Coverage Summary

Prostate: Services and Procedures

Policy Number: C-009  Products: UnitedHealthcare Medicare Advantage Plans  Original Approval Date: 02/26/2008
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 07/23/2019

Related Medicare Advantage Policy Guidelines:
- Cryosurgery of Prostate (NCD 230.9)
- Category III CPT Codes
- Prostate Rectal Spacers

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

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.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

Coverage Statement: Services and procedures for the diagnosis and treatment of prostate conditions may be covered when Medicare criteria are met.

Guidelines/Notes:
1. Prostate Cancer Screening; see the Coverage Summary for Preventive Health Services and Procedures.
2. **Cryosurgery of Prostate**
   Salvage cryosurgery of prostate is covered when Medicare criteria are met. *See the NCD for Cryosurgery of Prostate (230.9).* (Accessed July 8, 2019)

3. **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 at this time.*
   - *For coverage guideline, see the UnitedHealthcare Commercial Medical Policy for Omnibus Codes.* (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - *Committee approval date: July 23, 2019*
   - *Accessed August 26, 2019*

4. **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 state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment A).*
   - *For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Omnibus Codes for coverage guideline.* (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - *Committee approval date: July 23, 2019*
   - *Accessed August 26, 2019*

5. **Prostatic Urethral Lift (e.g., UroLift®)** (CPT/HCPCS codes 52441, 52442, C9739, C9740 and L8699)
   - *Medicare does not have National Coverage Determination (NCD) for prostatic urethral stent.*
   - *Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. See the LCD Availability Grid (Attachment B) for state-specific LCDs/LCAs.*
   - *For coverage guidelines, see the Palmetto GBA LCD for Minimally Invasive Treatment for Benign Prostatic Hyperplasia Involving Prostatic Urethral Lift (Urolift®)(L36109).* (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - *Committee approval date: July 23, 2019*
   - *Accessed August 26, 2019*

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**II. DEFINITIONS**

**Cryosurgery of the Prostate Gland:** Also known as cryosurgical ablation of the prostate (CSAP) destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland. *NCD for Cryosurgery of Prostate (230.9).* (Accessed July 8, 2019)
III. REFERENCES

See above

IV. REVISION HISTORY

07/23/2019  Attachments
- Updated Local Coverage Determination (LCD) Availability Grids to reflect the most current reference links

V. ATTACHMENTS

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<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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<td>National Government Services, Inc.</td>
<td>CT, IL, ME, MA, MN, NH, NY, RI, VT, WI</td>
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End of Attachment A

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<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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<td>Prostatic Urethral Lift (PUL)</td>
<td>A and B MAC</td>
<td>First Coast Service</td>
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End of Attachment B