

Medical Necessity Guidelines: Procedures for the Treatment of Benign Prostatic Hypertrophy (BPH)

Effective: April 15, 2020

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<p>Applies to: COMMERCIAL Products <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409 • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</p> <p>TUFTS HEALTH PUBLIC PLANS Products <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products • Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List • Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</p>	
<p>To obtain InterQual[®] SmartSheets[™]:</p> <ul style="list-style-type: none"> • Tufts Health Plan Commercial Plan products and Tufts Health Freedom 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 SmartSheet(s) available as part of the prior authorization process. 	

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Tufts Health Plan requires prior authorization for certain procedures for the treatment of benign prostatic hypertrophy. Please note the information in the Tufts Health Plan Modification to InterQual section.

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

- **Prostatectomy, Transurethral Resection (TURP)**
- **Prostatectomy, Transurethral Ablation (TUNA)**

TUFTS HEALTH PLAN MODIFICATION TO INTERQUAL

- *For Tufts Health Plan Members, PSA testing is optional but not required.*

Additional Clinical Coverage Criteria

Tufts Health Plan may authorize a prostatic urethral lift approach (e.g., Urolift[®]) when:

- InterQual criteria for Prostatectomy, Transurethral Resection are met

CODES

Procedures Requiring Prior Authorization

Tufts Health Plan uses InterQual SmartSheet(s) for the following procedure code(s).

PROSTATECOMY, TRANSURETHRAL RESECTION (TURP)

The following CPT code(s) require prior authorization:

Code	Description
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)
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)
Note: For the following CPT code(s), submit completed InterQual SmartSheet "Prostatectomy, Transurethral Resection"	
52450	Transurethral incision of prostate
Note: For prostatic urethral lift, submit completed InterQual smartsheet "Prostatectomy, Transurethral Resection" 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

PROSTATECOMY, TRANSURETHRAL ABLATION (TUNA)

The following CPT code(s) require prior authorization:

Code	Description
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy
53852	Transurethral destruction of prostate tissue; by microwave thermotherapy
Note: For the following CPT code(s), submit completed InterQual SmartSheet "Prostatectomy, Transurethral Ablation"	
52450	Transurethral incision of prostate

REFERENCE

- Hayes, Winifred S. Health Technology Brief. UroLift system for treatment of benign prostatic hyperplasia. July 14, 2016. Available at: hayesinc.com. Accessed May 30, 2017.
- Centers for Medicaid and Medicare. Prostatic urethral lift. Local Coverage Determinations L36601. Available at cms.gov/medicare-coverage-database/search/advanced-search.aspx. Accessed May 30, 2017.

APPROVAL HISTORY

October 2010: Reviewed by Medical Affairs, Medical Policy for a January 1, 2011 effective date.

Subsequent endorsement date(s) and changes made:

- July 13, 2011: Reviewed by MSPAC - Integrated Medical Policy Advisory Committee; no changes
- October 10, 2012: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC). The CPT codes were clarified for InterQual® SmartSheet™ identification.
- October 9, 2013: Reviewed by IMPAC, renewed without changes.
- November 25, 2013: Reviewed by IMPAC. Age-specific PSA clarified as follows: For Tufts Health Plan Members, age-specific PSA testing will not be required.
- September 10, 2014: Reviewed by IMPAC, renewed without changes.
- March 11, 2015: Reviewed by IMPAC, Medical Necessity Guideline for Network Health-Commercial and Network Health-Medicaid products effective June 1, 2015.
- April 1, 2015: PSA testing not required. Refer to notation in the 'Tufts Health Plan Modification to InterQual®' section of this document
- July 23, 2015: Reviewed by IMPAC, renewed without changes.

- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- May 11, 2016: Reviewed by IMPAC. Criteria renewed without changes. Format change under the Modification to Interqual® section for PSA testing not required.
- June 14, 2017: Reviewed by IMPAC. Effective October 1, 2017 Tufts Health Plan may authorize a prostatic urethral lift (PUL) approach using the Interqual SmartSheet for TURP.
- July 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- April 11, 2018: Reviewed by IMPAC, renewed without changes
- October 2018: Template and disclaimer updated
- December 3, 2018: 2018.2 Interqual upgrade for Tufts Health Commercial products including Tufts Health Freedom Plan. Effective December 17, 2018, Interqual upgrade is effective for Tufts Health Direct and Tufts Health Together. Effective January 14, 2019, Interqual upgrade effective for Tufts Health RITogether. Clarification of THP modification to Interqual; PSA testing, although not required, is optional.
- April 17, 2019: Reviewed by IMPAC, renewed without changes
- April 15, 2020: Reviewed by IMPAC, renewed without changes
- April 15, 2020: Unify fax number updated

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.

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.

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