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Medicare Advantage Policy Manual **Policy ID:** M-SUR117

Nerve Graft with Radical Prostatectomy

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Nerve grafting is performed to replace cavernous nerves resected during radical prostatectomy. The intent of this nerve grafting is to treat erectile dysfunction, which is a common problem when nerve sparing surgical techniques are unsuccessful or cannot be accomplished due to the location or extent of the tumor. The sural nerve is the most common donor nerve because it is considered expendable and has been used extensively in other nerve grafting procedures (e.g., brachial plexus and peripheral nerve injuries). However, other nerves, such as the genitofemoral nerve, have also been used. Grafting may be unilateral or bilateral.

MEDICARE ADVANTAGE POLICY CRITERIA

CMS Coverage Manuals*	None
National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	None
Medical Policy Manual	*Medicare coverage guidance is not available for nerve graft with radical prostatectomy to treat erectile dysfunction. Therefore, the health plan's medical policy is applicable.* Nerve Graft with Radical Prostatectomy, Surgery, Policy No. 117 *(see "NOTE" below)*

NOTE: According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an ***objective, evidence-based process, based on authoritative evidence***. (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan's evidence-assessment process (see Cross References).

POLICY GUIDELINES

REGULATORY STATUS

This is a surgical procedure and therefore is not subject to regulation by the U.S. Food and Drug Administration (FDA).

CROSS REFERENCES

Investigational (Experimental) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services, Medicine, Policy No. M-149

REFERENCES

None

CODING

NOTE: There are no specific CPT codes describing nerve grafting of the cavernous nerves. The CPT codes describing nerve grafts specifically identify the anatomic site and do not include the cavernous nerves. Therefore, CPT code 64999 (unlisted procedure, nervous system) should be used to describe the nerve harvest and grafting component of the procedure. A non-specific CPT code for nerve repair, such as 64910, 64911, 64912, or 64913 may be used.

Codes	Number	Description
CPT	64999	Unlisted procedure, nervous system
HCPCS	None	

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*