OFFICE BASED PROGRAM

Policy Number: SURGERY 107.6 T2

Effective Date: December 1, 2018

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Related Policies

- Ablative Treatment for Spinal Pain
- Epidural Steroid and Facet Injections for Spinal Pain
- Occipital Neuralgia and Headache Treatment
- Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, 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.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

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

CONDITIONS OF COVERAGE

Applicable Lines of Business/Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General Benefits Package
Referral Required (Does not apply to non-gatekeeper products)	Yes - Office
Authorization Required (Precertification always required for inpatient admission)	Yes[1,2] - Outpatient
Precertification with Medical Director Review Required	Yes[1,2,3]
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Office[2,3] - Outpatient
Special Considerations	[1]Precertification requests for any of the CPT codes listed in the Applicable Codes section of this policy require review by a Medical Director or their designee when provided in an outpatient facility setting. [2]CPT codes 36473, 36475, 36478, 64633, and 64635 require review by a Medical Director or their designee regardless of the site of service. [3]**Participating Providers in the Office Setting**: Precertification is required for CPT codes 36473, 36475,

Special Considerations *(continued)*	36478, 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.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

This guideline applies to participating providers that are providing services to members enrolled on Oxford commercial products.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Coverage Rationale

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

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

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

Certain Qualifying Conditions

Some patients 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).

- Patient 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

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 Applicable Codes).

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.

CPT Code	Description
Dermatology	
10120	Incision and removal of foreign body, subcutaneous tissues; simple
10140	Incision and drainage of hematoma, seroma or fluid collection
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
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
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 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
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 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
Gastroenterology	
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
46922	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
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
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)

CPT Code	Description
Neurologic	
62270	Spinal puncture, lumbar, diagnostic
62320	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; without imaging guidance
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)
62322	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); without imaging guidance
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)
Urology	
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
Vascular	
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

DESCRIPTION OF SERVICES

In an effort to minimize out-of-pocket costs for UnitedHealthcare members and to improve cost efficiencies for the overall health care system, we are implementing prior authorization guidelines that aim to encourage more cost-effective sites of service for certain outpatient surgical procedures, when medically appropriate.

These prior authorization requirements apply to UnitedHealthcare commercial plans that require services to be medically necessary, including being cost-effective. Refer to the member specific benefit plan document to determine if medical necessity applies.

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-12.04*]

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 April 10, 2018

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 April 10, 2018.

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. https://www.guideline.gov/summaries/summary/50327?f=rss&osrc=12. Accessed April 10, 2018.

Neighborhood Health Plan (NHP). Prior Authorization Requirements. Refer to mynhp.com > References > Utilization Management > Pre-Certification Process. Accessed April 10, 2018.

United HealthCare Advance Notification List. To view the most current and complete Advance Notification List, including procedure codes and associated services, go to UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements. Accessed April 10, 2018.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
12/01/2018	• Updated conditions of coverage/special considerations; modified notation to clarify: ○ For **participating providers in the office setting**: Precertification is required for CPT codes 36473, 36475, 36478, 64633, and 64635 performed in the office of a participating provider ○ For **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 • Archived previous policy version SURGERY 107.5 T2