

Medicare Advantage Medical Policy



Focal Treatments for Prostate Cancer – Medicare Advantage

Medicare Advantage Plan

☒ Medicare Plus BlueSM

☒ BCN AdvantageSM

UM Committee Approval Date: 3/18/2026

Effective Date: 4/18/2026

Description

Focal treatments for prostate cancer are targeted therapies that use various types of energy to destroy tumor cells, while minimizing damage to surrounding healthy tissue. This approach can be an alternative to whole-gland treatments, such as radical prostatectomy or radiation therapy. There are several types of focal treatment including: cryotherapy, high-intensity focused ultrasound (HIFU), focal laser ablation (FLA), irreversible electroporation (IRE), transurethral ultrasound ablation of the prostate (TULSA), stereotactic body radiotherapy, and proton beam therapy. Cancer that hasn't spread outside the prostate and has a low risk of spreading might be appropriate for focal therapy.

Related Medical Policies

- Brachytherapy for Clinically Localized Prostate Cancer Using Permanently Implanted Seeds – Medicare Advantage
 - Intensity-Modulated Radiation Therapy (IMRT) of the Prostate – Medicare Advantage
 - Charged-Particle (Proton or Helium Ion) Radiotherapy for Neoplastic Conditions – Medicare Advantage
 - Stereotactic Radiosurgery and Body Radiotherapy – Medicare Advantage
 - Magnetic Resonance-Guided Focused Ultrasound (MRGFUS) – Medicare Advantage
 - Saturation Biopsy for Diagnosis and Staging of Prostate Cancer – Medicare Advantage
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Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize "internal coverage criteria", such as independent criteria, health plan policy research, LCD/LCAs outside the services area

or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at <https://www.bcbsm.com/providers/mpradmin/> by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

CMS Guidance	Additional Guidance
National Coverage Determinations 230.9 Cryosurgery of Prostate 310.1 Routine Costs in Clinical Trials For additional information related to clinical trials related to focal treatments for prostate cancer: Please refer to this URL: https://clinicaltrials.gov	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making.
Local Coverage Determinations and Articles WPS None CGS L34090, A56467 - Laser Ablation of the Prostate	In such cases, please refer to the relevant BCBSM/BCN policy for guidance: <i>Focal Treatments for Prostate Cancer</i> To access this policy, please visit the BCBSM Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.
First Coast None	
NGS None	
Noridian JE None	
Noridian JF None	
Novitas None	
Palmetto None	

Code	Description
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance
55877	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous
55899	Unlisted procedure, male genital system [As it pertains to Focal Treatments for Prostate Cancer]
51721	Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed
55881	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation (TULSA)
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed (TULSA)
0601T	Ablation, irreversible electroporation (IRE); 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC, Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC, Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	

CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may be permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
08/17/2024	07/17/2024	Medicare Advantage policy established
4/19/2025	3/19/2025	Annual Review: MA policy foundational language updated. Adoption of JUMP policy updates.
4/18/2026	3/18/2026	Annual Review: Reformatted guidance and code tables. Updated CMS guidance with NCD 310.1. Adoption of JUMP policy updates