Clinical Policy Bulletin: Transrectal Ultrasound

Revised February 2015

Number: 0001
(Replaces CPB 286)

Policy

I. Aetna considers transrectal ultrasound (TRUS) medically necessary for any of the specific conditions involving the prostate, rectum and surrounding tissues listed below:

   A. A suspicion of prostatic disease documented by any of the following:

      1. Abnormal digital rectal examination; or
      2. Elevation of prostate-specific antigen (PSA greater than 10 ng/ml); or
      3. Member's history; or

   B. Assessment of anal sphincter dysfunction; or
   C. Clinical staging of a member with prostate cancer; or
   D. Clinical staging of a member with rectal carcinoma; or
   E. Determining volume of the prostate prior to brachytherapy; or
   F. Evaluation of anal and/or rectal fistula; or
   G. Evaluation of anal and/or rectal peri-rectal abscesses; or
   H. Evaluation of hematospermia (hemospermia), to distinguish idiopathic from secondary causes; or
   I. Evaluation of malignant or benign peri-rectal tumors; or
   J. Evaluation of members who have had definitive treatment for carcinoma of the rectum where recurrent disease is noted; or
   K. Infertility and azoospermia where an ejaculatory duct cyst is suspected. (Note: Some benefit plans exclude coverage of infertility services. Please check benefit plan descriptions for details); or
   L. Metastatic lesions of unknown source, with a high PSA level (PSA greater than 10 ng/ml), which could have their origin in the prostate.

II. Aetna considers TRUS experimental and investigational as a screening test for prostate disease and for all other indications because peer-reviewed medical literature does not support its use for these indications.
III. Aetna considers TRUS elastography (sono-elastography or shear-wave elastography) experimental and investigational for the evaluation of prostate cancer because its effectiveness has not been established.

IV. Aetna considers fusion imaging of multi-parametric magnetic resonance imaging (MRI) with TRUS to guide prostate biopsy experimental and investigational because the effectiveness of this approach has not been established.

See also CPB 0327 - Infertility, CPB 0521 - Prostate Cancer Screening.

Background

Prostate cancer is the most common cause of cancer and the second most common cause of cancer deaths in men in the United States. Prostatic carcinoma generally is slowly progressive and may cause no symptoms. Approximately 50 % of patients with carcinoma of the prostate have either advanced local disease or metastases at the time of diagnosis. This emphasizes the need to detect those patients with potentially curable carcinoma of the prostate at a localized pathologic state. With the development of prostatic ultrasonographic technology, urologists have gained a tool that allows better visualization, more accurate biopsy and earlier detection of carcinoma of the prostate.

Carcinoma of the prostate should be suspected on the basis of abnormal digital rectal findings, hypoechoic lesions on transrectal ultrasound (TRUS), or elevated levels of prostate-specific antigen (PSA). However, diagnosis requires histologic confirmation, most commonly by TRUS-guided transrectal needle biopsy, which can be done without anesthesia. The advent of TRUS-guided biopsies of the prostate, as opposed to blind finger-guided biopsies, has increased the detection rate of prostate cancer when performed in the presence of an abnormal digital rectal examination (DRE) or with an elevation of PSA above 10 ng/ml.

Among several treatment options available, transperineal prostate brachytherapy has evolved as a medically successful, cost-effective outpatient procedure for treating localized prostate cancer. Transperineal prostate brachytherapy utilizes TRUS as the primary imaging procedure to accurately plan and execute the placement of radioactive seeds into the prostate.

There is insufficient information in the published medical literature to support the use of TRUS alone as a screening tool for prostate cancer; however, TRUS can reduce the number of missed cancers in patients with signs or symptoms that may be related to prostate cancer.

In the pre-operative staging of rectal cancer, TRUS is the most accurate imaging modality. It is possible to evaluate the layers of the rectal wall, the depth of tumor penetration and the peri-rectal lymph nodes. TRUS is 85 to 95 % accurate in determining bowel wall penetration and 70 to 80 % accurate in identifying lymph node involvement. The accuracy of the findings, as with all ultrasound examinations, depends on the operator.
Obstructive azoospermia represents approximately 10% of male hypofertility cases. Cystic lesions of the prostate involving the ejaculatory duct are uncommon in healthy, fertile men; their prevalence increases in infertile men whose examination and semen analyses make them “at risk” for having ductal obstruction. TRUS accurately visualizes abnormalities of the caudal junction of the vas deferens and seminal vesicles, providing a definitive diagnosis without scrototomy.

