MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Medical Policy

Transrectal Ultrasound of the Prostate

Table of Contents

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 Blue℠ and Medicare PPO Blue℠ 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 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**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **not required**.
Commercial PPO and Indemnity	Prior authorization is **not required**.
Medicare HMO Blue℠	Prior authorization is **not required**.
Medicare PPO Blue℠	Prior authorization is **not required**.

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:

CPT Codes

CPT codes:	Code Description
76872	Ultrasound, transrectal;
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

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

Date	Action
1/2015	Medical policy remediation: Formatting, editing and coding updates. Language transferred from medical policy #007, Ultrasounds.

7/2011	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
9/2009	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
10/2008	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
9/2007	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.

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