SITE OF SERVICE GUIDELINES FOR CERTAIN OUTPATIENT SURGICAL PROCEDURES

Policy Number: SURGERY 106.7 T2 **Effective Date**: May 1, 2018

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Related Policy

- Glaucoma Surgical Treatments
- Obstructive Sleep Apnea Treatment

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] - Outpatient
Precertification with Medical Director Review Required	Yes[1] - Outpatient
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Office, 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 a hospital outpatient facility setting. **Exception**: If the provider performing the service does not have privileges at an Ambulatory Surgical Center (ASC), MD review is not required and standard precertification rules apply.

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 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.

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

With the exception of the qualifying conditions below, certain elective procedures should be performed in an Ambulatory Surgical Center (ASC).

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
- Ambulatory Surgical Care (ASC) capability
- Physician privileging
- Significant member comorbidities (see list of examples of Qualifying Conditions below)
- American Society of Anesthesiologist (ASA) physical status (PS), classification system

Potential Documentation Requirements

- Physician office notes
- Physician privileging
- ASA score

Certain Qualifying Conditions

Some patients may require more complex care due to factors such as age or medical conditions. Also, some ASCs may have specific guidelines that prohibit members who are above a certain weight or have certain health conditions from receiving care in those facilities.

Patients with severe systemic disease and some functional limitation (ASA PS classification III or higher) may be appropriate to have the procedure in an outpatient hospital setting (not an all-inclusive list):

- Morbid obesity (>BMI.40)
- Diabetes (Brittle Diabetes)
- Resistant hypertension (Poorly Controlled)
- Chronic Obstructive Pulmonary Disease (COPD) (FEV1 < 50%)
- Advance liver disease (MELD Score > 8)
- Alcohol dependence (at risk for withdrawal syndrome)
- End stage renal disease [Hyperkalemia (above reference range peritoneal or hemodialysis)]
- Uncompensated Chronic Heart Failure (CHF) (NYHA class III or IV)
- History of Myocardial Infarction (MI) [recent event (< 3 mo.)]
- History of Cerebrovascular Accident (CVA) or Transient Ischemic Attack (TIA) [recent event (< 3 mo.)]
- Coronary Artery Disease (CAD)/Peripheral Vascular Disease (PVD) [ongoing cardiac ischemia requiring medical management recently placed drug eluting stent (within 1 year)]
- Sleep apnea [moderate to severe Obstructive Sleep Apnea (OSA)]
- Implanted pacemaker
- Personal history or family history of complication of anesthesia such as malignant hyperthermia
- Pregnancy
- Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect (DDAVP is not blood product and is OK)

- Prolonged surgery (>3 hrs.)
- Anticipated need for transfusion
- Recent history of drug abuse (especially cocaine)
- 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
- Ongoing evidence of myocardial ischemia
- Poorly controlled asthma (FEV1 < 80% despite medical management)
- Significant valvular heart disease
- Cardiac arrhythmia (symptomatic arrhythmia despite medication)

Elective Procedures List

Prior authorization is required for the following procedures if performed in an outpatient hospital setting (see Applicable Codes table).

DEFINITIONS

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.

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
Carpal Tunnel Surgery	
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
Cataract Surgery	
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (1 or more stages)
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)
Cosmetic & Reconstructive	
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm

CPT Code	Description
Cosmetic & Reconstructive	
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater
ENT Procedures	
21320	Closed treatment of nasal bone fracture; with stabilization
30140	Submucous resection inferior turbinate, partial or complete, any method
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
Gynecologic Procedures	
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision
58353	Endometrial ablation, thermal, without hysteroscopic guidance
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58563	Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
Hernia	
49505	Repair initial inguinal hernia, age 5 years or older; reducible
49585	Repair umbilical hernia, age 5 years or older; reducible
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated
49650	Laparoscopy, surgical; repair initial inguinal hernia
49651	Laparoscopy, surgical; repair recurrent inguinal hernia
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated
Liver Biopsy	
47000	Biopsy of liver, needle; percutaneous
Miscellaneous	
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)
Ophthalmologic	
65426	Excision or transposition of pterygium; with graft
65730	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)
65855	Trabeculoplasty by laser surgery
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery

CPT Code	Description
Ophthalmologic	
66761	Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (per session)
67028	Intravitreal injection of a pharmacologic agent (separate procedure)
67036	Vitrectomy, mechanical, pars plana approach;
67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation
67228	Treatment of extensive or progressive retinopathy (e.g., diabetic retinopathy), photocoagulation
67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle
67312	Strabismus surgery, recession or resection procedure; 2 horizontal muscles
Tonsillectomy & Adenectomy	
42820	Tonsillectomy and adenoidectomy; younger than age 12
42821	Tonsillectomy and adenoidectomy; age 12 or over
42825	Tonsillectomy, primary or secondary; younger than age 12
42826	Tonsillectomy, primary or secondary; age 12 or over
42830	Adenoidectomy, primary; younger than age 12
Upper & Lower Gastrointestinal Endoscopy	
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45380	Colonoscopy, flexible; with biopsy, single or multiple
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
Urology	
50590	Lithotripsy, extracorporeal shock wave
52000	Cystourethroscopy (separate procedure)
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
52204	Cystourethroscopy, with biopsy(s)
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

CPT Code	Description
Urology	
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age
55040	Excision of hydrocele; unilateral
55700	Biopsy, prostate; needle or punch, single or multiple, any approach
57288	Sling operation for stress incontinence (e.g., fascia or synthetic)

DESCRIPTION OF SERVICES

In an effort to minimize out-of-pocket costs for Oxford 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.

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-11.03*]

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UnitedHealthcare® Oxford Services Requiring Prior Authorization List. To view the most current and complete list of policies, including procedure codes and associated services requiring prior authorization, go to OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Services Requiring Prior Authorization. Accessed February 19, 2018.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
05/01/2018	• Updated supporting information to reflect the most current references; no change to coverage rationale or list of applicable codes • Archived previous policy version SURGERY 106.6 T2