Prostate Services and Procedures and Impotence Treatment

Policy Number: MCS075.09
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Instructions for Use

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Related Medicare Advantage Policy Guideline

- Category III CPT Codes

Coverage Guidelines

Services and procedures for the diagnosis and treatment of prostate conditions and related impotence treatment may be covered when Medicare criteria are met.

Note: The guidelines in this Coverage Summary are for specific procedures/medications only. For procedures/medications not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies (National Coverage Determinations, Local Coverage Determinations and Local Coverage Articles).

Prostate Cancer Screening

Prostate cancer screening is covered when coverage criteria is met. Refer to the Medicare Preventive Services-MLN Educational Tool at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html. (Accessed August 1, 2023)

Prostate Needle Biopsy (CPT Code 55700)

Medicare does not have National Coverage Determination (NCD) for prostate needle biopsy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Biopsy, Prostate, Needle.

Click here to view the InterQual® criteria.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

Prostatectomy, Transurethral (CPT Codes 52601, 52630, and 52648)

Medicare does not have National Coverage Determination (NCD) for transurethral prostatectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to InterQual® CP: Procedures, Prostatectomy, Transurethral Resection.

Click here to view the InterQual® criteria.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

Prostatectomy, Open (CPT Code 55801)

Medicare does not have National Coverage Determination (NCD) for prostatectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Prostatectomy, Open.

Click here to view the InterQual® criteria.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

Prostate Brachytherapy (CPT Codes 55875 and 55876)

Medicare does not have National Coverage Determination (NCD) for prostate brachytherapy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Brachytherapy, Prostate.

Click here to view the InterQual® criteria.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

Impotence Related Prosthetics and Devices

Refer to the Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid.

Temporary Prostatic Stent (e.g., Spanner® and Memokath Temporary Prostatic Stent) (CPT Code 53855)

Medicare does not have National Coverage Determination (NCD) for temporary prostatic stent. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

UroLift® System (CPT Codes 52441, 52442, C9739, C9740, and L8699)

Medicare does not have National Coverage Determination (NCD) for the UroLift® System. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Note: May also refer to UroLift® System reported HCPCS code L8699.

Prostate Rectal Spacers Placement (CPT Code 55874)

Medicare does not have National Coverage Determination (NCD) for prostate rectal spacers.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Prostate Rectal Spacers Placement.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Note: After checking the Prostate Rectal Spacers Placement table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Nerve Graft to Restore Erectile Function During Radical Prostatectomy

Medicare does not have a National Coverage Determination (NCD) nerve graft to restore erectile function during radical prostatectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Nerve Graft to Restore Erectile Function During Radical Prostatectomy.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Prostate Artery Embolization (CPT Code 37243)

Medicare does not have a National Coverage Determination (NCD) for prostate artery embolization. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Hydrocelectomy (CPT Codes 55040, 55041, 55060, and 55500)

Medicare does not have a National Coverage Determination (NCD) for hydrocelectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the InterQual® CP: Procedures, Hydrocelectomy.

Click here to view the InterQual® criteria.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

Supporting Information

Prostate Rectal Spacers Placement Accessed January 12, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L37485 (A56539)	Prostate Rectal Spacers	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
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Policy History/Revision Information

Date	Summary of Changes
04/01/2024	**Coverage Guidelines** • Updated reference link to reflect title change for *Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid*
01/18/2024	**Coverage Guidelines** ***Prostate Needle Biopsy (CPT Code 55700)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for prostate needle biopsy; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Biopsy, Prostate, Needle ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Prostatectomy, Transurethral (CPT Code 52601, 52630, and 52648)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for transurethral prostatectomy; LCDs/LCAs do not exist ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Prostatectomy, Transurethral Resection ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Prostatectomy, Open (CPT Code 55801)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for prostatectomy; LCDs/LCAs do not exist ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Prostatectomy, Open ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Prostate Brachytherapy (CPT Codes 55875 and 55876)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for prostate brachytherapy; LCDs/LCAs do not exist ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Brachytherapy, Prostate ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Prostate Artery Embolization (CPT Code 37243)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for prostate artery embolization; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Prostate Surgeries and Interventions* ***Hydrocelectomy (CPT Codes 55040, 55041, 55060, and 55500)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for hydrocelectomy; LCDs/LCAs do not exist at this time

Date	Summary of Changes
	○ For coverage guidelines, refer to the InterQual® CP: Procedures, Hydrocelectomy ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines **Supporting Information** • Archived previous policy version MCS075.08

Instructions for Use

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.