Prostate Services and Procedures

Policy Number: MCS075.05
Approval Date: July 6, 2022

Instructions for Use

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Related Medicare Advantage Policy Guidelines

- Category III CPT Codes
- Prostate Rectal Spacers

Coverage Guidelines

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

Note: The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the following websites to search for applicable coverage policies:

- Medicare Coverage Database
- National Coverage NCD Report
- Local Coverage Final LCDs Report

Prostate Cancer Screening

Refer to the Coverage Summary titled Preventive Health Services and Procedures.

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.

Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH) (CPT code 0421T)

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 for all states/territories and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH).

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.

Supporting Information

Prostate Rectal Spacers Placement Accessed June 7, 2022				
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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Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH) Accessed June 7, 2022				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38378 (A57926)	Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH)	Part A and B MAC	CGS Administrators, LLC	KY, OH
L38726 (A58264)	Transurethral Waterjet Ablation of the Prostate	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L38367 (A56797)	Fluid Jet System Treatment for LUTS/BPH	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, WI, VT
L38705 (A58227)	Transurethral Waterjet Ablation of the Prostate	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, CA, GU, HI, MP, NV
L38707 (A58229)	Transurethral Waterjet Ablation of the Prostate	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L38712 (A58243)	Transurethral Waterjet Ablation of the Prostate	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX

Fluid Jet System for Treatment of Benign Prostatic Hyperplasia (BPH) Accessed June 7, 2022				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38549 (A58008)	Transurethral Waterjet Ablation of the Prostate	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L38682 (A58209)	Transurethral Waterjet Ablation of the Prostate	Part A MAC	Wisconsin Physicians Service Insurance Corporation	AK*, AL*, AR*, AZ*, CA*, CO*, CT*, DE*, FL*, GA*, HI*, IA, ID*, IL*, IN, KS, KY*, LA*, MA*, MD*, ME*, MI, MO, MS*, MT*, NC*, ND*, NE, NH*, NJ*, NM*, NV*, OH*, OK*, OR*, PA*, RI*, SC*, SD*, TN*, TX*, UT*, VA*, VT*, WA*, WI*, WV*, WY* Note: States notated with an asterisk should follow the other available state-specific LCD/LCA listed in this table. This WPS LCD/LCA only applies to states without asterisk.
L38682 (A58209)	Transurethral Waterjet Ablation of the Prostate	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
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Policy History/Revision Information

Date	Summary of Changes

07/06/2022	**Coverage Guidelines**
	• Added notation to indicate the guidelines in this UnitedHealthcare Medicare Advantage Coverage Summary are for specific procedures only; for procedures not addressed in this UnitedHealthcare Medicare Advantage Coverage Summary, refer to the following websites to search for applicable coverage policies:
	  ○ Medicare Coverage Database
	  ○ National Coverage NCD Report
	  ○ Local Coverage Final LCDs Report
	• Removed content/language addressing cryosurgery of prostate
	Definitions
	• Removed definition of “Cryosurgery of the Prostate Gland”
	Supporting Information
	• Archived previous policy version MCS075.04

Instructions for Use

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).