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

Effective: May 11, 2016


Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
☐ Tufts Health Direct — Health Connector; Fax: 888.415.9055
☒ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607
☒ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

To obtain InterQual® SmartSheets™:
• 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 to treat benign prostatic hypertrophy. Please note the information in the Tufts Health Plan Modification to InterQual section.

In order 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 not required.

CODES
PROCEDURES REQUIRING PRIOR AUTHORIZATION:
Tufts Health Plan will be using the InterQual SmartSheet for the following procedure codes only.

PROSTATECOMY, TRANSURETHRAL RESECTION (TURP)
The following CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52601</td>
<td>Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)</td>
</tr>
<tr>
<td>52648</td>
<td>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)</td>
</tr>
</tbody>
</table>

Note: For the following CPT code(s) use the InterQual SmartSheet for Prostatectomy, Transurethral Resection

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52450</td>
<td>Transurethral incision of prostate</td>
</tr>
</tbody>
</table>
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<table>
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<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>52630</td>
<td>Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatomcy, cystourethroscope, urethral calibration and/or dilation, and internal urethrotomy are included)</td>
</tr>
</tbody>
</table>

**PROSTATECOMY, TRANSURETHRAL ABLATION (TUNA)**

The following CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53850</td>
<td>Transurethral destruction of prostate tissue; by microwave thermotherapy</td>
</tr>
<tr>
<td>53852</td>
<td>Transurethral destruction of prostate tissue; by microwave thermotherapy</td>
</tr>
</tbody>
</table>

**Note:** For the following CPT code(s) use the InterQual SmartSheet for Prostatectomy, Transurethral Ablation.

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</tbody>
</table>

**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.
- 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.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is May 30, 2017

**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 the 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.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. 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. Applicable state or federal mandates or other requirements will take precedence. For CareLink℠ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines 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.