Prostate Services and Procedures and Impotence Treatment

Policy Number: MMP075.10
Last Committee Approval Date: August 14, 2024
Effective Date: October 1, 2024

Instructions for Use

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Related Policies
None

Coverage Rationale

Impotence Related Prosthetics and Devices

Refer to the Medicare Advantage Medical Policy 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)

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.

UroLift® System

Medicare does not have NCD for the UroLift® System. LCDs/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 with HCPCS code L8699.

Prostate Rectal Spacers Placement

Medicare does not have NCD for prostate rectal spacers. LCDs/LCAs do not exist.

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

Nerve Graft to Restore Erectile Function During Radical Prostatectomy

Medicare does not have a NCD for nerve graft to restore erectile function during radical prostatectomy. LCDs/LCAs do not exist.

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

Prostate Artery Embolization (PAE) for Benign Prostatic Hyperplasia (BPH) Related Lower Urinary Tract Symptoms (LUTS)

Medicare has a general NCD for Therapeutic Embolization (20.28), but does not have a NCD for PAE used to treat BPH related LUTS. LCDs/LCAs do not exist.

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

UnitedHealthcare uses the criteria in the Commercial Medical Policy referenced above to supplement the general Medicare criteria within the NCD for Therapeutic Embolization (20.28) regarding when prostate artery embolization (PAE) is reasonable and necessary to treat BPH related LUTS. Complications related to long-term untreated BPH can lead to the development of chronic high-pressure retention (a potentially life-threatening condition) and long-term or permanent changes to the bladder detrusor muscle. UnitedHealthcare uses the criteria noted above in order to ensure consistency in reviewing the conditions to be met for coverage of PAE, as well as reviewing when such services may be reasonable and necessary. Use of this criteria to supplement the general provisions noted above provides clinical benefits by helping ensure PAE is not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient. The potential clinical harms of using these criteria may include inappropriately denying an PAE when it is otherwise indicated, which could lead to the member obtaining another alternative treatment and/or increased urinary incontinence, worsening bladder function which may become permanent, inflamed prostate, urinary tract infections, narrowing of the urethra, bladder and kidney stones, gross hematuria, and renal insufficiency. This may impact their functional independence, activities of daily living, and overall quality of life. The benefits to using these criteria include that the criteria may decrease inappropriate denials by creating a consistent set of review criteria and will provide clinical benefits in helping ensure that the patient obtains an appropriate surgical procedure for the requested indication. Further, use of the criteria should limit the circumstances where PAE is incorrectly approved, which itself provides benefits because it prevents unnecessary development of adverse events (e.g., blood in the urine, semen, or stool; leakage of blood in the puncture site; bladder spasm; or infection). Additionally, patients undergoing PAE may be at risk of developing post embolization syndrome. Symptoms include pelvic pain, cramping, nausea, vomiting, fatigue, and discomfort. Overall, based on the information above, the clinical benefits of using these criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services.

High Intensity Focused Ultrasound (HIFU) and Cryoablation of Prostate

Medicare does not have NCD for HIFU and cryoablation of prostate.LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, High-Intensity Focused Ultrasound (HIFU).

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Temporary Prostatic Stent	
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement [Refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions]
UroLift® System	
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

CPT Code	Description
Prostate Rectal Spacer	
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed [Refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions]
Nerve Graft to Restore Erectile Function During Radical Prostatectomy	
55899	Unlisted procedure, male genital system
64999	Unlisted procedure, nervous system
Prostate Artery Embolization	
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention: for tumors, organ ischemia, or infarction (when performed on prostate tissue)
High Intensity Focused Ultrasound (HIFU) and Cryoablation of Prostate	
55899	Unlisted procedure, male genital system

HCPCS Code	Description
L8699	Prosthetic implant, not otherwise specified

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Policy History/Revision Information

Date	Summary of Changes
10/01/2024	**Template Update** • Reformatted and reorganized policy; transferred content to new template • Changed policy type classification from “Coverage Summary” to “Medical Policy” • Updated Instructions for Use **Related Policies** • Removed reference link to the UnitedHealthcare Medicare Advantage Medical Policy titled *Category III CPT Codes*

