Coverage Summary

Prostate: Services and Procedures

Policy Number: C-009  Products: UnitedHealthcare Medicare Advantage Plans
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee
Original Approval Date: 02/26/2008
Last Review Date: 10/20/2020

Related Medicare Advantage Policy Guidelines:

- Category III CPT Codes
- Cryosurgery of Prostate (NCD 230.9)
- Prostate Rectal Spacers

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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.

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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   3. Temporary Prostatic Stent (e.g., Spanner® and Memokath™ Temporary Prostatic Stent)
   4. Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH)
   5. Prostate Rectal Spacers Placement

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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 June 18, 2020)

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 guidelines, see the UnitedHealthcare Commercial Medical Policy for Omnibus Codes. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: July 21, 2020
   - Accessed June 18, 2020

   - Medicare does not have National Coverage Determination (NCD) for fluid jet system for treatment of BPH.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, see the LCD/LCA Availability Grid (Attachment B).
   - For coverage guidelines for states/territories with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Omnibus Codes. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: October 20, 2020
   - Accessed December 1, 2020

5. 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, see the LCD/LCA Availability Grid (Attachment A).
   - For coverage guidelines for states/territories with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Omnibus Codes. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: July 21, 2020
   - Accessed December 1, 2020

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 June 18, 2020)

III. REFERENCES
IV. REVISION HISTORY

10/20/2020 Guideline 4 [Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH) (0421T)] (new to policy)
- Added coverage guidelines to indicate:
  - Medicare does not have National Coverage Determination (NCD) for fluid jet system for treatment of Benign Prostatic Hyperplasia (BPH)
  - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable
    - For specific LCDs/LCAs, see Attachment B: Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH)
    - For states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Policy titled Omnibus Codes

Attachments
- Added Attachment B: Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH)

### Attachment A – LCD/LCA Availability Grid

#### Prostate Rectal Spacers Placement

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States/Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>L37485</td>
<td>Prostate Rectal Spacers</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
</tr>
</tbody>
</table>

End of Attachment A

### Attachment B – LCD/LCA Availability Grid

#### Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH)

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States/Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>L38378</td>
<td>Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH)</td>
<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
</tr>
<tr>
<td>L38726</td>
<td>Transurethral Waterjet Ablation of the Prostate</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L38705</td>
<td>Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (Effective 12/27/2020)</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
<tr>
<td>L38712</td>
<td>Transurethral Waterjet Ablation of the Prostate</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
</tr>
</tbody>
</table>
## Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH)

**CMS website accessed December 1, 2020**

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States/Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>L38682 (A58209)</td>
<td><strong>Fluid Jet System Treatment for LUTS/BPH</strong>  (Effective 12/27/2020)</td>
<td>MAC Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
</tr>
</tbody>
</table>

**End of Attachment B**