** plan members the following LCDs are being used:

- Rezum [LCD - Water Vapor Thermal Therapy for LUTS/BPH \(L37808\) \(cms.gov\)](#)
- Cryoablation, Prostate: For Cryoablation of the prostate the [NCD - Cryosurgery of Prostate \(230.9\) \(cms.gov\)](#) is being supplemented by InterQual for allow for coverage for initial treatment of prostate cancer.
- For all other procedures, evidence is sufficient for coverage. The use of InterQual provides guidance for the coverage of these additional BPH procedures. The guidance for the use of this expanded criteria for these indications is supported by the American Urological Association.

The use of this criteria in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

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## Clinical Guideline Coverage Criteria

The Plan requires the use of InterQual® Subsets or SmartSheets for prior authorization for the following procedures:

- Prostatectomy, Transurethral Resection (TURP)
- Prostatectomy, Transurethral Ablation
  - Photoselective Vaporization of the Prostate (PVP)
  - Transurethral Holmium Laser Ablation of the Prostate (HoLAP)
  - Transurethral Microwave Thermotherapy (TUMT)
- Cryoablation, Prostate

## Additional Clinical Coverage Criteria

### Urethral Lift

The Plan may authorize a prostatic urethral lift approach (e.g., Urolift®) when InterQual criteria for Prostatectomy, Transurethral Resection are met.

### Water Vapor Thermal Therapy

The Plan considers water vapor thermal therapy (Rezūm System) as reasonable and medically necessary for the treatment of moderate to severe lower urinary tract symptoms in benign prostatic hyperplasia (BPH) when **ALL** of the following criteria are met:

1. The Member is 50 years of age or older;
2. Testing confirms the Member does not have a diagnosis of prostate cancer and there are no contraindications to the procedure (e.g., active urinary tract infection, recent prostatitis, neurogenic bladder, prior prostate surgery, active urethral stricture);
3. Estimated Prostate volume of  $\geq 30$  and  $< 80$  cc;
4. Failure, contraindication or intolerance to at least three months of pharmacologic therapy for BPH (e.g., alpha-1-adrenergic antagonist, PDE5 Inhibitor, finasteride/dutasteride)

Note: Repeat use of transurethral water vapor thermal therapy for treatment of BPH is considered investigational

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## Codes

The following code(s) require prior authorization:

**Table 1 Water Vapor Thermal Therapy: CPT/HCPCS Codes**

Code	Description
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor

Code	Description
	thermotherapy

**Table 2 Cryoablation, Prostate: CPT/HCPCS Codes**

Code	Description
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

**Table 3 Prostatectomy, Transurethral Resection (TURP): CPT/HCPCS Codes**

Code	Description
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilatation, and internal urethrotomy are included)
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
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)
For the following CPT code(s), use the "Prostatectomy, Transurethral Resection" InterQual criteria	
52450	Transurethral incision of prostate
For Prostatic Urethral Lift, please use the "Prostatectomy, Transurethral Resection" criteria when requesting prior authorization of the following CPT code(s)	
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

**Table 4 Prostatectomy, Transurethral Ablation (TUNA) CPT/HCPCS Codes**

Code	Description
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
For the following CPT code(s) use the "Prostatectomy, Transurethral Ablation" InterQual criteria	
52450	Transurethral incision of prostate

**References:**

- Centers for Medicaid and Medicare. Water Vapor Thermal Therapy for LUTS/BPH. Local Coverage Determination L37808. Available at <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lclid=37808&ver=24&>. Accessed July 18, 2023.
- FDA Rezum 510K clearance. 2015. Available at: [https://www.accessdata.fda.gov/cdrh\\_docs/pdf15/K150786.pdf](https://www.accessdata.fda.gov/cdrh_docs/pdf15/K150786.pdf). Accessed July 26, 2022.
- Foster HE, Dahm P, Kohler TS, et al. Surgical Management of Lower Urinary Tract Symptoms Attributed to Benign Prostatic Hyperplasia: AUA Guideline Amendment 2019. J Urol. 2019;202(3):592-598. doi:10.1097/JU.0000000000000319.
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- Kang TW, Jung JH, Hwang EC, Borofsky M, Kim MH, Dahm P. Convective radiofrequency water vapour thermal therapy for lower urinary tract symptoms in men with benign prostatic hyperplasia. Cochrane Database Syst Rev. 2020;3(3):CD013251. Published 2020 Mar 25.

7. McVary KT, Gange SN, Gittelman MC, et al. Minimally Invasive Prostate Convective Water Vapor Energy Ablation: A Multicenter, Randomized, Controlled Study for the Treatment of Lower Urinary Tract Symptoms Secondary to Benign Prostatic Hyperplasia. *J Urol*. 2016;195(5):1529-1538.
8. National Institute for Health and Care Excellence (NICE). UroLift for treating lower urinary tract symptoms of benign prostatic hyperplasia, Medical technologies guidance [MTG58]. 2021; nice.org.uk/guidance/MTG58/chapter/1-Recommendations. Accessed November 21, 2023.
9. Sandhu JS, Bixler BR, Dahm P, et al. Management of lower urinary tract symptoms attributed to benign prostatic hyperplasia (BPH): AUA Guideline amendment 2023. *J Urol*. 2023;10.1097/JU.0000000000003698. <https://doi.org/10.1097/JU.0000000000003698>
10. Westwood J, Geraghty R, Jones P, Rai BP, Somani BK. Rezum: a new transurethral water vapour therapy for benign prostatic hyperplasia. *TherAdv Urol*. 2018;10(11):327-333. Published 2018 Aug 12. doi:10.1177/1756287218793084.

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## Approval And Revision History

April 15, 2020 : Reviewed by the Medical Policy Approval Committee (MPAC) with no changes

Subsequent endorsement date(s) and changes made:

- April 21, 2021: Reviewed by IMPAC, renewed without changes
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan. Removed the following modification to InterQual content, “Tufts Health Plan Members, PSA testing is optional but not required”.
- March 24, 2022: Template updated
- August 17, 2022: Reviewed by MPAC, with an effective date of December 1, 2022. Added procedures requiring prior authorization; Cryoablation, Prostate to follow InterQual SmartSheet and criteria added for Water Vapor Thermal Therapy
- October 18, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated overview effective January 1, 2024
- April 17, 2024: Reviewed by MPAC, code 52441 will require prior authorization for MA Together, Direct, and One Care; code 55873 will require prior authorization for Harvard Pilgrim Health Care; codes 52450, 52441, 52442, 53850, and 53852 will require prior authorization for RItogether effective, August 1, 2024

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## Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.