Date	Summary of Changes
	Coverage Rationale • Removed content/language addressing: • Hydrocelectomy (CPT codes 55040, 55041, 55060, and 55500) • Prostate brachytherapy (CPT codes 55875 and 55876) • Prostate cancer screening (refer to the Medicare Coverage Database for applicable coverage guidelines) • Prostate needle biopsy (CPT code 55700) • Prostatectomy, open (CPT code 55801) • Prostatectomy, transurethral (CPT codes 52601, 52630, and 52648) ***Temporary Prostatic Stent (e.g., Spanner® and Memokath Temporary Prostatic Stent)*** • Removed reference link to the *Medicare Coverage Database* ***Prostate Rectal Spacers Placement*** • Revised language to indicate: • Medicare does not have a National Coverage Determination (NCD) for prostate rectal spacers • 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* ***Nerve Graft to Restore Erectile Function During Radical Prostatectomy*** • Removed reference link to the *Medicare Coverage Database* ***Prostate Artery Embolization (PAE) for Benign Prostatic Hyperplasia (BPH) Related Lower Urinary Tract Symptoms (LUTS)*** • Modified service heading • Revised language to indicate: • Medicare has a general NCD for therapeutic embolization (NCD 20.28), but does not have a NCD for prostate artery embolization (PAE) used to treat benign prostatic hyperplasia (BPH) related lower urinary tract symptoms (LUTS) • LCDs/LCAs do not exist • For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Prostate Surgeries and Interventions* • UnitedHealthcare uses the criteria in the Commercial Medical Policy referenced above to supplement the general Medicare criteria within the NCD for therapeutic embolization (NCD 20.28) regarding when PAE is reasonable and necessary to treat BPH related LUTS; complications related to long-term untreated BPH can lead to the development of chronic high-pressure retention (a potentially life-threatening condition) and long-term or permanent changes to the bladder detrusor muscle • UnitedHealthcare uses the criteria noted above in order to ensure consistency in reviewing the conditions to be met for coverage of PAE, as well as reviewing when such services may be reasonable and necessary; use of this criteria to supplement the general provisions noted above provides clinical benefits by helping ensure PAE is not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient • The potential clinical harms of using these criteria may include inappropriately denying an PAE when it is otherwise indicated, which could lead to the member obtaining another alternative treatment and/or increased urinary incontinence, worsening bladder function which may become permanent, inflamed prostate, urinary tract infections, narrowing of the urethra, bladder and kidney stones, gross hematuria, and renal insufficiency; this may impact their functional independence, activities of daily living, and overall quality of life • The benefits to using these criteria include that the criteria may decrease inappropriate denials by creating a consistent set of review criteria and will provide clinical benefits in helping ensure that the patient obtains an appropriate surgical procedure for the requested indication • Further, use of the criteria should limit the circumstances where PAE is incorrectly approved, which itself provides benefits because it prevents unnecessary development of adverse events (e.g., blood in the urine, semen, or stool; leakage of blood in the puncture site; bladder spasm; or infection)

Date	Summary of Changes
	• Additionally, patients undergoing PAE may be at risk of developing post embolization syndrome; symptoms include pelvic pain, cramping, nausea, vomiting, fatigue, and discomfort • Overall, based on the information above, the clinical benefits of using these criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services ***High Intensity Focused Ultrasound (HIFU) and Cryoablation of Prostate*** • Added language to indicate: • Medicare does not have a NCD for high intensity focused ultrasound (HIFU) and cryoablation of prostate • LCDs/LCAs do not exist • For coverage guidelines, refer to the InterQual® CP: Procedures, High-Intensity Focused Ultrasound (HIFU) **Applicable Codes** • Updated list of applicable CPT/HCPCS codes (previously located in the *Coverage Rationale* section): • Added 55899 and 64999 • Removed 52601, 52630, 52648, 55040, 55041, 55060, 55500, 55700, 55801, 55875, 55876, C9739, and C9740 **Centers for Medicare and Medicaid Services (CMS) Related Documents** • Added list of applicable Medicare Administrative Contractors (MACs) With Corresponding States/Territories • Added notation to indicate for the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction **Supporting Information** • Archived previous policy version MCS075.09

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference 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. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy 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, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy 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.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.