Transrectal ultrasound is a useful clinical tool for specific conditions involving the prostate, rectum and surrounding tissues. It is less expensive than computed tomography (CT) or magnetic resonance imaging (MRI); the equipment is more mobile, and the procedure can be performed more quickly. Finally, TRUS is well-tolerated by patients, and involves no radiation exposure.

Transrectal ultrasound is the imaging procedure of choice for patients with hematospermia. Polito et al (2006) stated that the presence of blood in ejaculate represents 1% of all andrological and urological symptoms. In most cases it has a benign character and tends to regress spontaneously after the first episode. But in the same case it can be caused by bladder-prostate or systemic malignant pathology, so it is necessary to subject the patient to laboratory and instrumental tests in order to find the best treatment that, as for hematospermia, is an etiological one. Most important for correct diagnosis are patient history, physical examination, laboratory tests, TRUS examination of the prostate, MRI, CT, cystoscopy. Hematospermia is rarely associated with significant pathology, especially in younger men. The three factors that dictate the extent of the evaluation and treatment are age of patient, the duration and recurrence of the hematospermia, and the presence of any associated hematuria. Thus, it is possible to distinguish idiopathic from secondary hematospermia, because secondary hematospermia, namely, the one in which the bleeding cause is known or suspected, requires an etiologic treatment. Understanding the pathophysiology and prevalence in populations of different ages helps minimize the likelihood of problems. When in doubt, performing a TRUS, cystoscopy, and basic laboratory analyses limits exposure. Also, Zhang et al (2003) reported that TRUS-guided transperineal aspiration of seminal vesicle fluid was helpful to the etiologic diagnosis of persistent hematospermia. Furthermore, Yagci et al (2004) noted that TRUS is a safe, non-invasive method for examining causes of hematospermia. These researchers believed that it should be the first radiological investigation to be performed in patients presenting with hematospermia.

Tissue elasticity has been employed as a qualitative biomarker for prostate cancer and sono-elastography is an emerging imaging tool for providing qualitative as well as quantitative measurements of prostate tissue stiffness. Hoyt and associates (2008) reported that elasticity images obtained with quantitative sono-elastography agree with mechanical testing and histological results. They stated that sono-elastography is a promising biomarker for prostate cancer.

Although elastography is a promising method, prospective studies are needed to define its applications. Janssen (2008) stated that (endo)sonographic real-time elastography is a new method to describe the mechanical properties of tissue. Similar to color-flow Doppler ultrasonography, a region of interest is defined. The relative stiffness of the tissues within this area is described by colors
superimposing on the B-mode image. Real-time elastography can be performed with linear scanners for transcutaneous use, rigid endocavitary probes and with flexible echoendoscopes. The probes can be used to compress the tissue. The elasticity modulus is calculated from the resulting deformation of the tissue. In endoscopic ultrasound, arterial and cardiac pulsations or respiratory movements cause the deformation of the tissue that is used for the calculation. The author concluded that (endo)sonographic real-time elastography is a promising new method. Nevertheless, prospective studies are needed to define useful applications and the clinical significance of the method.

There is emerging evidence to suggest that elastography has the potential to increase ultrasound-based prostate cancer detection. Salomon et al (2008) noted that conventional gray scale ultrasound has a low sensitivity and specificity for prostate cancer detection. These researchers determined sensitivity and specificity for prostate cancer detection with ultrasound-based real-time elastography in patients scheduled for radical prostatectomy (RP). A total of 109 patients with biopsy-proven localized prostate cancer (PCa) underwent elastography before RP. The investigator was blinded to clinical data. A EUB-6500HV ultrasound system with a V53W 7.5 MHz end-fire transrectal probe was used pre-operatively. Areas found to be suspicious for PCa were recorded for left and right side of the apex, mid-gland, and base. These findings were correlated with the obtained whole-mount sections after RP. Sensitivity and specificity for detecting PCa were 75.4 % and 76.6 %, respectively. A total of 439 suspicious areas in elastography were recorded, and 451 cancerous areas were found in the RP specimens. Positive predictive value, negative predictive value, and accuracy for elastography were 87.8 %, 59 %, and 76 %, respectively. Nevertheless, there are limitations to these findings because these researchers investigated specific patients scheduled for RP with apparent PCa. Whether elastography is practical as a diagnostic tool or can be used to target a biopsy and be at least as sensitive in tumor detection as extended biopsy schemes has yet to be determined. The authors concluded that elastography can detect prostate cancer foci within the prostate with good accuracy and has potential to increase ultrasound-based PCa detection. They stated that further studies are needed to validate these data and to assess if tumor detection can be increased by elastography-guided biopsies.

