OUTPATIENT SURGICAL PROCEDURES – SITE OF SERVICE

Guideline Number: CS143.F  Effective Date: September 1, 2019

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APPLICATION

This policy does not apply to the states of Maryland, Michigan, Missouri, Ohio, Rhode Island, Tennessee, and Washington.

- For the states of Maryland, Michigan, Missouri, Ohio, Rhode Island, and Washington, refer to the Utilization Review Guideline titled Outpatient Surgical Procedures – Site of Service (for Maryland, Michigan, Missouri, Ohio, Rhode Island, and Washington Only).
- For the state of Tennessee, refer to the Utilization Review Guideline titled Outpatient Surgical Procedures – Site of Service (for Tennessee Only).

COVERAGE RATIONALE

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

Certain elective procedures performed in a hospital outpatient department are considered medically necessary for an individual who meets ANY of the following criteria:

- Advanced liver disease (MELD Score > 8)
- Advanced surgical planning determines an individual requires overnight recovery and care following a surgical procedure
- Anticipated need for transfusion
- Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect
- Brittle Diabetes
- Cardiac arrhythmia (symptomatic arrhythmia despite medication)
- Chronic obstructive pulmonary disease (COPD) (FEV1 <50%)
- Coronary artery disease ([ICAD]/peripheral vascular disease [PVD]) (ongoing cardiac ischemia requiring medical management recently placed [within 1 year] drug eluting stent)
- Developmental stage or cognitive status warranting use of a hospital outpatient department
- End stage renal disease (hyperkalemia (above reference range peritoneal or hemodialysis)
- History of cerebrovascular accident (CVA) or transient ischemic attack (TIA) (recent event [< 3 months])
- History of myocardial infarction (MI) (recent event [< 3 months])
- Individuals with drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless acetylsalicylic acid and antiplatelet drugs will be continued by agreement of surgeon, cardiologist and anesthesia
- Ongoing evidence of myocardial ischemia
- Poorly Controlled asthma (FEV1 < 80% despite medical management)
- Pregnancy
- Prolonged surgery (> 3 hours)
- Resistant hypertension (Poorly Controlled)
• Severe valvular heart disease
• Sleep apnea (moderate to severe Obstructive Sleep Apnea [OSA])
• Uncompensated chronic heart failure (CHF) (NYHA class III or IV)

An elective surgical procedure performed in a hospital outpatient department is considered medically necessary if there is an inability to access an ambulatory surgical center for the procedure due to the following:
• There is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure
• There is no geographically accessible ambulatory surgical center available at which the individual’s physician has privileges
• An ASC’s specific guideline regarding the individual’s weight or health conditions that prevents the use of an ASC

**Documentation Requirements**
Documentation requirements include the following:
• Physician office notes including current history, examination and surgical plan
• American Society of Anesthesiologists (ASA) score (if applicable)

**Elective Procedures List**
Prior authorization may be required for the following procedures only when performed in an outpatient hospital setting:
• Carpal tunnel surgery
• Cataract surgery and other ophthalmologic procedures
• Cosmetic and reconstructive
• Gynecologic procedures
• Hernia repair
• Liver biopsy
• Tonsillectomy, adenectomy and other ENT procedures
• Upper & lower gastrointestinal endoscopy
• Urologic procedures

For the complete list of procedure codes requiring prior authorization for each state, please refer to the UnitedHealthcare Community Plan Prior Authorization List. (Accessed June 10, 2019)

**DEFINITIONS**

Please check the definitions within the member benefit plan document that supersede the definitions below.

**ASA Physical Status Classification System Risk Scoring Tool**: While anesthesia providers use this scale to indicate one’s overall physical health or “sickness” preoperatively, it is regarded by hospitals, law firms, accrediting boards and other healthcare groups as a scale to predict risk and thus decide if a patient should have – or should have had – an operation. To predict operative risk, age and obesity, the nature and severity of the operative procedure, selection of anesthetic techniques, the competency of the surgical team (surgeon, anesthesia providers and assisting staff), duration of surgery or anesthesia, availability of equipment, medicine, blood, implants and especially the level of post-operative care etc. are often far more important than multiple ASA classification.

**Brittle Diabetes**: Diabetes that is difficult to control due to symptoms such as (1) predominant hyperglycemia with recurrent ketoacidosis, (2) predominant hypoglycemia, and (3) mixed hyper- and hypoglycemia.

**Obstructive Sleep Apnea (OSA)**: Severity is defined as:
• Moderate for AHI or RDI ≥ 15 and ≤ 30
• Severe for AHI or RDI > 30/hr

**Poorly Controlled**: Requiring three or more drugs to control blood pressure.

**REFERENCES**


American Society of Anesthesiologists (ASA) Physical Status Classification System.


GUIDELINE HISTORY/REVISION INFORMATION

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<td>• Added language to indicate this policy does not apply to the states of Michigan, Missouri, and Ohio; refer to the Utilization Review Guideline titled Outpatient Surgical Procedures – Site of Service (for Maryland, Michigan, Missouri, Ohio, Rhode Island, and Washington Only)</td>
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<tr>
<td>09/01/2019</td>
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<td>• Previously titled Site of Service Guidelines for Certain Outpatient Surgical Procedures</td>
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<td>Template Update</td>
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<td>• Reorganized policy template:</td>
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<td>• Simplified and relocated Instructions for Use</td>
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<td>• Removed Benefit Considerations and Utilization Management Guiding Principles sections</td>
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<td>Coverage Rationale</td>
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determine whether the outpatient hospital department is medically necessary, in accordance with the terms of the member's benefit plan; if the outpatient hospital department is not considered medically necessary, this location will not be covered under the member’s plan

- Revised medical necessity criteria for certain elective procedures performed in a hospital outpatient department:
  - Added criterion requiring:
    - Advanced surgical planning determines an individual requires overnight recovery and care following a surgical procedure
    - Developmental stage or cognitive status warranting use of a hospital outpatient department
  - Removed criterion requiring:
    - Alcohol dependence (at risk for withdrawal syndrome)
    - Implanted pacemaker
    - Morbid obesity (> BMI.40)
    - Patients with drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless acetylsalicylic acid (ASA) and antiplatelet drugs will be continued by agreement of surgeon, cardiologist and anesthesia
    - Personal history or family history of complication of anesthesia such as malignant hyperthermia
    - Recent history of drug abuse (especially cocaine)
  - Replaced criterion requiring “significant valvular heart disease” with “severe valvular heart disease”

- Updated list of Documentation Requirements:
  - Replaced “physician office notes” with “physician office notes including current history, examination and surgical plan”
  - Removed “physician privileging”
  - Replaced language indicating “specific procedure codes for services can be found on the UnitedHealthcare Community Plan Prior Authorization List” with “for the complete list of procedure codes requiring prior authorization for each state, please refer to the UnitedHealthcare Community Plan Prior Authorization List”

Supporting Information
- Updated References section to reflect the most current information
- Archived previous policy version CS143.E

INSTRUCTIONS FOR USE

This Utilization Review Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage.

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. The 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.