

Policy: MP286

Section: Medical Benefit Policy

Subject: Cholecystectomy

Applicable Lines of Business

Commercial	X	CHIP	X
Medicare		ACA	X
Medicaid	X		

I. Policy: Cholecystectomy

II. Purpose/Objective:

To provide a policy of coverage regarding cholecystectomy

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:

Fully Insured Commercial, TPA (unless specifically excluded), Medicaid Business Segments

INDICATIONS:

Open or laparoscopic cholecystectomy may be considered medically necessary for the following indications when criteria are met.

1. Symptomatic gallbladder disease evidenced by
 - Documented evidence of gallstones by either:
 - Visualization on cholecystography, ultrasound, CT or MRI; or
 - Non-visualizing gallbladder with HIDA scan or double-dose cholecystography and
 - Biliary obstruction (pain consistent with biliary colic) ; or
 - Acute inflammation of the gallbladder (cholecystitis); or
 - Acute pancreatitis not associated with ETOH (alcohol) excess
2. Symptomatic biliary disease evidenced by:
 - Acalculous cholecystitis; or
 - Biliary dyskinesia with abnormal ejection fraction defined as less than 35% on hepatobiliary scan
3. Asymptomatic biliary disease in an insured individual at high risk for cancer (eg, calcified gallbladder wall, adenomatous gallbladder polyps, choledochal cyst, anomalous pancreobiliary junction
4. Adenomyomatosis in individuals with atypical ultrasound findings.
5. Gallbladder polyps 5mm or greater, or symptomatic
6. Proven or suspected carcinoma of the gallbladder

Laparoscopic cholecystectomy may also be considered medically necessary for the following indications:

7. Prophylactic cholecystectomy for a remaining gallbladder after clearance of calculi
8. When used concurrently with another procedure to relieve small bowel obstruction due to gallstone ileus

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH:

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

- 47562 Laparoscopy, surgical; cholecystectomy
- 47563 Laparoscopy, surgical; cholecystectomy with cholangiography
- 47564 Laparoscopy, surgical; cholecystectomy with exploration of common duct
- 47600 Cholecystectomy

47605 Cholecystectomy with cholangiography
47610 Cholecystectomy with exploration of common duct
47612 Cholecystectomy with choledochenterostomy
47620 Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

Keus F, Gooszen HG, et al. Open, small incision, or laparoscopic cholecystectomy for patients with symptomatic cholecystolithiasis. An overview of Cochrane Hepato-Biliary Group reviews. Cochrane Database of Systematic Reviews.2010 (1):CD008318.

Strasberg SM. Clinical practice. Acute calculous cholecystitis. NEJM 2008;358(26):2804-2811.

McAneny D. Open cholecystectomy. Surg Clin N Am.2008;88(6):1273-1294.

Gurusamy KS, Junnarker S, et al. Cholecystectomy for suspected gallbladder dyskinesia. Cochrane Database of Systematic Reviews 2009(1):CD007086.

Ingraham AM, Cohen ME, et al. A current profile and assessment of North American cholecystectomy: results from the American College of Surgeons national surgical quality improvement program. J Am Coll Surg. 2010;211(2):176-186.

Gurusamy KS, Davidson C et al. Early versus late laparoscopic cholecystectomy for people with acute cholecystitis. Cochrane Database Syst Rev. 2013 June 30;6:CD005440

Pellino G, Sciaudone G, Candilino G, et al. Stepwise approach and surgery for gallbladder adenomyomatosis: a mini-review. Hepatobiliary Pancreat Dis Int. 2013; 12(2):136-142.

Nishimura A, Shiria Y et al. Segmental adenomyomatosis of the gallbladder predisposes to cholecystolithiasis. J hepatobiliary Pancreat Surg. 2004;11(5):342-347.

Persley KM. Gallbladder Polyps. Curr treat options gastroenterol. 2005 Apr; 8(2):105-108.

SAGES Guidelines: <http://www.sages.org/publications/guidelines/guidelines-for-the-clinical-application-of-laparoscopic-biliary-tract-surgery/>

Vogt DP. Gallbladder disease: an update on diagnosis and treatment. Cleve Clin J Med 2002 Dec;69(12):977-984.

National Coverage Determination (NCD) for Laparoscopic Cholecystectomy (100.13). Centers for Medicare & Medicaid Services.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 2/14

Revised: 3/15, 2/16 (Removed Prior Auth)

Reviewed: 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.