Subject: Benign Prostatic Hypertrophy

Overview: Benign prostatic hypertrophy, or benign prostatic hyperplasia (BPH), is characterized by the proliferation of cells of the prostate. This enlargement of the prostate may cause constriction of the urethra and/or bladder neck with possible negative impact on the function of the bladder.

Policy and Coverage Criteria:
Harvard Pilgrim considers the following procedures for the treatment of benign prostatic hypertrophy (BPH) as appropriate and medically necessary:

- Transurethral resection of the prostate (TURP)
- Channel TURP (for the treatment of members with a history of prostate cancer only)
- Transurethral incision of the prostate (TUIP)
- Transurethral vaporization of the prostate (TUVP)
- Transurethral enucleation of the prostate (TUEP)
- Transurethral microwave thermoablation (TUMT)
- Transurethral needle ablation (TUNA), also known as transurethral radiofrequency needle ablation (RFNA)
- Laser prostatectomy and laser based procedures including contact laser ablation of the prostate (CLAP), holmium laser procedures of the prostate (HoLAP, HoLEP, HoLRP), photoselective laser vaporization (PVP), transurethral ultrasound-guided laser induced prostatectomy (TULIP), and visually-guided laser ablation of the prostate (VLAP)

When ALL the following criteria are met:
- Member has been diagnosed with lower urinary tract symptoms (LUTS), renal insufficiency, recurrent UTI, bladder stones, or gross hematuria secondary to BPH,
- Symptoms interfere with activities of daily living,
- Member has a peak urine flow rate on a voided volume greater than 125cc no greater than 10 cc/second,
- Member has an intolerance to or unsuccessful history with alpha blockers and alpha-reductase inhibitors, and
- Member has received a prostate-specific antigen test in the past year yielding a result of no more than 2.5 ng/mL if the member is no older than 60 years or no more than 4.0 ng/mL if the member is over 60 years in age,

Or member has a history of prostate cancer and EITHER of the following criteria are met:
- Prostate cancer is in remission or
- Prostate cancer will be treated by radiation therapy and BPH symptoms of “severe” severity, as indicated by an International Prostate Symptom Score (IPSS)/American Urological Association Symptom Index (AUA-SI) score of at least twenty.

Harvard Pilgrim Health Care (HPHC) considers prostatic urethral lift (UroLift) as reasonable and medically necessary for the treatment of urinary outlet obstruction secondary to benign prostatic hypertrophy when ALL the following criteria are met:
1. Member has been diagnosed with lower urinary tract symptoms (LUTS) secondary to BPH that meet all of the following:
   - Symptoms interfere with activities of daily living, as indicated by an AUA symptom index (AUASI) rating of at least 13,
Symptoms are caused by enlargement of the lateral prostate lobes and no median lobe enlargement is observed,
Symptoms are refractory to medication or member is intolerant of medication,
Symptoms do not include signs or diagnostic evidence of active urinary infection and there is no history of bacterial prostatitis in the last quarter,

2. Member has a peak urine flow rate on a voided volume greater than 125cc no greater than 10cc/second,
3. Renal function is normal,
4. Prostate volume is no greater than 80cc,
5. Member is a poor candidate for other surgical treatments of BPH, with sexual function being an allowable factor.

Exclusions:
Harvard Pilgrim considers the following procedures for the treatment of benign prostatic hypertrophy experimental and investigational and therefore not medically necessary:
- Water-induced thermotherapy (WIT)
- Insertion of temporary prostatic urethral stent (UroLume)
- Plasma kinetic vaporization

Guidelines
The International Prostate Symptom Score (IPSS)/American Urological Association Symptom Index (AUA-SI) index is as follows:
- 0-7: Mild
- 8-19: Moderate
- 20-35: Severe

Supporting Information:
1. Technology Assessment

Transurethral resection of the prostate (TURP): TURP is a surgical procedure where a resectoscope is inserted through the tip of the penis and into the urethra. Excess prostate tissue that is blocking urine flow is trimmed and the size of the channel is increased.

Transurethral incision of the prostate (TUIP): TUIP is a surgical procedure where a resectoscope is inserted through the tip of the penis into the urethra. One or two grooves are cut into the bladder neck to open the urinary channel, allowing urine to pass more easily.

Transurethral vaporization of the prostate (TUVP): TUVP is a surgical procedure which utilizes a loop electrode or grooved roller electrode which is attached to a resectoscope that applies heat from high-voltage electric current ablating obstructive prostatic tissue and sealing the surrounding blood vessels.

