Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Tennessee Only)

Policy Number: CS081TN.L
Effective Date: January 1, 2024

Instructions for Use

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Related Policy

- Prostate Surgeries and Interventions (for Tennessee Only)

Application

This Medical Policy applies to Medicaid and CoverKids in the state of Tennessee.

Coverage Rationale

Refer to the TennCare Medicaid Chapter 1200-13.13-.10, Exclusions for coverage of autologous (e.g., sural) or allogenic nerve grafts to restore erectile function during or after radical prostatectomy.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
55899	Unlisted procedure, male genital system
64999	Unlisted procedure, nervous system

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U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Sural nerve transplant is a procedure, and as such, is not regulated by the FDA.

References

Rules of The Tennessee Department of Finance and Administration, Bureau of TennCare, Chapter 1200-13-13.-10. Retrieved from 1200-13-13.20220124.pdf. (tnsosfiles.com). Accessed August 2, 2023.

Policy History/Revision Information

Date	Summary of Changes
01/01/2024	**Coverage Rationale** • Replaced coverage guidelines with instruction to refer to *TennCare Medicaid Chapter 1200-13.13-.10, Exclusions* for coverage of autologous (e.g., sural) or allogenic nerve grafts to restore erectile function during or after radical prostatectomy **Supporting Information** • Updated *References* section to reflect the most current information • Removed *Description of Services* and *Clinical Evidence* sections • Archived previous policy version CS081TN.K

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.