Robotic Assisted Surgery

Origination: 01/22/09	**Revised:** 7/23/20	**Annual Review:** 11/04/21

Purpose:

To provide robotic assisted surgery guidelines for Population Health and Provider Alliances associates to reference when making determinations.

Recommendation:

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to Robotic Assisted Surgery in order to determine inclusion in the benefit plan.

A recommendation was made by the MTAC following discussion by committee members based on current literature:

- *Robotic Assisted Surgery* is approved when the following criteria are met:
  - Reimbursement must be integral to the procedure and not a separate service.
  - Credentialing of surgeons are the responsibility of the individual hospital.

Background Information:

- Robotic assisted surgery systems are used in minimally invasive and endoscopic surgical procedures in general, urological, gynecological, thoracic, and pediatric surgery. There are a variety of systems on the market, and the choice of system is left to the discretion of the surgeon and facility.

Coverage Guidelines

- Robotic assisted surgery is considered to be equivalent to, but not superior to non-robotic surgery. If standard surgery is available in-network, out-of-network benefits will not be extended for robotic assisted surgery if not available in-network.

- Providers are expected to be certified, credentialed, and considered proficient with the use of robotic assisted surgery in their respective specialties and with the systems at their respective facilities.

Reimbursement

- Robotic assisted surgery is considered to be integral to the laparoscopic procedure and not a separate service. Additional technical or professional reimbursement (using HCPCS code S2900) will not be made.

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Reference:

1. *Medical Technology Assessment Committee Recommendation*, January 22, 2009.

Disclaimer Information

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.