INFORMATION ON ENDOSCOPIC, ARTHROSCOPIC, LAPAROSCOPIC, THORACOSCOPIC SURGERY
SUR701.014

COVERAGE:

Endoscopic procedures for biopsy, repair/resection, removal of foreign body, cyst, tumor, or mass MAY BE ELIGIBLE FOR COVERAGE as an alternative to the corresponding open surgical procedure. The procedures are:

• Endoscopy/Laparoscopy of the;
  ▪ peritoneum,
  ▪ reproductive organs,
  ▪ appendix,
  ▪ gall bladder,
  ▪ adrenal gland (except for cancer),
  ▪ spleen,
  ▪ repair of initial or recurrent inguinal hernia;
  ▪ intestinal tract (except colectomy for cancer),
  ▪ esophagus by fundoplication for hiatal hernia; and,

• Endoscopy/Thoracoscopy of the;
  ▪ lungs and pleural space,
  ▪ pericardial sac,
  ▪ mediastinal space; and

• Endoscopy/Arthroscopy for carpal tunnel release.

Any Endoscopy procedure in which the surgical technique significantly differs from the open surgical procedure is still considered investigational until long-term comparative outcome studies show safety and effectiveness/durability. The following Endoscopy procedures are examples of such alternative procedures and ARE NOT ELIGIBLE FOR COVERAGE. These alternative procedures include, but are not limited to:

• Laparoscopy for;
  ▪ retroperitoneal lymph nodes resection, also known as retroperitoneoscopy;
  ▪ cancer resection, including but not limited to resection of kidneys, adrenal glands, and intestines;
  ▪ acquisition of donor kidney from living donor (laparoscopic live donor nephrectomy) (LapNx);
  ▪ anterior decompression/discotomy or fusion of the thoracolumbar spine;

• arthroscopy with;
  ▪ electro-thermal augmentation of joint ligaments; and
  ▪ thermally-induced capsulorrhaphy of the shoulder.

DESCRIPTION:
An endoscope is a long, flexible glass fiberoptic magnifying tube that enables the physician to look into a body cavity, photograph or video the interior, take tissue samples, and perform surgical procedures. The fiberoptic tube is either inserted through body cavity incisions or body orifices/openings. Endoscopes used in different parts of the body have different names, such as cystoscopy for the bladder, hysteroscopy for the uterus, and bronchoscopy for the bronchi/air passages (these applications are not addressed in this policy). While endoscopic surgery is a general term, the following endoscopic techniques involve other body areas:

- Endoscopy uses an endoscope (colonoscope, esophagoscope, gastroduodenoscope, sigmoidoscope) to directly visualize the inside of the intestinal tract (colon). These applications are not addressed in this policy;

- Arthroscopy directly visualizes the interior of a joint to detect and repair any injury or damage, by using a type of endoscope known as an arthroscope;

- Laparoscopy directly visualizes the interior of the abdominal or pelvic cavity; and,

- Thoracoscopy uses an endoscope to examine or perform procedures within the chest cavity.

The endoscopic technique often attempts to duplicate the same surgical techniques and principles of the corresponding open technique with the only difference being the surgical access. Some surgeries can combine an open approach with the endoscopic approach, such as laparoscopic-assisted vaginal hysterectomy.

**RATIONALE:**

The advantages of endoscopic surgery include shorter hospital stays and more rapid recovery. Disadvantages include a longer operative time, particularly if the surgeon is early on the learning curve for these new techniques.

Any endoscopic surgery, which differs substantially from the open surgery will be considered experimental/investigative until adequate outcomes studies confirm benefits at least equivalent to the open surgery.

Although laparoscopically-assisted resection of the intestines or bowel and laparoscopic colectomy are feasible, studies have reported a high incidence of complications and questionable benefits.

The long-term efficacy of laparoscopic inguinal hernia repair remains unknown and may be considered investigational. A retrospective study was conducted to determine the efficacy of this procedure in comparison with the open technique and to evaluate the possible factors of recurrence. For the open technique, five-year outcomes for recurrence rates are the standard for inguinal hernia repairs. However, a review of the literature through 1999, has not revealed any five-year outcome studies. An exception for approval of benefit coverage for the utilization of this technique/procedure was based upon patient/provider demand.

Laparoscopic adrenalectomy (LA) is safe and effective for small,
benign, functioning tumors. In situations of cancer, such as an invasive carcinoma, invasive extra-adrenal carcinomas or large adrenal carcinoma masses, the complication rate was higher for the LA groups when compared to either to those undergoing LA for small, benign tumors or to those undergoing the open procedure.

Further development of surgical techniques of retroperitoneal endoscopic live donor nephrectomy is being established as an alternative surgical method for harvesting donated kidneys. Small case studies have shown promise with regard to the graft biopsy findings or postoperative graft function when comparing retroperitoneoscopy assisted and open donor nephrectomy.

Few studies have been completed investigating endoscopic approaches for spinal decompression or fusion. In one study of 100 cases, there were no permanent iatrogenic neurologic injuries and no deep spinal infections. However, intercostal neuralgia, atelectasis, and bone graft donor site (via laparoscopy) infections were reported. Anterior spinal fusion by laparoscopy has not been established as safe and effective due to the limited available research.

Published reports reviewing the performance of retroperitoneal lymph node resection are limited and have critical deficiencies. In one study of 200 cases, only eight cases (4%) were completed. These procedures were classified as difficult reflected by the longer surgical time, higher complication rate, conversion to open surgery, and open re-intervention rates.

No literature was found in MEDLINE or within any WEB SITES addressing joint ligament electro-thermal augmentation or shoulder arthroscopy, with thermally-induced capsulorrhaphy. Without any information, this procedure is assumed to be under investigation.

DISCLAIMER:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, takes precedence over Medical Policy and must be considered first in determining coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Any benefits are subject to the payment of premiums for the date on which services are rendered. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general polices and procedures.

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