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Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) Corporate Medical Policy

File Name: Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)
File Code: 7.01.VT151
Origination: 05/2018
Last Review: 10/2025
Next Review: 10/2026
Effective Date: 02/01/2026

Description/Summary

Benign prostatic hyperplasia (BPH) is a common condition in older individuals. Other names for benign prostatic hyperplasia (BPH) include benign prostatic hypertrophy, an enlarged prostate, and BPH. Approximately 8 percent of individuals with prostates aged 31 to 40 have BPH. In people over age 80, more than 80 percent have BPH. Many people with BPH have no symptoms. In people with symptoms, the most common include needing to urinate frequently (during the day and night), a weak urine stream, and leaking or dribbling of urine. These symptoms are called lower urinary tract symptoms (LUTS). For people with bothersome symptoms, treatment with one or more medicines or surgery is available.

The prostatic urethral lift procedure involves the insertion of one or more permanent implants into the prostate, which retract prostatic tissue and maintain an expanded urethral lumen, hence increasing the size of the urethral opening and reducing obstruction to urine flow.

Rezūm™ water vapor thermal therapy delivers a heated stream of water vaporizing to prostate tissue and immediately reducing symptoms.

Transurethral water vapor thermal therapy and transurethral waterjet ablation (aquablation) procedure that utilizes water vapor thermal therapy uses radiofrequency-generated water vapor (~103°C) thermal energy based on the thermodynamic properties of convective versus conductive heat transfer to ablate prostate tissue. Aquablation cuts tissue by using a pressurized jet of fluid delivered to the prostatic urethra.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I

When a service may be considered medically necessary

Prostatic Urethral Lift

1. For members with a diagnosis of moderate-to-severe lower urinary tract obstruction due to benign prostatic hyperplasia, prostatic urethral lift may be considered **medically necessary** when **ALL** the following criteria are met:

    a. Age 45 years of age or older; **AND**
    b. Estimated prostate volume <= 100cc by radiologic studies, or by digital rectal exam and/or cystoscopy if obvious or if radiology studies are not possible (may be confirmed with transrectal ultrasound); **AND**
    c. Prostate anatomy demonstrates normal bladder neck without an obstructive median lobe; **AND**
    d. Contraindication to, intolerance of, or failure of at least three months of standard medical therapy for BPH (i.e. alpha blocker, 5α-reductase inhibitor, phosphodiesterase-5 (PDE5) inhibitor); **AND**
    e. A diagnosis of urinary obstruction either by a clear clinical history, cystoscopy, urodynamics, or a peak urine flow rate (Qmax) less than 15 cc/sec on a voided volume that is greater than 125 cc; **AND**
    f. If a prostate specific antigen (PSA) is indicated in an individual with a diagnosis of LUTS and BPH with the PSA level meeting the following criteria:
        i. Taken within 12 months of the procedure; **AND**
        ii. Resulted in a value of 4.0 ng/mL or less, or age adjusted level; **OR**
        iii. Has had at least one negative biopsy if the PSA is elevated for age

2. For members with a diagnosis of moderate-to-severe lower urinary tract obstruction with a history of or current prostate cancer prostatic urethral lift may be considered **medically necessary** when ONE of the following criteria are met:

    a. The individual is not a candidate for surgical resection of the prostate but will be treated by radiation therapy and has symptoms that are so severe that immediate relief is required; **OR**
    b. The individual is clinically in remission and satisfies medical criteria b, c & e above; **OR**
    c. The individual is on active surveillance for low or very low risk prostate cancer; **AND** satisfies medical criteria b, c & e above.

Transurethral Water Vapor Thermal Therapy (Rezūm™) and Waterjet Tissue Ablation

Transurethral Water Vapor Thermal Therapy (**Rezūm™)** and Waterjet Tisue Ablation (for example Aquablation®)in patients 45 and older with or without obstructed median lobe, may be considered **medically necessary** for 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. Patient is not an appropriate candidate for an invasive surgical procedure using general anesthesia such as transurethral resection of the prostate due to underlying disease (e.g., cardiac disease, pulmonary disease, etc.), or at high risk of bleeding; **OR**
2. The patient opts to undergo a minimally invasive procedure; **AND**
3. Patient has persistent or progressive lower urinary tract symptoms or is unable to tolerate medical therapy for BPH, after an appropriate trial period, defined as one month following an alpha-1-adrenergic antagonist or 3 months following a 5-alphareductase inhibitor, or intolerance or other contraindication to medical therapy; **AND**
4. Estimated prostate volume <= 80cc by radiologic studies, or by digital rectal exam and/or cystoscopy if obvious or if radiology studies are not possible (may be confirmed with transrectal ultrasound); **AND**
5. The patient is 45 years of age or older; **AND**
6. The device system is used by a physician trained in the specialty of Urology; **AND**
7. Patient does not have an active urinary tract infection or prostatitis within past year; **AND**
8. Patient has had appropriate testing to exclude diagnosis of prostate cancer.

When a service is considered investigational

Prostatic urethral lift (i.e., UroLift) and transurethral water vapor thermal therapy (i.e. Rezūm™) and water tissue ablation are considered investigational for all other indications including repeat procedure.

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Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The

applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

05/2018	New policy, external input received, reviewed BCBSA MPRM 7.01.151, updated references. Codes 52441, 52442, C9739 & C9740 require prior authorization.
01/2019	Updated policy criteria with network provider subject matter expert input. Clarified criteria and age range especially around definition of obstructive uropathy and eliminated PSA requirement for subgroups who would not otherwise require PSA such as elderly patients with BPH and LUTS and known cancer patients.
01/2020	Updated policy language for clarity and after receipt of clinical feedback and review of literature amended prostate volume from 80 to 100ccs. Updated references.
05/2021	Policy statement changed to include medically necessary criteria for Rezūm™ water vapor thermal therapy. References updated. Policy title changed from Prostatic Urethral Lift to Minimally Invasive Treatments for Benign Prostatic Hyperplasia. Added code 53854 to require prior approval.
10/2022	Policy statement changed to include medically necessary criteria for Waterjet tissue ablation for (i.e. Aquablation®). References updated. Added code 0421T as medically necessary if medical policy criteria has been met. Code 0421T removed as investigational.
10/2023	References updated, added waterjet tissue ablation to water vapor as criteria are the same at this time.
12/2023	Adaptive Maintenance Effective 01/01/2024: Added code C2596 as medically necessary to coding table.
12/2024	Policy reviewed. No change to policy statement. Minor formatting changes for clarity and consistency. References updated.
10/2025	Policy reviewed. No change to policy statement. References updated.

Eligible providers

Qualified healthcare professionals practicing within the scope of theirlicense(s).

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I

Code Type	Number	Brief Description	Policy Instructions
The following codes are considered as medically necessary when applicable criteria have been met.			
CPT®	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)	No Prior Approval Required
CPT®	52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Requires Prior Approval
CPT®	52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Requires Prior Approval
CPT®	53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Requires Prior Approval
HCPCS	C2596	Probe, image guided, robotic, waterjet ablation	No Prior Approval Required
HCPCS	C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	Requires Prior Approval
HCPCS	C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	Requires Prior Approval