Cholecystectomy
MPM 3.9

Disclaimer
Refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description
Cholecystectomy is the surgical excision of the gallbladder. With traditional (open) cholecystectomy, the gallbladder is removed through a large abdominal incision. Laparoscopic cholecystectomy uses a laparoscope to remove the gallbladder. Several small incisions are used rather than one large incision.

Coverage Determination
Prior Authorization is required. Log on to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

Procedure is indicated for 1 or more of the following:

A. Symptomatic gallstone disease as indicated by ALL of the following being present:
   1) Evidence of gallbladder disease as indicated by 1 or more of the following:
      • Stones or sludge demonstrated on cholecystography, ultrasound, CT, or MRI
      • Gallbladder polyp (greater than 0.5 cm)
      • Non-visualizing gallbladder with double-dose cholecystography or HIDA scan
   2) Symptoms of gallstone disease indicated by 1 or more of the following:
      • Biliary colic
      • Acute cholecystitis
      • Acute pancreatitis not associated with alcohol excess

B. Asymptomatic gallstone disease in patient at high risk for cancer (eg, calcified gallbladder wall, gallbladder polyps (greater than 0.5 cm or increasing in size), choledochal cyst, anomalous pancreaticobiliary junction)

C. Asymptomatic gallstone disease in patient at high risk for acute cholecystitis or other biliary tract complications (eg, pretransplant, chronic hemolytic syndromes, diabetes mellitus, in conjunction with bariatric surgery)

D. Other symptomatic biliary disease indicated by 1 or more of the following:
   1) Acalculous cholecystitis
   2) Biliary dyskinesia with abnormal ejection fraction (less than 35%) on hepatobiliary scan
   3) Biliary hyperkinesis with abnormal ejection fraction (greater than 75%) on hepatobiliary scan
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E. Proven or suspected carcinoma of the gallbladder
F. Prophylactic cholecystectomy for removing gallbladder after stone clearance (e.g., endoscopic sphincterotomy and common bile duct clearance)
G. As part of combined procedure to relieve small bowel obstruction due to gallstone ileus

Approval Signatures:
Clinical Quality Committee: Thomas Rothfeld MD
Medical Director: Norman White MD

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References:
MCG Guideline: S-365 Cholecystectomy by Laparoscopy

Publication History:
05-17-10: Original effective date
05-25-11: Annual Review and Revision
06-27-12: Annual Review and Revision
01-29-14: Presbyterian Policy Retired
01-29-14: Presbyterian now uses MCG Criteria S-365
11-23-15: Updated MCG link to 19th Edition
01-27-16: Stopped use of MCG. Original effective date of new Pres policy
03-22-17: Annual Review. No changes.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian medical policies are available on the Internet at:
http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm