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National Commercial Coverage for SpaceOAR™ Hydrogel

Health Plan Payer	State	SpaceOAR Coverage	Coverage Criteria
United Health Care	National	Yes	United Healthcare Medical Policy The transperineal placement of biodegradable material, peri-prostatic (via needle) is proven and medically necessary for use with radiotherapy for treating prostate cancer. Omnibus Codes Medical Policy #: 2021T0535III
Aetna	National	Yes	Aetna Medical Policy Aetna considers transperineal periprostatic placement of biodegradable material (SpaceOAR) medically necessary for reducing rectal toxicity in men undergoing radiotherapy for prostate cancer. Transperineal Placement of Biodegradable Material (SpaceOAR™) for Prostate Cancer Medical Policy #: 0926
Cigna	National	Yes	Cigna Medical Policy Transperineal placement of biodegradable material, peri-prostatic, (i.e. SpaceOAR) is considered medically necessary for men undergoing external beam radiation therapy (EBRT) for prostate cancer. Omnibus Codes Medical Policy #: 0504
Humana	National	Yes	Humana Medical Policy Humana members may be eligible under the Plan for the placement of a transperineal biodegradable spacer (eg, SpaceOAR) for individuals receiving external beam radiation therapy (EBRT) for prostate cancer. Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) Medical Policy # HCS-0395-019
Anthem	CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, OH, VA, WI	Yes	Anthem Medical Policy SpaceOAR is now considered Medically Necessary when all the conditions listed in the policy are met, including: The individual is planning to undergo hypofractionated radiation therapy or stereotactic body radiotherapy; AND There has NOT been tumor invasion into rectum: AND There is NO posterior extraprostatic extension.Perirectal Spacers for Use During Prostate Radiotherapy Medical Policy #: SURG.00143

From a Private Payer perspective, for each insurance plan payer listed above as well as for the insurance payers who are not listed above and do not have a formalized coverage policy, we do recommend to perform a complete verification of benefits for each patient, in order to ensure that the patient is eligible as well as to inquire if SpaceOAR, CPT Code 55874 is a covered procedure. We recommend to seek a Pre Authorization or Approval, pre-implant, with all payers, in order to ensure medical necessity and appropriate reimbursement for each case, upon claims submission. We are seeing case by case approvals based on medical necessity. Specific payment for SpaceOAR will be contract specific and will need to be confirmed by each provider or facility internally.

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Information included herein is current as of November 2020 but is subject to change without notice. Rates for services are effective January 1, 2021.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

Sequestration Disclaimer

Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2021.

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