Prostatectomy (Laparoscopic Radical and da Vinci™ Prostatectomy)
MPM 16.12

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 these criteria.

Description
Laparoscopic radical prostatectomy is one of two minimally invasive surgical procedures in which traditional laparoscopy instruments and a two-dimensional camera are used to remove the prostate. The other minimally invasive procedure is robotic-assisted prostatectomy.

Robotic-assisted prostatectomy is a minimally invasive surgical procedure during which a specially trained urologist uses a three-dimensional, high definition camera and advanced robotic technology to remove the prostate through several dime-sized incisions. The da Vinci™ Surgical System is the predominant robotic system used for prostatectomy.

Robotic-assisted prostatectomy is an alternative to conventional open or laparoscopic radical prostatectomy, but is not considered a more effective treatment for localized prostate cancer, due to a lack of available evidence comparing the procedures. Both robotic-assisted and laparoscopic prostatectomy require many hours of intense training. As with open radical prostatectomy, possible complications of both procedures include, but are not limited to, urinary incontinence, urethral stricture and impotence.

Coverage Determination
Prior Authorization is not required for in-plan providers for laparoscopic radical prostatectomy or da Vinci™ robotic-assisted prostatectomy. However, all claims are subject to retrospective review.

Please note: PHP does not provide additional reimbursement for robotic-assisted procedures. For billing purposes, use of a robotic system is deemed to be the same as surgery performed by standard methods.

Both laparoscopic radical prostatectomy or da Vinci™ robotic-assisted prostatectomy are indicated for localized prostate cancer.

This Medical Policy has been reviewed by the Technology Assessment Committee and the Medical Policy Committee (formerly known as the Benefit Interpretation Committee).

Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage.
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Exclusions
All other robotic-assisted prostatectomy systems, except for the da Vinci™ Surgical System, are excluded from coverage.

Coding
The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

Please note: PHP does not provide additional reimbursement for robotic-assisted procedures. For billing purposes, use of a robotic system is deemed to be the same as surgery performed by standard methods.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55866</td>
<td>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2900</td>
<td>Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9® Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>185</td>
<td>Malignant neoplasm of prostate</td>
</tr>
<tr>
<td>198.82</td>
<td>Secondary malignant neoplasm of genital organs</td>
</tr>
<tr>
<td>233.4</td>
<td>Carcinoma in situ of prostate</td>
</tr>
</tbody>
</table>
Prostatectomy (Laparoscopic Radical and da Vinci™ Prostatectomy)

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Reviewed by:
2. Satyan Shah, MD, Director of Robotic Surgery, University of New Mexico Hospital, Albuquerque, NM. December 2008.

References:

Approval Signatures:
Clinical Quality Committee: Mark Whitaker MD

Medical Director: Albert Rizzoli MD

Date: January 30, 2013

Publication History:
08-22-05: Benefit/Technology Alert “da Vinci™ Prostatectomy”
10-23-06: Benefit/Technology Alert “Laparoscopic Radical Prostatectomy”
02-28-08: Both above Benefit/Technology Alerts combined into Med Policy
01-28-09: Annual update with change in coverage policy
01-19-11: Biennial Review
01-30-13: Biennial Review

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 online at our website at: http://www.phs.org/resources/documents/HLTHCRIT.pdf.

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[MPMPPC010909]