Medical Policy
Transrectal Ultrasound of the Prostate

Table of Contents
- Policy: Commercial
- Policy: Medicare
- Authorization Information
- Coding Information
- Description
- Information Pertaining to All Policies
- Policy History

Policy Number: 680
BCBSA Reference Number: 6.01.08A
NCD/LCD: Local Coverage Determination (LCD): Transrectal Ultrasound (L33578)

Related Policies
Transrectal Ultrasound for Staging Rectal Cancer, #679

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

Transrectal ultrasound may be considered MEDICALLY NECESSARY for the following prostatic conditions:
- Local staging of prostate cancer in patients with established diagnosis of prostate cancer
- Monitoring of response to therapy in patients with prostate cancer
- Measuring size/volume of prostate tissue prior to radiation therapy
- Evaluation of prostate for finding foci of possible cancerous tissue in asymptomatic patient with normal digital rectal examination (DRE) but elevated PSA levels
- Abnormal gland upon exam such as palpable nodules or asymmetry, or in BPH patients as preoperative assessment for covered therapeutic procedures
- Examination of seminal vesicles in patients being evaluated for infertility
- Evaluation of suspected prostatitis or prostatic abscess
- Congenital and acquired cystic conditions of prostate, seminal vesicles, and related tissue.

Transrectal ultrasound may be considered MEDICALLY NECESSARY for ultrasonographic guidance of prostatic needle biopsy, for obtaining prostatic tissue for pathologic examination.

Transrectal ultrasound is INVESTIGATIONAL for conditions not listed above.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

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>Plan Type</th>
<th>Requires Prior Authorization</th>
</tr>
</thead>
<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>
<td>No</td>
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<tr>
<td>Medicare PPO BlueSM</td>
<td>No</td>
</tr>
</tbody>
</table>

CPT Codes / HCPCS Codes / ICD-9 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:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>76872</td>
<td>Ultrasound, transrectal:</td>
</tr>
<tr>
<td>76942</td>
<td>Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation</td>
</tr>
</tbody>
</table>

Description
Transrectal ultrasound is a diagnostic imaging procedure used in the diagnosis, staging, and 
management of malignant diseases of the prostate. It is also used to screen for prostate cancer. 
Instrumentation consists of a transducer (probe), which is inserted into the rectum, a radial and/or linear 
scanner, and an imaging screen.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</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>
</tr>
<tr>
<td>Date</td>
<td>Review Information</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](#)