2015 Procedures Criteria

PATIENT:	Name	DOB	ID#	GROUP#
	Facility		Service Date	
PROVIDER:	Name		Fax#	Phone#
	Signature		Date	NPI/ID#

ICD-9:
CPT®:
HCPCS:

Subset: Prostatectomy, Radical[1, 2, 3, 4, 5, 6, 7]
Requested Service: Prostatectomy, Radical
Age: Age ≥ 18

INSTRUCTIONS: Answer the following questions

☐ **Prostate cancer diagnosed by biopsy**

1. Cancer localized to prostate, Choose one:[8, 9, 10, 11]
   - ☐ A) Stage ≥ T1 and ≤ T2c (low- to intermediate-risk)
   - ☐ B) Stage T3a (high-risk)[12]
   - ☐ C) Other clinical information (add comment)

   - If option B selected, then the rule is satisfied; you may stop here ***(Inpatient)***
   - If option A selected, then go to question 2
   - No other options lead to the requested service

2. Life expectancy ≥ 10 years[13, 14]
   - ☐ Yes
   - ☐ No

   - If option Yes selected, then the rule is satisfied; you may stop here ***(Inpatient)***
   - No other options lead to the requested service

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Notes

(1)
I/O Setting: Inpatient

(2)
These criteria include the following procedures:
Radical Prostatectomy, Laparoscopically-Assisted
Radical Prostatectomy, Laparoscopic
Radical Prostatectomy, Open
Radical Prostatectomy, Robotic-Assisted

(3)
For content addressing cryoablation to treat prostate cancer see the "Cryoablation, Prostate" criteria subset. For content addressing transurethral resection of the prostate (TURP), see the "Prostatectomy, Transurethral Resection" criteria subset.

(4)
Options for treating localized prostate cancer include radical prostatectomy, brachytherapy, external beam radiation therapy, cryosurgical ablation, and active surveillance or watchful waiting. Overall survival and tumor recurrence rates are similar for low-risk prostate cancer, regardless of the treatment used (Mohler et al., J Natl Compr Canc Netw 2013, 11: 1471-9; Chafen et al., 2012; Wilt, J Natl Cancer Inst Monogr 2012, 2012: 184-90).

(5)
A systematic review comparing different operative approaches for radical prostatectomy (i.e., open to robotic-assisted laparoscopic and laparoscopic to robotic-assisted laparoscopic) found that the open approach had a statistically significant shorter operating time, but the robotic-assisted laparoscopic approach was associated with a statistically significant decrease in length of hospital stay, blood loss, transfusions, and complications. There were no statistically significant differences between the laparoscopic and robotic-assisted laparoscopic approaches (Moran et al., Database of Abstracts of Reviews of Effects 2013).

(6)
Prostate cancer is usually slow growing and the lifetime risk of related death is 3%. While 15% to 20% of men will be diagnosed with prostate cancer in their lifetime, 60% to 70% of men have prostate cancer upon autopsy (Thompson et al., J Urol 2011). Since 1989, prostate-specific antigen (PSA) testing has become widely used and has resulted in more men being identified as having prostate cancer at earlier stages. Widespread PSA testing, however, has led to an increase in the number of radical prostatectomies, many to treat low-risk prostate cancer. A randomized controlled trial (RCT) of men with clinically localized prostate cancer compared radical prostatectomy to watchful waiting and concluded that radical prostatectomy did not provide a survival benefit in men with low-risk prostate cancer. The study did, however, show an improved survival rate after radical prostatectomy for men with intermediate- and high-risk prostate cancer. Men with a PSA higher than 10 ng/mL had a reduction in all-cause mortality after radical prostatectomy (Wilt, J Natl Cancer Inst Monogr 2012, 2012: 184-90).
A separate RCT comparing radical prostatectomy and watchful waiting found an 18 year absolute risk reduction (ARR) for disease-specific death of 10.3% (18.1% versus 28.4%) after radical prostatectomy; the number needed to treat (NNT) to prevent one prostate cancer death was 10. Men younger than 65 years old, when treated by radical prostatectomy, had an ARR for disease-specific death of 7.8% compared with 2.6% in the 65 and older group. NNT in the younger than 65 age group was 13 and 38 for the 65 and older group (Bill-Axelson et al., New England Journal of Medicine 2014, 370: 932-42). There was one postoperative death and a self-reported incidence of 35% more erectile dysfunction and 27% more urinary leakage after radical prostatectomy (Hegarty et al., Cochrane Database of Systematic Reviews 2010).