Transurethral enucleation of the prostate (TUEP): TUEP is a surgical procedure a spatula attached to a tungsten wire loop is used to dissect between the surgical capsule and adenoma by enucleation.

Transurethral microwave thermotherapy (TUMT): TUMT is a procedure where a small microwave antenna is inserted through the tip of the penis into the urethra. The antenna emits a microwave energy that heats up and destroys excess prostate tissue blocking urine flow.

Transurethral needle ablation (TUNA) and (RFNA): TUNA is a procedure where interstitial radiofrequency needles are placed through the urethra into the lateral lobes of the prostate causing heat-induced necrosis.
2. Literature Review

TURP: TURP has been considered the gold standard surgical treatment for lower urinary tract symptoms resulting from BPH. Milonas et al (2015) evaluated the impact of the resected prostate tissue weight on the IPSS, QoL, and voiding function following TURP in 89 men. According to the Qmax results, TURP was effective in 74.2%. According to the IPSS results, TURP was effective in 91% and according to QoL, effective in 74.2%. The most significant predictors of obtaining favorable results were the RPTW/TZV and RPTW/TPV ratios. The survival analysis shows that in order to achieve 50% improvement on Qmax, IPSS, and QoL, more than 30-35% of TPV and more than 60% of theTZV should be removed. The authors concluded that the efficacy of TURP at short term follow-up depends on the completeness of the resection.

Tang et al (2014) conducted a systematic review and meta-analysis to evaluate the efficacy and safety of monopolar and bipolar TURP of the prostate in BPH patients. Thirty-one trials were included in the analysis. The analysis showed a significant difference in efficacy between monopolar and bipolar TURP. A significant improvement in transurethral resection syndrome was seen in the bipolar TURP group compared to the monopolar group. Clot retention was significantly higher in the monotherapy group compared to the bipolar group. There was no difference between groups in the blood transfusion frequency or late complications and bladder neck restriction. The authors concluded that the review indicates that bipolar TURP was significantly better in the result of Qmax and for decreasing the incidence of transurethral resection syndrome and clot retention.

Jang et al (2011) aimed to verify the current status of TURP through a review of medical records of 1,341 men who underwent TURP. The authors concluded that the use of TURP is expected to remain constant and lower urinary tract symptoms was the most common indication for TURP in patients with BPH.

Wasson et al (1995) conducted a randomized trial to compare TURP (n=280) with watchful waiting (n=276) with moderate symptoms of BPH. Patients were followed for 3 years and the primary outcome measure was treatment failure. Treatment failure was defined as the occurrence of any of the following: death, repeated or intractable urinary retention, a residual urinary volume over 350 ml, the development of bladder calculus, new and persistent incontinence, a high symptom score, or a doubling of the serum creatinine concentration. The outcomes of surgery were best for the men who were most bothered by urinary symptoms at baseline. Surgery was associated with improvement in symptoms and in scores for urinary difficulties and interference with ADLs and was significant for all comparisons. The authors concluded that surgery is more effective than watchful waiting in reducing the rate of treatment failure and improving genitourinary symptoms for men with moderate symptoms of BPH.

TUIP: Cordeiro et al (2015) performed a long-term comparison between preoperative and postoperative parameters in order to infer the long-term clinical efficacy of TUIP. The medical records of 73 patients who underwent TUIP were analyzed. The patients presented with obstructive urinary symptoms as well as a prostate volume of around 30g. The results showed TUIP is an effective treatment for patients with benign prostatic obstruction and small prostates, with excellent long-term results. All compared preoperative and postoperative parameters showed significant improvements.

