

Outpatient Surgical Procedures – Site of Service (for Individual Exchange Only)

Policy Number: IEX-MP-11.08

Effective Date: July 1, 2023

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Application

This Medical Policy applies to Individual Exchange benefit plans in all states except for those listed below:

State	Policy/Guidelines
Texas	Refer to the member specific benefit plan document
Colorado	Refer to the MCG® Care Guidelines
Nevada	Refer to the Health Plan of Nevada’s Medical Policies
Wisconsin	Refer to the member specific benefit plan document

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 planned surgical 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)
- Advance 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
- Cardiac arrhythmia (symptomatic arrhythmia despite medication)
- Chronic obstructive pulmonary disease (COPD) (FEV1 < 50%)
- Coronary artery disease ([CAD]/peripheral vascular disease [PVD]) (ongoing cardiac ischemia requiring medical management or 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] receiving 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)
- Uncontrolled diabetes with recurrent diabetic ketoacidosis (DKA) or severe hypoglycemia
- Under 18 years of age

A planned 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 any one of the following:

- An ASC's specific guideline regarding the individual's health conditions or weight that would preclude management of an individual within an ASC setting; or
- There is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure; (Examples include but are not limited to fluoroscopy, laser, ocular equipment, operating microscope, nonstandard scopes required to perform specialized procedures (i.e., duodenoscope, ureteroscopy)*; or

There is no geographically accessible ambulatory surgical center available at which the individual's physician has privileges

***Note:** This specifically excludes surgeon preferred or proprietary instruments, instrument sets, or hardware sets.

Planned Surgical Procedures List

Site of service medical necessity reviews will be conducted for surgical procedures only when performed in an outpatient hospital setting. For the complete list of surgical procedures codes requiring prior authorization, refer to [UHCProvider.com > Exchange Plans Advanced Notification/Prior Authorization Requirements](https://www.uhc.com/individual-exchange-plans/advanced-notification-prior-authorization-requirements).

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

Outpatient Surgical Procedures – Site of Service

Medical notes documenting the following, when applicable:

- History
- Physical examination including patient weight and co-morbidities
- Surgical plan
- Physician privileging information related to the need for the use of the hospital outpatient department
- American Society of Anesthesiologists (ASA) score, as applicable
- Specific criteria (refer to the [Coverage Rationale](#)) that qualifies the individual for the site of service requested

In addition to the above, additional documentation requirements may apply for the following codes. Review the below listed policies in conjunction with the guidelines in this document.

- For CPT codes 15576, refer to the Medical Policy titled [Cosmetic and Reconstructive Procedures](#)
- For CPT codes 17106, 17107, and 17108, refer to the Medical Policy titled [Light and Laser Therapy](#)
- For CPT codes 29800, and 29804, refer to the Medical Policy titled [Temporomandibular Joint Disorders](#)
- For CPT codes 20605, 20606, 20610, and 20611, refer to the Medical Benefit Drug Policy titled [Sodium Hyaluronate](#)
- For CPT codes 22513 and 22514, refer to the Medical Policy titled [Percutaneous Vertebroplasty and Kyphoplasty](#)
- For CPT codes 23700 and 27570, refer to the Medical Policy titled [Manipulation Under Anesthesia](#)
- For CPT codes 29914, 29915, and 29916, refer to the Medical Policy titled [Surgery of the Hip](#)
- For CPT codes 42145, refer to the Medical Policy titled [Obstructive and Central Sleep Apnea Treatment](#)

Definitions

ASA Physical Status Classification System Risk Scoring Tool: The American Society of Anesthesiologists (ASA) physical status classification system was developed to offer clinicians a simple categorization of a patient's physiological status that can be helpful in predicting operative risk. The ASA score is a subjective assessment of a patient's overall health that is based on five classes (ASA, 2020).

Obstructive Sleep Apnea (OSA):

The American Academy of Sleep Medicine (AASM) defines OSA as a sleep related breathing disorder that involves a decrease or complete halt in airflow despite an ongoing effort to breathe. OSA severity is defined as:

- Mild for AHI or RDI ≥ 5 and < 15
- Moderate for AHI or RDI ≥ 15 and ≤ 30
- Severe for AHI or RDI > 30 /hr

(AASM, 2021)

Poorly Controlled: Requiring three or more drugs to control blood pressure (Sheppard, 2017).

References

American Academy of Sleep Medicine (AASM). Obstructive Sleep Apnea.

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American Society of Anesthesiologists. Guidelines for ambulatory anesthesia and surgery. October 17, 2018.

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American Society of Anesthesiologists. Position on monitored anesthesia care. October 17, 2018.

American Society of Anesthesiologists. Practice Guidelines for moderate procedural sedation and analgesia 2018: a report by the American Society of Anesthesiologists Task Force on Moderate Procedural Sedation and Analgesia, the American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Dental Association, American Society of Dentist Anesthesiologists, and Society of Interventional Radiology. Anesthesiology March 2018, Vol. 128, 437–479.

American Society of Anesthesiologists. Position Statement for distinguishing monitored anesthesia care (“MAC”) from moderate sedation/analgesia (conscious sedation). October 17, 2018.

Joshi G; Chung F; Vann Mary Ann, et al. Society for Ambulatory Anesthesia Consensus Statement on perioperative blood glucose management in diabetic patients undergoing ambulatory surgery. *Anesthesia & Analgesia*. December 2010; 111(6): 1378–1387.

Mathis MR, Naughton NN, Shanks AM, et al. Patient selection for day case-eligible surgery: identifying those at high risk for major complications. *Anesthesiology*. 2013 Dec;119(6):1310-21.

Medicare Claims Processing Manual. Chapter 14 - Ambulatory Surgical Centers.

Whippey A, Kostandoff G, Ma HK, et al. Predictors of unanticipated admission following ambulatory surgery in the pediatric population: a retrospective case-control study. *Paediatr Anaesth*. 2016 Aug;26(8):831-7.

Policy History/Revision Information

Date	Summary of Changes
01/01/2024	<p>Application</p> <ul style="list-style-type: none"> Reformatted list of states excluded from this policy; refer to the appropriate policy/guideline, if noted
07/01/2023	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Updated list of conditions in which a planned surgical procedure performed in a hospital outpatient department is considered medically necessary if there is an inability to access an ambulatory surgical center (ASC); replaced “an ASC’s specific guideline regarding the individual’s weight or health conditions <i>prevents the use of an ASC</i>” with “an ASC’s specific guideline regarding the individual’s health conditions or weight <i>precludes management of an individual within an ASC setting</i>” <p>Documentation Requirements</p> <ul style="list-style-type: none"> Removed reference link to the Medical Policy titled: <ul style="list-style-type: none"> <i>Hysterectomy</i> for CPT code 58263 Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) for CPT code 62281 <i>Temporomandibular Joint Disorders</i> for CPT code 20551 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information Archived previous policy version IEX-MP-11.07

Instructions for Use

This Medical Policy 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 policy, 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 Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical 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.