Office Based Procedures - Site of Service

Guideline Number: URG-12.09
Effective Date: January 1, 2021

Instructions for Use

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Related Commercial Policies

- Ablative Treatment for Spinal Pain
- Epidural Steroid and Facet Injections for Spinal Pain
- Occipital Neuralgia and Headache Treatment

Coverage Rationale

UnitedHealthcare members may choose to receive surgical procedures in an office setting or other locations. We are conducting site of service medical necessity reviews, however, to determine whether the ambulatory surgical center (ASC) is medically necessary, in accordance with the terms of the member's benefit plan. If the ambulatory surgical center is not considered medically necessary, this location will not be covered under the member's plan.

Certain elective procedures performed in an ambulatory surgical center are considered medically necessary for an individual who meets any of the following criteria:

- Allergy to local anesthetic
- Bleeding disorder that would cause a significant risk of morbidity
- Developmental stage or cognitive status warranting use of an ambulatory surgical center
- Failed office based procedure attempt due to body habitus, abnormal anatomy, or technical difficulties
- Presence of complications and comorbid disease that would cause office based procedure to be unsafe or unsuitable

An elective surgical procedure performed in an ambulatory surgical center is considered medically necessary if there is an inability to access an office setting for the procedure due to the following:

- There is no geographically accessible office that has the necessary equipment for the procedure
- There is no geographically accessible in-network provider

Elective Procedures List

Prior authorization is required for procedures listed in the Applicable Codes section if not performed in an office setting.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Office Based Procedures – Site of Service	
11402, 11403, 11406, 11422, 11426, 11442, 19000, 27096, 31579, 57460, 62270, 62321, 64479, 64490, 64493, 64633, 64635	Medical notes documenting all of the following: • History • Physical examination including patient weight and co-morbidities • Surgical plan For CPT codes 64633 and 64635, in addition to the above, refer to the Medical Policy titled Ablative Treatment for Spinal Pain.

**For code descriptions, see the Applicable Codes section.*

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Dermatology	
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
General Surgery	
19000	Puncture aspiration of cyst of breast
Muscular/Skeletal	
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

CPT Code	Description
Neurologic	
62270	Spinal puncture, lumbar, diagnostic
62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
Obstetrics & Gynecology	
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
Respiratory	
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscopy (only flexible to be performed in office setting)

References

American College of Surgeons. Patient safety principles for office-based surgery. March 17, 2003. https://www.facs.org/education/patient-education/patient-safety/office-based-surgery. Accessed May 18, 2020.

The American College of Surgeons (ACS). Statement on patient safety principles for office-based surgery utilizing moderate sedation/analgesia. September 1, 2019.

American Society of American Society of Anesthesiologists. Guidelines for office-based anesthesia. October 21, 2009. Amended on October 23, 2019.

Federation of State Medical Boards of the United States, Inc. Report of the Special Committee on outpatient (office-based) surgery. 2002. http://www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf. Accessed June 18, 2020.

Kouba DJ, LoPiccolo MC, Alam M, et al. Guidelines for the use of local anesthesia in office-based dermatologic surgery. J Am Acad Dermatol. 2016 Jun;74(6):1201-19.

Neighborhood Health Plan (NHP). Prior Authorization Requirements. Available at: https://www.uhcprovider.com/en/prior-auth-advance-notification/adv-notification-plan-reqs.html. Accessed June 18, 2020.

United HealthCare Advance Notification List. To view the most current and complete Advance Notification List, including procedure codes and associated services. https://www.uhcprovider.com/en/prior-auth-advance-notification/adv-notification-plan-reqs.html. Accessed June 18, 2020.

Guideline History/Revision Information

Date	Summary of Changes
01/01/2021	Applicable Codes • Updated list of applicable CPT codes to reflect annual edits; revised description for 64479 Supporting Information • Archived previous policy version URG-12.08

Instructions for Use

This Utilization Review Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan

may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Utilization Review Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.