Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines: **Minimally Invasive Procedures for the Treatment of Benign Prostatic Hypertrophy**

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

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® 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. 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® 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, 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® SmartSheets™"

- **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® 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

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:

- Waterjet Tissue Ablation (Aquablation): LCD - Fluid Jet System Treatment for LUTS/BPH (L38367)
- 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.

Clinical Guideline Coverage Criteria

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

- Prostatectomy, Transurethral Resection/Urethral Lift (TURP)
- Prostatectomy, Transurethral Ablation
    - Photoselective Vaporization of the Prostate (PVP)
    - Transurethral Holmium Laser Ablation of the Prostate (HoLAP)
    - Transurethral Microwave Thermotherapy (TUMT)
    - Water Vapor Thermal Therapy
- Cryoablation, Prostate

*** Note**: TURP does not requires prior authorization for codes 52601, 52630, and 52648.

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/Urethral Lift are met.

Waterjet Tissue Ablation (Aquablation)

Waterjet tissue ablation (Aquablation) may be medically necessary in the treatment of moderate to severe lower urinary tract symptoms (LUTS) due to benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) or open prostatectomy when **All** of the following criteria are met:

1. The Member has persistent or progressive lower urinary tract symptoms despite conventional medical therapy for at least 3 months (alpha blocker, PDE5 Inhibitor, finasteride/dutasteride) or the Member has a contraindication or intolerance to medical therapy; **and**
2. International Prostate Symptom Score (IPSS) ≥ 12; **and**
3. Prostate volume of 30-150 cc; **and**
4. Maximum urinary flow rate (Qmax) of ≤ 15 mL/s (voided volume greater than 125 cc); **and**
5. Member does not have any of the following condition(s):
    a. Active urinary tract infection or prostatitis or systemic infection; **or**
    b. Diagnosis of urethral stricture, meatal stenosis, or bladder neck contracture, **or**
    c. Damaged external urinary sphincter; **or**
    d. Body mass index ≥ 42 kg/m2; **or**
    e. Known or suspected prostate cancer (based on NCCN Prostate Cancer Early Detection guidelines) or a

prostate specific antigen (PSA) >10 ng/mL unless the patient has had a negative prostate biopsy within the last 6 months; **or**

f. Bladder cancer, neurogenic bladder, bladder calculus or clinically significant bladder diverticulum; **or**

g. Known allergy to device materials (e.g., nickel, titanium or stainless steel).

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 thermotherapy

Table 2 Cryoablation, Prostate: CPT/HCPCS Codes

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

Table 3 Urethral Lift: CPT/HCPCS Codes

Code	Description
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

Table 5 Water Vapor Therapy, Aquablation

Code	Description
52597	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)
C2596	Probe, image guided, robotic, waterjet ablation

References:

1. Baboudjian M, Hashim H, Bhatt N, et al. Summary Paper on Underactive Bladder from the European Association of Urology Guidelines on Non-neurogenic Male Lower Urinary Tract Symptoms. *Eur Urol*. 2024;86(3):213-220. doi:10.1016/j.eururo.2024.04.004.
2. Desai M, Bidair M, Bhojani N, et al. Aquablation for benign prostatic hyperplasia in large prostates (80-150 cc): 2-year results. *Can J Urol*. 2020;27(2):10147-10153.
3. FDA Rezum 510K clearance. 2015. Available at: https://www.accessdata.fda.gov/cdrh_docs/pdf15/K150786.pdf. Accessed April 2, 2025.

4. For prostatic artery embolization (PAE) for treatment of benign prostatic hyperplasia (BPH) that is refractory to medical treatment. Hayesinc.com/login [via subscription only]. Published April 25, 2023. Updated May 21, 2025. Accessed January 5, 2026.
5. Gilling P, Barber N, Bidair M, et al. Three-year outcomes after Aquablation therapy compared to TURP: results from a blinded randomized trial. *Can J Urol*. 2020;27(1):10072-10079.
6. Gupta N, Rogers T, Holland B, Helo S, Dynda D, McVary KT. Three-Year Treatment Outcomes of Water Vapor Thermal Therapy Compared to Doxazosin, Finasteride and Combination Drug Therapy in Men with Benign Prostatic Hyperplasia: Cohort Data from the MTOPS Trial. J Urol. 2018;200(2):405-413. doi:10.1016/j.juro.2018.02.3088.
7. Jung JH, McCutcheon KA, Borofsky M, et al. Prostatic arterial embolization for the treatment of lower urinary tract symptoms in men with benign prostatic hyperplasia. *Cochrane Database Syst Rev*. 2022;3(3):CD012867. Published 2022 Mar 29. doi:10.1002/14651858.CD012867.pub3.
8. 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.
9. Knight L, Dale M, Cleves A, Pelekanou C, Morris R. UroLift for Treating Lower Urinary Tract Symptoms of Benign Prostatic Hyperplasia: A NICE Medical Technology Guidance Update. *Appl Health Econ Health Policy*. 2022;20(5):669-680. doi:10.1007/s40258-022-00735-y.
10. 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.
11. Nguyen DD BN, Bidair M, Gilling P, Anderson P, Zorn KC, et al. Waterjet Ablation Therapy for Endoscopic Resection of prostate tissue trial (WATER) vs WATER II: comparing Aquablation therapy for benign prostatic hyperplasia in 30-80 and 80-150 mL prostates. BJU Int 2020;125(1):112-122.
12. Prostatic Urethral Lift (UroLift System) for Treatment of Symptoms Associated with Benign Prostatic Hyperplasia. Hayesinc.com/login [via subscription only]. Published Jun 9, 2020. Updated June 13, 2023. Accessed April 2, 2025.
13. Rezūm System (Boston Scientific Corp.) for Benign Prostatic Hyperplasia. Hayesinc.com/login [via subscription only]. Published October 8, 2021. Updated November 26, 2024. Accessed April 2, 2025.
14. 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*. 2024;211(1):11-19. doi:10.1097/JU.0000000000003698.
15. 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.

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
- December 1, 2023: Reviewed and approved by the UM Committee 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
- May 15, 2024: Reviewed by MPAC; code 52601, 52630, and 52648 removed from prior authorization effective July 1, 2024
  - Medical Necessity Guideline (MNG) name changed to Minimally Invasive Procedures for the Treatment of Benign Prostatic Hypertrophy
  - The Plan will use InterQual criteria for Water Vapor Thermal Therapy effective September 1, 2024
  - New coverage and criteria for Waterjet Tissue Ablation using codes 0421T and C2596; Tufts Health One Care will utilize CMS criteria for Waterjet Tissue Ablation effective September 1, 2024
- June 13, 2024: Reviewed and Approved by the UM Committee effective July 1, 2024
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025
- June 17, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template

- January 1, 2026: per new coding guidelines, category III CPT code 0421T updated to code 52597, effective January 1, 2026
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, administrative update to guideline template, and annual review; effective July 1, 2026

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.