PROVIDER POLICIES & PROCEDURES

TRANSURETHRAL ABLATION OF PROSTATE TISSUE USING THERMAL ULTRASOUND WITH GUIDANCE

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for transurethral ablation of prostate tissue using thermal ultrasound with MRI guidance. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

The TULSA and TULSA-Pro procedures have been proposed as minimally invasive alternatives to traditional and standard methods of treatment for localized prostate cancer.

CLINICAL GUIDELINE

Coverage guidelines for transurethral ablation of prostate tissue using thermal ultrasound with MRI guidance will be made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Transurethral ablation of prostate tissue using thermal ultrasound with MRI guidance for the treatment of localized prostate cancer is considered **investigational and therefore not medically necessary** as there is insufficient evidence in peer-reviewed, published, medical literature supporting its clinical efficacy and safety.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Requests for coverage of transurethral ablation of prostate tissue using thermal ultrasound with MRI guidance will be reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

EFFECTIVE DATE

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

This Clinical Guideline is effective for prior authorization requests for transurethral ablation of prostate tissue using thermal ultrasound with MRI guidance for individuals covered under the HUSKY A, B, C, and D programs on or after February 01, 2026.

LIMITATIONS
N/A

CODES:

Code	Description
55881*	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation (more than one physician)
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed (one physician)

*Code 55881 is used in conjunction with code 51721 (Insertion of transducer through urethra for delivery of heat ultrasound). 51721 does not require prior authorization.

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce

equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. prescription.

8. **Prior authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- Babalola O, Lee TJ, Viviano CJ. Prostate Ablation Using High Intensity Focused Ultrasound: A Literature Review of the Potential Role for Patient Preference Information. *J Urol*. 2018;200(3):512-519. doi:10.1016/j.juro.2018.04.066
- Bekelman JE, Rumble RB, Chen RC, et al. Clinically Localized Prostate Cancer: ASCO Clinical Practice Guideline Endorsement of an American Urological Association/American Society for Radiation Oncology/Society of Urologic Oncology Guideline. J Clin Oncol. 2018;36(32):3251-3258. doi:10.1200/JCO.18.00606
- Bates AS, Ayers J, Kostakopoulos N, Lumsden T, Schoots IG, Willemse PPM et al. A Systematic Review of Focal Ablative Therapy for Clinically Localized Prostate Cancer in Comparison with Standard Management Options: Limitations of the Available Evidence and Recommendations for Clinical Practice and Further Research. European urology oncology. 2021 Jun 1;4(3):405-423. doi: 10.1016/j.euo.2020.12.008
- Chin JL, Billia M, Relle J, et al. Magnetic Resonance Imaging-Guided Transurethral Ultrasound Ablation of Prostate Tissue in Patients with Localized Prostate Cancer: A Prospective Phase 1 Clinical Trial. Eur Urol. 2016;70(3):447-455. doi:10.1016/j.eururo.2015.12.029
- Ciezki JP. Overview of low- and very low-risk clinically localized prostate cancer. In: *UpToDate*, Lee WR, Richie JP (Eds.). Wolters Kluwer. Updated May 28, 2025. Accessed October 10, 2025.
- Eastham JA, Auffenberg GB, Barocas DA, et al. Clinically localized prostate cancer: AUA/ASTRO guideline, part I: introduction, risk assessment, staging, and risk-based management. J Urol. 2022;208(1):10-18.
- National Comprehensive Cancer Network (NCCN). Prostate Cancer. NCCN Clinical Practice Guidelines in Oncology, Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed June 25, 2025.
- Pisters LL, Spiess PE. Cryotherapy and other ablative techniques for the initial treatment of prostate cancer. In: *UpToDate*, Lee WR, Richie JP, Yushak M (Eds.). Wolters Kluwer. Updated February 18, 2025. Accessed October 10, 2025.

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	October 2025	Approved at the October 22, 2025, CHNCT Medical Reviewer meeting. Approved at the December 15, 2025, CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on December 26, 2025.