However, there is other evidence to suggest that elastography does not improve cancer detection rates. Eggert and colleagues (2008) found that elastography-guided prostate biopsies did not improve cancer detection in men with suspected prostate cancer. A total of 351 prospectively randomized patients underwent prostate biopsies for the first time. The indication for biopsy was abnormal DRE in 25 % or suspicious PSA elevation in 75 %. In the elastography group (n = 189) and the control group (n = 162), these researchers assessed PSA, DRE, and B-mode TRUS. Both groups underwent classic TRUS-guided 10-core biopsy. Patients in the elastography group underwent additional elastographic examination prior to biopsy using a Voluson 730 ultrasound system. According to the ultrasound or elastographic findings for each biopsy location, the researcher tried to predict whether cancer was present. This prediction was correlated with histopathological findings. The statistical power of this study was sufficient to detect a 15 % difference in detection rate. The study groups did not differ in PSA, clinical stages, or prostate volume (p < 0.05). The overall cancer detection rate was 39 % (137/351); 40.2 % (76/189) in the elastography group and 37.7 %
in the control group, respectively. The difference in detection rate in clinical stages T2 and T3 between the elastography and the control groups was not statistically significant ($p < 0.05$). Within the T1c subgroup, elastography showed a slightly higher detection rate of 55.6% versus 50% without reaching statistical significance ($p > 0.05$). Histopathological findings were adequately predicted by elastography in only 44.5%. The authors concluded that elastography did not improve the cancer detection rate in this cohort of patients.

In a review on the value of real-time elastography in the diagnosis of prostate cancer, Salomon et al (2009) stated that randomized biopsy sampling under TRUS guidance is the gold standard for the diagnosis of prostate cancer. In addition, improvements in the quality of conventional ultrasound, new methods that complement conventional TRUS are opening the door to earlier and better targeted diagnosis of prostate cancer. One of these new methods is sonoelastography. However, its impact on prostate cancer diagnostics has not yet been fully investigated.

Elastography is among a number of new technologies under development for improvement in prostate cancer detection. Trabulsi et al (2010) stated that standard grayscale TRUS has a poor sensitivity for detection of prostate cancer. Saturation biopsy schemes have improved prostate cancer detection rates over standard template biopsy schemes, but carry additional morbidity and cost. Enhanced ultrasound modalities (EUM), including color and power Doppler, contrast-enhancement, harmonic and flash replenishment imaging, as well as elastography have the potential to improve prostate cancer detection. Enhanced ultrasound modalities targeting areas with increased or abnormal vascularity or firmness for biopsy offer improved prostate cancer detection. These new approaches detect prostate cancer more efficiently than standard ultrasound guided biopsies. The authors concluded that these emerging technologies may potentially augment standard prostate biopsy in clinical practice.

Eggert et al (2010) noted that previous studies investigated the clinical impact of elastography for pre-operative staging and as an additional imaging modality to improve prostate cancer detection during prostate biopsy. This rapidly improving technique has facilitated progress toward feasibility and reproducibility of transrectal elastography. Recent studies show significant improvements using the latest generation of elastographic devices. Moreover, the authors stated that further studies are needed to evaluate on the one hand elastography-guided prostate biopsy schemes and results of saturation biopsies; and on the other hand to compare sensitivity and specificity of elastographic detection of prostate cancer with different imaging techniques, especially MRI and spectroscopy.

