

OFFICE BASED PROGRAM

Guideline Number: URG-12.05

Effective Date: April 1, 2019

[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

Before using this guideline, please check the member specific benefit plan document. The purpose of this guideline is the following:

- To aim to encourage more cost-effective sites of service for certain outpatient surgical procedures, when medically appropriate to minimize out-of-pocket costs for UnitedHealthCare members and to improve cost efficiencies for the overall health care system.
- To apply to UnitedHealthcare commercial plans that require services to be medically necessary. Refer to the member specific benefit plan document to determine if medical necessity applies.

With the exception of the following qualifying conditions, certain elective procedures should be performed in an office setting.

Some individuals may require more complex care due to certain medical factors or functional limitations and it may be appropriate to have the procedure in an outpatient hospital setting or ambulatory surgery center (not an all-inclusive list):

- Individual unable to cooperate with procedure due to mental status, severe anxiety, or extreme pain sensitivity
- Failed office based procedure attempt due to body habitus, abnormal anatomy, or technical difficulties
- Bleeding disorder that would cause a significant risk of morbidity
- Allergy to local anesthetic

The following will be taken into account to determine whether the elective procedure is being performed in a cost-effective setting:

- Member specific benefit plan document
- Geographic availability of an in-network provider
- Office capability (i.e., appropriate equipment)
- Significant member comorbidities

Potential Documentation Requirements

- Physician office notes

Elective Procedures List

Prior authorization is required for the following procedures if not performed in an office setting (see list of [Applicable Codes](#)).

Specific procedure codes for services can be found on the Prior Authorization List (refer to the [References](#) 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 and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, 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
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)
62323	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, lumbar or sacral (caudal); 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)

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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 February 5, 2019.
- American Society of American Society of Anesthesiologists. Guidelines for office-based anesthesia. October 21, 2009. Reaffirmed on October 15, 2014.
- Federation of State Medical Boards of the United States, Inc. Report of the Special Committee on outpatient (office-based) surgery. 2002. <https://www.fsmb.org/policy/advocacy-policy/policy-documents>. Accessed February 5, 2019.
- 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. Refer to <https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/pa-requirements/nhp/UHC-NHP-Prior-Authorization-Effective-01012019.pdf>. Accessed February 5, 2019.
- United HealthCare Advance Notification List. To view the most current and complete Advance Notification List, including procedure codes and associated services, go to <https://www.uhcprovider.com/en/prior-auth-advance-notification/adv-notification-plan-reqs.html>. Accessed February 5, 2019.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
04/01/2019	<ul style="list-style-type: none"> • Reorganized policy template: <ul style="list-style-type: none"> ○ Simplified and relocated <i>Instructions for Use</i> ○ Removed <i>Benefit Considerations</i> and <i>Description of Services</i> sections • Updated list of related policies; removed reference link to the policy titled <i>Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins</i> • Revised and reformatted coverage rationale: <ul style="list-style-type: none"> ○ Added content previously located in the <i>Description of Services</i> section ○ Replaced references to "patient(s)" with "individual(s)" ○ Added language to indicate specific procedure codes for services can be found on the <i>Prior Authorization List</i> (refer to the <i>References</i> section [of the policy]) • Revised list of applicable codes for which prior authorization is required if not performed in an office setting; removed 10120, 10140, 11400, 11401, 11404, 11420, 11421, 11423, 11424, 36473, 36475, 36478, 45300, 45330, 46922, 55250, 62320, 62322, and 64520 • Updated supporting information to reflect the most current references • Archived previous policy version URG-12.04

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.