Tkocz and Prajsner (2002) randomized 100 patients with BPH to receive TUIP or TURP. Follow up was performed 24 months following the operation. After treatment there were statistically significant daytime and
nocturnal reduction in voiding frequencies of 2.9 and 1.7 after TUIP, and 2.0 and 1.5 after TURP. In both
groups, there occurred significantly better maximal flow rate from 7.6 mL/s to 16.9 mL/s in TUIP and from
6.9 mL/s to 17.6 mL/s in TURP. The mean values of linearized passive urethral resistance relation in both
groups significantly decreased from 3.6 +/- 0.6 to 1.0 +/- 0.5 after TUIP and from 3.9 +/- 0.4 to 1.4 +/- 0.5
after TURP. The authors concluded that the TUIP procedure is effective and safe for patients with a small
number of complications.
Riehmann et al (1995) conducted a randomized, prospective study to evaluate longer term effects of TURP
and TUIP of the prostate in 112 patients. Fifty-six patients received TURP and 61 received TUIP.
Improvements in mean urine peak flow rates were seen in both groups. Postoperative irritative, obstructive,
as well as total symptom scores decreased significantly at all follow-up visits in both groups. Both groups
indicated an overall subjective improvement. The authors concluded that TURP and TUIP were generally
equally effective in relieving bladder outlet obstruction secondary to BPH in small prostates. Most surgically
treated BPH cases can be well managed by the incision technique, which is an underutilized procedure.

TUVP: Lu et al (2015) compared the outcomes of TUVP with traditional TURP. A total of 38 patients with
moderate to severe lower urinary tract symptoms secondary to BPH either received TUVP or TURP by the
patient’s choice. A total of 19 patients underwent TUVP and a random selection of 19 patients underwent
TURP. There were no differences between groups for improvement of IPSS score, QoL, Qmax, and PVRU at
6 weeks post procedure. There was a significant reduction in intraoperative blood loss, operative time,
postoperative CBWO time and length of stay in the TUVP group.
Falahatkar et al (2014) conducted a prospective, randomized trial to compare the outcomes of bipolar TUVP
with bipolar TURP in 88 patients with moderate to severe lower urinary tract symptoms secondary to BPH.
There were no differences between groups regarding complications. Re-hospitalization and transfusion due to
clot retention and urethral stricture were only reported in the TURP group. Both groups had significant
improvement in IPSS and Qmax 3 months after surgery. The TUVP had significantly lower IPSS and higher
Qmax than the TURP group. The authors concluded that bipolar TUVP is a safe, effective and low cost
procedure among minimally invasive surgeries of BPH. Compared with bipolar TURP, bipolar TUVP had similar
complications, better perioperative outcomes, superior hemostasis and higher efficacy.

TUEP: Giulianelli et al (2015) evaluated the safety and efficacy of TUEP with a button electrode for the
treatment of bladder outlet obstruction due to BPH. Three months after surgery, 82% of the patients showed
significant improvement in maximum urine flow. At 6 and 12 months, 80% and 83.3% maintained significant
improvement. A significant improvement was seen in IPSS, QoL, IIEF-5, and PVR compared with baseline
values. The authors concluded that B-TUEP is a rapid and safe technique with optimal outcomes.
Lin et al (2015) conducted a meta-analysis of randomized controlled trials to evaluate the efficacy and safety
of TUEP versus transvesical open prostatectomy for the management of BPH. Nine RCTs were identified
included 758 patients. The analysis showed no differences between groups in maximum urinary flow rate at
1, 3, 6 months and 1 year. No difference was found in erectile function at 3, 6 months and 1 year. TUEP was
favored in perioperative outcomes including hemoglobin level drop, catheter period, irrigation length and
hospital stay. Open prostatectomy was favored in operative time and resected prostate weight. There was
significantly less blood transfusion in TUEP patients, but no differences in other complications. The authors
concluded that TUEP can be performed effectively and safely with functional outcomes and complications
similar to open prostatectomy for large BPH and has the advantages of shorter catheter period, shorter
hospital stay and less blood transfusion.
Xu et al (2010) conducted a small study with 12 patients to evaluate the therapeutic effect of TUEP for the
treatment of BPH in patients below 50 years of age. Patients were followed for 3 to 6 months following TUEP.
Symptoms of lower urinary tract obstruction were improved after the surgery, and the IPSS decreased from
24±5.1 to 8.8±1.4 and peak urine flow rate (Qmax) increased from 8.1±4.2 ml/s to 20.1±4.2 ml/s at 3
months postoperatively. All cases had residual urine (12-44 ml) preoperatively, but after the surgery, only 4
still had residual urine of less than 30 ml. All the patients had normal erection function postoperatively, and
10 had normal ejaculation; 2 patients recovered normal ejaculation 3 and 5 months after the operation. The

HPC Medical Review Criteria

Benign Prostatic Hypertrophy

HPC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members’ unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.
authors concluded that TUEP can alleviate the lower urinary tract obstruction symptoms and improve sexual function by avoiding preprosthetic sphincter injury in relatively young patients with BPH.