(7)
InterQual® criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. The majority of the content in this subset is based on the following citation(s):
•(Mohler et al., J Natl Compr Canc Netw 2013, 11: 1471-9).

(8)
This content addresses cancer localized to the prostate gland itself or that has extended through the capsule, but has not spread to other organs.

(9)
Prostate-specific antigen (PSA) value, Gleason score (evaluation of the 2 most prevalent types of cancer cells found on biopsy), and clinical stage are used to stratify prostate cancer into low-, intermediate-, and high-risk groups. For this content, stage is used to differentiate between levels of risk.

(10)

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Staging of prostate cancer is defined as: (Edge et al., AJCC cancer staging handbook: from the AJCC cancer staging manual, 7th ed. 2010).

T0 No evidence of a primary tumor
T1 Tumor is not palpable or seen on imaging
T1a Tumor is ≤ 5% of biopsied tissue
T1b Tumor is > 5% of biopsied tissue
T1c Biopsy performed secondary to elevated PSA and tumor confirmed by biopsy
T2 Tumor is confined to prostate, including invasion into, but not extending beyond, the prostatic capsule
T2a Tumor is in one-half or less of a prostate lobe
T2b Tumor is in one lobe of the prostate
T2c Tumor is in both lobes of the prostate
T3 Tumor extends through the capsule of the prostate
T3a Extracapsular extension
T3b Seminal vesicle invasion by tumor
T4 Tumor involves adjacent structures other than seminal vesicles (e.g., pelvic wall, levator muscles, bladder)

(11)

The decision to perform radical prostatectomy on patients with very advanced prostate cancer is based on multiple factors (e.g., tumor size, involvement of pelvic organs, extent of metastases) (Mohler et al., J Natl Compr Canc Netw 2013, 11: 1471-9). These criteria only address localized disease.

(12)

Several evidence-based guidelines support the use of radical prostatectomy in treating men with high-risk prostate cancer (Heidenreich et al., Eur Urol 2014, 65: 124-37; National Institute for Health and Clinical Excellence (NICE), Prostate Cancer: diagnosis and treatment. Clinical guideline. 2014; Mohler et al., J Natl Compr Canc Netw 2013, 11: 1471-9; Thompson et al., J Urol 2011). Locally advanced prostate cancer may be appropriate for treatment with radical prostatectomy and should include extensive pelvic lymph node dissection. Several well-done studies found overall survival improves from 60% at 5 years and 28% at 10 years to 84% and 64% in patients with advanced prostate cancer when radical prostatectomy with extensive pelvic lymph node dissection is performed (Engel et al., Eur Urol 2010, 57: 754-61; Gontero et al., Eur Urol 2007, 51: 922-9; discussion 9-30; Ward et al., BJU Int 2005, 95: 751-6).

(13)

Factors that have an impact on life expectancy include age, current health (healthy with or without well managed comorbidities), short-term illness, chronic illness, ability to perform activities of daily living, and family history (Droz et al., BJU Int 2010, 106: 462-9). The Social Security Administration Period Life table (www.ssa.gov/oact/STATS/table4c6.html) can be used to estimate an individual's current health status (Mohler et al., J Natl Compr Canc Netw 2013, 11: 1471-9).

(14)

Radical prostatectomy is only considered an option for men with low- to intermediate-risk prostate cancer if they are expected to live longer than 10 years. Otherwise, the majority will succumb to comorbid disease rather than to prostate cancer (Heidenreich et al., Eur Urol 2014, 65: 124-37; Mohler et al., J Natl Compr Canc Netw 2013, 11: 1471-9; Thompson et al., J Urol 2011).

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ICD-9 (circle all that apply): 185, 198.82, 233.4, 60.5, 600.00, 600.11, 600.20, 602.3, 790.93, 795.4, V10.46, V16.42, V84.03, Other_____

CPT® (circle all that apply): 55810, 55812, 55815, 55840, 55842, 55845, 55866, Other_____

HCPCS (circle all that apply): S2900, Other_____

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