OFFICE BASED PROCEDURES – SITE OF SERVICE

Policy Number: SURGERY 107.8 T2  
Effective Date: October 1, 2019

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CONDITIONS OF COVERAGE

This policy applies to Oxford Commercial plan membership.

Applicable Lines of Business/Products

General Benefits Package

Benefit Type

Referral Required
(Does not apply to non-gatekeeper products)

Yes

Yes

Yes

Yes

Yes

Yes

Authorization Required
(Precertification always required for inpatient admission)

Precertification with Medical Director Review Required

Applicable Site(s) of Service
(If site of service is not listed, Medical Director review is required)

Office

Outpatient

Special Considerations

1 Medical Director review is required when a service addressed in this policy is to be provided in an outpatient facility setting.

2 Medical Director review is required for CPT codes 64633 and 64635 regardless of the site of service.

3 Participating Providers in the Office Setting:
Precertification is required for CPT codes 64633 and 64635 performed in the office of a participating provider.

Non-Participating/Out-of-Network Providers in the Office Setting:
Precertification is not required, but is encouraged for out-of-network services performed in the office. If precertification is not obtained, Oxford will review for out-of-network benefits and medical necessity after the service is rendered.

COVERAGE RATIONALE

Oxford 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.

**Required Clinical Information**

**Office Based Procedures – Site of Service**

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 Clinical Policy titled **Ablative Treatment for Spinal Pain**.

**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 policy 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 may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>11402</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm</td>
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<tr>
<td>11403</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm</td>
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<tr>
<td>11406</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm</td>
</tr>
<tr>
<td>11422</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11426</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm</td>
</tr>
<tr>
<td>11442</td>
<td>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</td>
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<tr>
<td>19000</td>
<td>Puncture aspiration of cyst of breast</td>
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**General Surgery**

**Muscular/Skeletal**

<table>
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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>27096</td>
<td>Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed</td>
</tr>
<tr>
<td>64479</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level</td>
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<tr>
<td>CPT Code</td>
<td>Description</td>
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<tr>
<td><strong>Muscular/Skeletal</strong></td>
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<tr>
<td>64483</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level</td>
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<tr>
<td>64490</td>
<td>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</td>
</tr>
<tr>
<td>64493</td>
<td>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</td>
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<tr>
<td><strong>Neurologic</strong></td>
<td></td>
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<tr>
<td>62270</td>
<td>Spinal puncture, lumbar, diagnostic</td>
</tr>
<tr>
<td>62321</td>
<td>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)</td>
</tr>
<tr>
<td>62323</td>
<td>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)</td>
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<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint</td>
</tr>
<tr>
<td>64635</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint</td>
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<tr>
<td><strong>Obstetrics &amp; Gynecology</strong></td>
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<tr>
<td>57460</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix</td>
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<tr>
<td><strong>Respiratory</strong></td>
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<tr>
<td>31579</td>
<td>Laryngoscopy, flexible or rigid telescopic, with stroboscopy (only flexible to be performed in office setting)</td>
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**REFERENCES**

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [URG-12.06]


POLICY HISTORY/REVISION INFORMATION

Date | Action/Description
--- | ---
10/01/2019 | **Title Change**
- Previously titled *Office Based Program*

**Coverage Rationale**
- Simplified content
- Added language to indicate:
  - Oxford 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
- Revised medical necessity criteria for certain elective procedures performed in an ambulatory surgical center:
  - Added criterion requiring:
    - Developmental stage or cognitive status warranting use of an ambulatory surgical center
    - Presence of complications and comorbid disease that would cause office based procedure to be unsafe or unsuitable
  - Removed criterion requiring:
    - Individual unable to cooperate with procedure due to mental status, severe anxiety, or extreme pain sensitivity
    - Significant member comorbidities
- Removed language indicating 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

**Documentation Requirements** (relocated from Coverage Rationale)
- Updated and reformatted documentation requirements

**Supporting Information**
- Updated References section to reflect the most current information
- Archived previous policy version SURGERY 107.7 T2

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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 policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical Policies 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.