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(s) below.

Local Coverage Determinations (LCDs) for National Government Services, Inc.
Local Coverage Determination (LCD): Transrectal Ultrasound (L33578)

**Note:** To review the specific LCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

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 at [https://www.cms.gov](https://www.cms.gov) for information regarding your specific jurisdiction.

**Prior Authorization Information**

**Inpatient**
- For services described in this policy, precertification/preauthorization is **required** for all products if the procedure is performed **inpatient**.

**Outpatient**
- For services described in this policy, see below for products where prior authorization might be **required** if the procedure is performed **outpatient**.

<table>
<thead>
<tr>
<th>Product</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Not required.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Not required.</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>Not required.</td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>Not required.</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 Code</th>
<th>Description</th>
</tr>
</thead>
<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>
</tr>
</thead>
<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 Details</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
</tr>
</tbody>
</table>

**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