Medical Policy
Transrectal Ultrasound for Staging Rectal Cancer

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Policy Number: 679
BCBSA Reference Number: 6.01.28A
NCD/LCD: Local Coverage Determination (LCD): Transrectal Ultrasound (L33578)

Related Policies
- Transrectal Ultrasound of the Prostate, #680

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Transrectal ultrasound may be considered MEDICALLY NECESSARY for the following anorectal conditions:
- Clinical staging of a patient with rectal carcinoma
- Evaluation of patients who have had definitive treatment for carcinoma of the rectum where recurrent disease is noted
- Evaluation of patients with an anal or rectal fistula
- Diagnostic evaluation of malignant or benign perirectal tumors such as, but not limited to villous adenomas, chordomas, leiomyosarcomas, and dermoid cysts
- Evaluation of anal and/or rectal or perirectal abscesses.

Transrectal ultrasound is INVESTIGATIONAL for conditions not listed above.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Indications:

Prostate:
1. Clinical staging of a patient with prostate cancer in whom radical prostatectomy or radiation therapy is considered.
2. Evaluation of a patient following radical prostatectomy or radiation therapy for prostate cancer who has rising prostate specific antigen (PSA) levels.
3. A suspicion of prostatic disease documented from the patient’s history, rectal examination, or a clinically significant PSA increase, and/or bone scan evidence of metastasis without a diagnosis of prostate cancer.
4. Transrectal ultrasound is allowed for metastatic lesions of unknown source, with a high PSA level, which could have their origin in the prostate.
5. Infertility and azosperma where an ejaculatory duct cyst is suspected.
6. Fever of unknown origin where a prostatic focus is suspected.
7. Evaluation of suspected prostatitis or prostatic abscess.
8. Congenital and acquired cystic conditions of prostate, seminal vesicles, and related tissues.
9. Measuring size/volume of prostate tissue prior to radiation therapy, transurethral needle ablation of the prostate (TUNA), or transurethral microwave thermotherapy (TUMT), Transurethral Resection of the Prostate (TURP) and Laser Ablation of Prostate (“green-light” laser).
10. Transrectal ultrasound is also used to guide correct interstitial radioelement application (CPT code 76965) and placement of radiation therapy fields (CPT code 76950).
11. Monitoring of response to therapy in patients with prostate cancer
12. Evaluation of seminal vesicles in the presence of hematospermia.

**Rectum:**
2. Evaluation of a patient who has had definitive treatment for carcinoma of the rectum at risk for recurrent disease.
3. Evaluation of a patient with anal or rectal fistula when documentation indicates the diagnostic result is necessary to determine the appropriate treatment.
4. Diagnostic evaluation of malignant or benign perirectal tumors such as, but not limited to, villous adenomas, chordomas, leiomyosarcomas, and dermoid cysts.
5. Evaluation of anal and/or rectal or perirectal abscesses when the documentation indicates the diagnostic result is likely to contribute to the development of a treatment plan.
6. Evaluation of anal incontinence symptoms that are likely due to anatomic sphincter defects for which surgical reconstruction is most likely to be done. Typically, the patient has fecal incontinence with a history of traumatic risk (e.g., childbirth, rectal surgery or irradiation).

**Limitations:**

Measurement of prostate volume via a transrectal echography prior to brachytherapy should be performed only for planned brachytherapy procedures.

Medicare will not cover transrectal ultrasound unless applicable criteria under the “Indications and Limitations of Coverage and/or Medical Necessity” section are met.

Examples of noncovered indications for the use of transrectal ultrasound include, but are not limited to, the following:
- Screening of asymptomatic patients;
- Confirmation of a known diagnosis when no significant additional information is expected;
- Evaluation of benign lesions except as noted in the “Indications” subsection above; and/or
- Family history of colorectal/prostate carcinoma.

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the link below.

**Local Coverage Determination (LCD): Transrectal Ultrasound (L33578)**
For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

**Prior Authorization Information**
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services. Yes indicates that prior authorization is required. No indicates that prior authorization is not required. N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>No</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>No</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
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<tr>
<td>Medicare PPO BlueSM</td>
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**CPT Codes / HCPCS Codes / ICD Codes**
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<tr>
<td>76872</td>
<td>Ultrasound, transrectal;</td>
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**Description**
Transrectal ultrasound (TRUS) of the rectum has been investigated as a technique to evaluate the local extent of rectal cancer, both to determine the penetration through the rectal wall and to assess neighboring lymph nodes. TRUS involves insertion of a transducer within a latex balloon filled with water. The transducer may either be inserted directly or through a sigmoidoscope to allow access to a more proximal lesion. In general, 5 ultrasonic layers can be distinguished corresponding to the following components of the bowel wall: mucosa, muscularis mucosa, submucosa, muscularis propria, perirectal fat. Tumors invading submucosa are called T1; invading muscularis propria, T2; penetrating rectal wall into perirectal fat, T3; and involving adjacent organs, T4. In terms of determining candidacy for local resection, it is most important to distinguish T1/T2 tumors from T3/T4. Prior surgery or radiation therapy disturbs the anatomy of the rectum; therefore, TRUS cannot distinguish between the layers of the rectal wall in previously treated patients.

**Policy History**

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<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>1/2015</td>
<td>Medical policy remediation: Formatting, editing and coding updates. Language transferred from medical policy #007, Ultrasounds.</td>
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<td>Date</td>
<td>Reviewed - Medical Policy Group - Hematology and Oncology.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References