Laser-based procedures: Yu et al (2015) investigated the clinical efficacy and safety of PVP and simultaneous suprapubic cystostomy for BPH in patients with mild to severe detrusor underactivity. The cohort included 78 patients with BPH who were divided into 3 groups according to severity of detrusor underactivity: mild, moderate, and severe. The results showed therapeutic effectiveness including cure and improvement in the mild and moderate detrusor underactivity groups was significantly higher than the severe group. Compared to the preoperative values, detrusor pressure at maximum flow, bladder compliance, maximum urinary flow, postvoid residual urine, International Prostate Symptom Score, and QoL scores at 12 months postoperatively had significantly improved. The authors concluded that PVP and simultaneous suprapubic cystostomy seem to be an appropriate treatment modality in BPH patients with mild and/or moderate detrusor underactivity as well as in patients with severe detrusor underactivity and slightly reduced bladder compliance.

Hueber et al (2015) evaluated the surgical performance, complication rates and outcomes up to 2 years of the Greenlight XPS-180W laser system for the treatment of BPH in high-risk patients. The analysis focused on subgroups of patients on anticoagulant (ACO) therapy, of older age ≥ 80, very large prostate ≥120cc or with indwelling catheter for urinary retention. A total of 1194 patients underwent Greenlight laser photo-selective vaporization of the prostate for the treatment of BPH. No differences were observed in terms of bleeding, transfusion, hematuria or clot retention including for patients on ACO. The PVI20 group had a significant increase in conversion to TURP (11%). There was a significant improvement in IPSS, QoL score, Qmax, and PVR in all subgroups at 24 months compared to baseline. The authors concluded that Greenlight PVP is safe, however, in patients with very large prostate the procedure is more difficult and warrants established greenlight laser experience by the surgeon.

Elshal et al (2015) conducted a randomized controlled study to assess whether PVP is not less effective than holmium laser enucleation of the prostate for improvement of lower urinary tract symptoms secondary to BPH. A total of 103 patients were included in the study: 50 in the holmium laser group and 53 in the PVP group. There was a significant improvement in IPSS and post void residual urine volume that was comparable between groups. After 4 months, reduction in prostate size was significantly higher in the holmium group. The authors concluded that compared to holmium laser enucleation of prostate, PVP of the prostate is safe, noninferior and effective in the treatment of BPH.

Bachmann et al (2015) conducted the GOLIATH prospective randomized controlled trial comparing TURP to PVP for the treatment of nonneurogenic lower urinary tract symptoms due to prostate enlargement. A total of 281 patients were enrolled and randomized 1:1 to undergo GreenLight XPS or TURP, 269 received treatment. Follow-up at 1 year demonstrated that PVP produced efficacy outcomes similar to those of TURP. The same result was found in at 2 year follow-up as reported by Thomas et al (2015).

TUMT: Aagaard et al (2014) evaluated TUMT in 124 patients for the treatment of chronic urinary retention due to BPH in patients unsuitable for surgery. TUMT was considered successful if patients were relieved of their catheter and by QoL improvement. Overall, 77% of patients were relieved of their catheter and 79% reported an improvement in QoL. The authors concluded that TUMT is an effective treatment for patients unsuitable for surgery with urinary retention.

Hoffman et al (2012) conducted a systematic review of randomized controlled trials to assess the therapeutic efficacy and safety of microwave thermotherapy for treating symptomatic benign prostatic obstruction. Fifteen studies involving 1585 patients met the inclusion criteria, including six comparisons of microwave thermotherapy with TURP, eight comparisons with sham thermotherapy procedures, and one comparison with an alpha-blocker. Study durations ranged from 3 to 60 months. The pooled mean urinary symptom scores decreased by 65% with TUMT and by 77% with TURP. The weighted mean difference for IPSS was -1.00, favoring TURP. The pooled mean peak urinary flow increased by 70% with TUMT and by 119% with TURP. The WMD for peak urinary flow was 5.08 ml/s, favoring TURP. Compared to TURP, TUMT was associated with decreased risks for retrograde ejaculation, treatment for strictures, hematuria, blood transfusions, and the transurethral resection syndrome, but increased risks for dysuria, urinary retention, and

**HPHC Medical Review Criteria**

**Benign Prostatic Hypertrophy**

HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members’ unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.
retreatment for BPH symptoms. Microwave thermotherapy improved IPSS symptom scores and peak urinary flow compared with sham procedures. Microwave thermotherapy also improved IPSS symptom scores and peak urinary flow in the one comparison with alpha-blockers. No studies evaluated the effects of symptom duration, patient characteristics, prostate-specific antigen levels, or prostate volume on treatment response. The authors concluded that TUMT is an effective alternative to TURP and alpha-blockers for treating symptomatic BPH. However, TURP provided greater symptom score and urinary flow improvements and reduced the need for subsequent BPH treatments compared to TUMT.