Aboumarzouk et al (2012) synthesized published data of transrectal elastosonography (TRES) using diagnostic review methodology. Transrectal elastosonography increases prostate cancer detection as compared with grey-scale US. Also, the study highlighted limitations and strengths of data in this area and included recommendations for future research. Two reviewers independently extracted the data from each study. Quality was assessed with a validated quality assessment tool for diagnostic accuracy studies. Diagnostic accuracy of TRES in relation to current standard references (TRUS biopsies and histopathology of RP specimens) was estimated. A bi-variate random effects model was used to obtain
sensitivity and specificity values. Hierarchical summary receiver operating characteristic (HSROC) were calculated. In all, 16 studies (2,278 patients) were included in the review. Using histopathology of the RP specimen as reference standard, the pooled data of 4 studies showed that the sensitivity of TRES ranged between 0.71 to 0.82 and the specificity ranged between 0.60 to 0.95 (pooled diagnostic odds ratio [DOR] 19.6; 95 % confidence interval [CI]: 7.7 to 50.03). The sensitivity varied from 0.26 to 0.87 and specificity varied from 0.17 to 0.76 (pooled DOR 2.141; 95 % CI: 0.525 to -8.737) using TRUS biopsies (minimum of 10) as a reference standard. The quality of most studies was modest. SROC estimated 0.8653 area under the curve predicting high chances of detecting prostate cancer. There were no health economics or health-related quality of life of the participants reported in the studies and all the studies used compressional technique with no reported standardisation. The TRES technique appears to improve the detection of prostate cancer compared with systematic biopsy and shows a good accuracy in comparison with histopathology of the RP specimen. However, the authors noted that studies lacked standardization of the technique, had poor quality of reporting and a large variation in the outcomes based on the reference standards and techniques used.

Pummer et al (2014) performed a Medline literature search of the time frame between 01/2007 and 06/2013 on imaging of localized PCa. Conventional TRUS is mainly used to guide prostate biopsy. Contrast-enhanced ultrasound is based on the assumption that PCa tissue is hyper-vascularized and might be better identified after intravenous injection of a microbubble contrast agent. However, results on its additional value for cancer detection are controversial. Computer-based analysis of the TRUS signal (C-TRUS) appears to detect cancer in a high rate of patients with previous biopsies. Real-time elastography seems to have higher sensitivity, specificity, and positive-predictive value than conventional TRUS. However, the method still awaits prospective validation. The same is true for prostate histo-scanning, an ultrasound-based method for tissue characterization. Currently, multi-parametric MRI provides improved tissue visualization of the prostate, which may be helpful in the diagnosis and targeting of prostate lesions. However, most published series are small and suffer from variations in indication, methodology, quality, interpretation, and reporting. The authors concluded that among ultrasound-based techniques, real-time elastography and C-TRUS seem the most promising techniques. Multi-parametric MRI appears to have advantages over conventional T2-weighted MRI in the detection of PCa. Moreover, they stated that despite these promising results, currently, no recommendation for the routine use of these novel imaging techniques can be made; prospective studies defining the value of various imaging modalities are urgently needed.

Penzkofer and Tempany-Afdhal (2014) stated that the primary role of imaging for the detection and diagnosis of PCa has been TRUS guidance during biopsy. Traditionally, MRI has been used primarily for the staging of disease in men with biopsy-proven cancer. It has a well-established role in the detection of T3 disease, planning of radiation therapy, especially 3-D conformal or intensity-modulated external beam radiation therapy, and planning and guiding of interstitial seed implant or brachytherapy. New advances have now established that prostate MRI can accurately characterize focal lesions within the gland, an ability that has led to new opportunities for improved cancer detection and guidance for biopsy.
Two new approaches to prostate biopsy are under investigation. Both use pre-biopsy MRI to define potential targets for sampling, and the biopsy is performed either with direct real-time MR guidance (in-bore) or MR fusion/registration with TRUS images (out-of-bore). In-bore and out-of-bore MRI-guided prostate biopsies have the advantage of using the MR target definition for the accurate localization and sampling of targets or suspicious lesions. The out-of-bore method uses combined MRI/TRUS with fusion soft-ware that provides target localization and increases the sampling accuracy of TRUS-guided biopsies by integrating prostate MRI information with TRUS. The authors concluded that newer parameters for each imaging modality, such as sono-elastography or shear-wave elastography, contrast-enhanced ultrasound and MRI elastography, show promise to further enrich datasets.

Magnetic resonance imaging-targeted, TRUS- guided transperineal fusion biopsy has shown encouraging results for detecting clinically significant prostate cancer. However, the clinical value of this approach in routine clinical practice has not been established.