Urolift: Hayes Inc reviewed the effectiveness of BPH to currently established procedures in 2017. They reported that while there is uncertainty in effectiveness of BPH to currently established invasive procedures, BPH shows promising results and may be a viable alternative in men who require surgical therapy due to medical refractory symptoms. Recent literature also support this assessment, finding that while head-to-head trials against dominant surgical treatments and long term data are needed, Urolift shows reliable improvement and relatively positive outcomes, over sham treatment and medication. Barber et al (2015) conducted a randomized study comparing prostatic urethral lift with TURP. There were 80 subjects enrolled who were ≥50 years of age, had an IPSS >12, peak flow ≤15 ml/s, and prostate volume ≤60 cc. Subjects were assessed using the BPH6 endpoint which incorporates symptom relief, recovery experience, sexual health and continence preservation, and lack of high grade adverse event. The BPH6 primary endpoint was met with 54.5% of urethral lift subjects responding and 20% TURP responding. There was a significant improvement in IPSS in both urethral lift and TURP at 12 months. Patient satisfaction was >85% for urethral lift by 1 month, but remained <75% for TURP until 12 months. Sonksen et al (2015) conducted a prospective, randomized controlled trial to compare prostatic urethral lift (PUL) to TURP in 80 men with BPH lower urinary tract symptoms improvement (LUTS) to assess LUTS, recovery, worsening of erectile and ejaculatory function, continence and safety. PUL was significantly superior for preservation of ejaculation and quality of recovery. Both groups had significant symptom relief. The authors concluded that PUL is superior to TURP, however, needs to be validated in further studies.

3. Professional/Governmental Organizations

CMS: follows the 2004 AHRQ Treatments for Benign Prostatic Hyperplasia

Codes:
Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52281</td>
<td>Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male</td>
</tr>
<tr>
<td>52282</td>
<td>Cystourethroscopy, with insertion of permanent urethral stent</td>
</tr>
<tr>
<td>52441</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant</td>
</tr>
<tr>
<td>52442</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>52450</td>
<td>Transurethral incision of the prostate</td>
</tr>
<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>
</tbody>
</table>

HPHC Medical Review Criteria

Benign Prostatic Hypertrophy

HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members’ unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.
HPHC Medical Review Criteria

Benign Prostatic Hypertrophy

HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members’ unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52630</td>
<td>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)</td>
</tr>
<tr>
<td>52647</td>
<td>Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)</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>
<tr>
<td>52649</td>
<td>Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethra calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)</td>
</tr>
<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 radiofrequency thermotherapy</td>
</tr>
<tr>
<td>53899</td>
<td>Unlisted procedure, urinary system [Water induced thermal therapy]</td>
</tr>
<tr>
<td>54520</td>
<td>Orchietomy, simple (including subscapular), with or without testicular prosthesis, scrotal or inguinal approach</td>
</tr>
<tr>
<td>55821</td>
<td>Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages</td>
</tr>
<tr>
<td>55831</td>
<td>Prostatectomy (Including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal</td>
</tr>
<tr>
<td>55873</td>
<td>Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)</td>
</tr>
<tr>
<td>75894</td>
<td>Transcatheter therapy, embolization, any method, radiological supervision and interpretation</td>
</tr>
</tbody>
</table>

Non-Covered Codes:

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53855</td>
<td>Insertion of a temporary prostatic urethral stent, including urethral measurement</td>
</tr>
</tbody>
</table>

Billing Guidelines:
Member’s medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

References:


**HPHC Medical Review Criteria**

**Benign Prostatic Hypertrophy**

HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members’ unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.

Summary of Changes:

<table>
<thead>
<tr>
<th>Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/18</td>
<td>Annual Review. Prostatic urethral lift given coverage with criteria. Criteria for other treatments rewritten.</td>
</tr>
</tbody>
</table>

Approved by Medical Policy Review Committee: 03/06/18
Reviewed/Revised: 06/16, 03/18
Initiated: 8/16