Marks et al (2013) stated that prostate cancer may be detected on MRI. Fusion of MRI with ultrasound allows urologists to progress from blind, systematic biopsies to biopsies, which are mapped, targeted and tracked. These investigators reviewed the current status of prostate biopsy via MRI/ultrasound fusion. Three methods of fusing MRI for targeted biopsy have been recently described: (i) MRI- ultrasound fusion, (ii) MRI-MRI fusion (‘in-bore’ biopsy) and (iii) cognitive fusion. Supportive data were emerging for the fusion devices, 2 of which received Food and Drug Administration (FDA) approval in the past 5 years: (i) Artemis (Eigen, USA) and (ii) Urostation (Koelis, France). Working with the Artemis device in more than 600 individuals, these researchers found that targeted biopsies are 2 to 3 times more sensitive for detection of prostate cancer than non-targeted systematic biopsies; nearly 40 % of men with Gleason score of at least 7 prostate cancer are diagnosed only by targeted biopsy; nearly 100 % of men with highly suspicious MRI lesions are diagnosed with prostate cancer; ability to return to a prior biopsy site was highly accurate (within 1.2 ± 1.1 mm); and targeted and systematic biopsies were twice as accurate as systematic biopsies alone in predicting whole-organ disease. The authors concluded that in the future, MRI-ultrasound fusion for lesion targeting is likely to result in fewer and more accurate prostate biopsies than the present use of systematic biopsies with ultrasound guidance alone.

Schilling et al (2013) noted that multi-parametric MRI represents the most accurate imaging modality for prostate cancer imaging to-date. Transrectal ultrasound is easily applied and therefore remains the gold standard for systematic prostate biopsies. However, the advantages of both modalities can be combined by image fusion. Currently, several image fusion devices are being implemented into clinical routine. First data showed an increased detection rate of prostate cancer compared to systematic TRUS biopsies. The authors concluded that a present prostatic deformation and intracorporeal movement represent technical challenges yet to be overcome.

Dumus et al (2013) examined if prostate cancer detection rates of TRUS-guided biopsy may be improved by an image fusion of state-of-the-art ultrasound (CEUS,
elastography) and MR (T2w, DWI) imaging. A total of 32 consecutive patients with a history of elevated PSA levels and at least 1 negative TRUS-guided biopsy with clinical indication for a systematic re-biopsy underwent multi-parametric 3 T MRI without endorectal coil. MR data (T2w) were uploaded to a modern sonography system and image fusion was performed in real-time mode during biopsy. B-mode, Doppler, elastography and CEUS imaging were applied to characterize suspicious lesions detected by MRI. Targeted biopsies were performed in MR/US fusion mode followed by a systematic standard TRUS-guided biopsy. Detection rates for both methods were calculated and compared using the Chi²-test. Patient age was not significantly different in patients with and without histologically confirmed prostate cancer (65.2 ± 8.0 and 64.1 ± 7.3 years [p = 0.93]). The PSA value was significantly higher in patients with prostate cancer (15.5 ± 9.3 ng/ml) compared to patients without cancer (PSA 10.4 ± 9.6 ng/ml; p = 0.02). The proportion of histologically confirmed cancers in the study group (n = 32) of the MR/US fusion biopsy (11/12; 34.4 %) was significantly higher (p = 0.01) in comparison to the TRUS systematic biopsy (6/12; 18.8 %). The authors concluded that real-time MR/US image fusion may enhance cancer detection rates of TRUS-guided biopsies and should therefore be studied in further larger studies.

Kuru et al (2013) evaluated MRI-targeted, TRUS- guided transperineal fusion biopsy in routine clinical practice. Included in this prospective study were 347 consecutive patients with findings suspicious for prostate cancer. Median age was 65 years (range of 42 to 84) and mean PSA was 9.85 ng/ml (range of 0.5 to 104). Of the men 49 % previously underwent TRUS- guided biopsies, which were negative, and 51 % underwent primary biopsy. In all patients 3 T multi-parametric MRI was done. Systematic stereotactic prostate biopsies plus MRI-targeted, TRUS- guided biopsies were performed in those with abnormalities on MRI. Imaging data and biopsy results were analyzed. A self-designed questionnaire was sent to all men on further clinical history and biopsy adverse effects. Of 347 patients, biopsy samples of 200 (58 %) showed prostate cancer and 73.5 % of biopsy proven prostate cancer were clinically relevant according to National Comprehensive Cancer Network (NCCN) criteria. On multi-parametric MRI, 104 men had findings highly suspicious for prostate cancer. The tumor detection rate was 82.6 % (86 of 104 men) with a Gleason score of 7 or greater in 72 %. Overall targeted cores detected significantly more cancer than systematic biopsies (30 % versus 8.2 %). Of 94 patients without cancer suspicious lesions on MRI, 11 (11.7 %) were diagnosed with intermediate risk disease. Regarding adverse effects, 152 of 300 patients (50.6 %) reported mild hematuria, 26 % had temporary erectile dysfunction and 2.6 % needed short-term catheterization after biopsy. Non-septic febrile urinary tract infections developed in 3 patients (1 %). The authors concluded that MRI- targeted, TRUS-guided transperineal fusion biopsy provided high detection of clinically significant tumors. Moreover, they stated that since multi-parametric MRI still has some limitations, systematic biopsies should currently not be omitted.

Shoji et al (2014) reported their early experience with manually controlled targeted biopsy with real-time multi-parametric MRI and TRUS fusion images for the diagnosis of prostate cancer. A total of 20 consecutive patients suspicious of prostate cancer at the multi-parametric MRI scan were recruited prospectively. Targeted biopsies were carried out for each cancer-suspicious lesion, and 12 systematic biopsies using the BioJet system. Pathological findings of targeted and
systematic biopsies were analyzed. The median age of the patients was 70 years (range of 52 to 83 years). The median pre-operative PSA value was 7.4 ng/ml (range of 3.54 to 19.9 ng/ml). Median pre-operative prostate volume was 38 ml (range of 24 to 68 ml). The number of cancer-detected cases was 14 (70 %). The median Gleason score was 6.5 (range of 6 to 8). Cancer-detected rates of the systematic and targeted biopsy cores were 6.7 and 31.8 %, respectively (p < 0.0001). In 6 patients who underwent radical prostatectomy, the geographic locations and pathological grades of clinically significant cancers and index lesions corresponded to the pathological results of the targeted biopsies. The authors concluded that prostate cancers detected by targeted biopsies with manually controlled targeted biopsy using real-time multi-parametric MRI and TRUS fusion imaging have significantly higher grades and longer length compared with those detected by systematic biopsies. Moreover, they stated that further studies and comparison with the pathological findings of whole-gland specimens have the potential to determine the role of this biopsy methodology in patients selected for focal therapy and those under active surveillance.

An UpToDate review on “Prostate biopsy” (Benway and Andriole, 2014) states that “The limitations of MR-targeted biopsy are its long examination time and that it requires radiologic expertise, and thus, is not generally available. The best of the MR-targeted biopsy options listed above for urologists, who perform the majority of prostate biopsies, may be biopsy with MR/TRUS image fusion technique (e.g., Koelis Urostation). However, the technique needs further validation”.

Furthermore, NCCN’s clinical practice guideline on “Prostate cancer” (Version 2.2014) states that “Multi-parametric MRI shows promise and a recent consensus conference should help with standardization of techniques and reporting”. It does not mention fusion imaging of multi-parametric MRI and TRUS as a means to guide prostate biopsy.

CPT Codes / HCPCS Codes / ICD-9 Codes

CPT codes covered if selection criteria are met:

45341 Sigmoidoscopy, flexible: with endoscopic ultrasound examination

45342 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

76872 Ultrasound, transrectal

76873 prostate volume study for brachytherapy treatment planning (separate procedure)

CPT codes not covered for indications listed in the CPB:

0346T Ultrasound, elastography (List separately in addition to code for primary procedure)

Other CPT codes related to the CPB:
ICD-9 codes covered if selection criteria are met:

- 154.0 - 154.8 Malignant neoplasm of the rectum, rectosigmoid junction, and anus
- 185 Malignant neoplasm of prostate
- 195.3 Malignant neoplasm of pelvis
- 197.5 Secondary malignant neoplasm of large intestine and rectum
- 198.82 Secondary malignant neoplasm of genital organs
- 211.4 Benign neoplasm of rectum and anal canal
- 222.2 Benign neoplasm of prostate
- 230.4 Carcinoma in situ of rectum
- 230.5 Carcinoma in situ of anal canal
- 230.6 Carcinoma in situ of anus, unspecified
- 233.4 Carcinoma in situ of prostate
- 235.2 Neoplasm of uncertain behavior of stomach, intestines, and rectum
- 236.5 Neoplasm of uncertain behavior of prostate
- 565.1 Anal fistula
- 566 Abscess of anal and rectal regions
- 569.49 Other specified disorders of rectum and anus (to be used for anal sphincter dysfunction)
- 606.0 - 606.9 Infertility, male
- 608.82 Hematospermia
- 790.93 Elevated prostate specific antigen

ICD-9 codes not covered for indications listed in the CPB: V71.1

Observation for suspected malignant neoplasm

V76.41 Special screening for malignant neoplasms of rectum
The above policy is based on the following references:


64. Benway BM, Andriole GL. Prostate biopsy. UpToDate [serial online]. Waltham, MA: UpToDate; reviewed September 2014.

