Medical Policy:
Site of Service Utilization (Commercial)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
M20190010	8/01/2019	MPC (Medical Policy Committee)

Overview

This Utilization Review Guideline provides assistance in interpreting ConnectiCare benefit plans. 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 Utilization Review Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Utilization Review Guideline. 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 Utilization Review Guideline. Other Policies and Guidelines may apply. ConnectiCare 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. ConnectiCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Benefit Considerations

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

Preauthorization requirements apply to ConnectiCare plans that require services to be medically necessary, including being cost effective. The medical necessity of the procedure may be separately reviewed against the appropriate criteria. Refer to the member specific benefit plan document to determine if medical necessity applies.

Coverage Rationale

Surgery may safely be performed in various settings. Some of the common settings used are an inpatient hospital or medical center, an off-campus outpatient hospital or medical center, an on-campus outpatient hospital or medical center, an ambulatory surgical center, or a doctor's office. Costs for surgical procedures may vary among these different settings. To encourage the use of the most safe and appropriate cost-effective sites of service for

certain medically necessary outpatient surgical procedures, prior authorization is required for the site of service for the surgical procedures listed below.

We will review the site of service for medical necessity for certain elective surgical procedures. Site of service is defined as the location where the surgical procedure is performed, such as an off campus-outpatient hospital or medical center, an on campus-outpatient hospital or medical center, an ambulatory surgical center, or an inpatient hospital or medical center or providers office. When there is more than one option for the site of surgery, and in the absence of any clinical contra-indication, the lowest level of site will be approved (i.e., physician office first, then ASC, then hospital outpatient, and last, hospital inpatient).

The following will be taken into account to determine whether the elective procedure is being performed in an optimal setting:

- Member's specific 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

Office Based Procedures

With the exception of the following qualifying conditions, most elective procedures should be performed in an Office setting *(not an all-inclusive list)*:

• Patient is 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

The following will be taken into account to determine whether the elective procedure is being performed in an optimal setting:

- The individual has clinical conditions which may compromise the safety of an office-based procedure, including but not limited to:
    - Medical conditions which require enhanced monitoring, medications or prolonged recovery period; **or**

- Increased risk for complications due to severe comorbidity, such as that evidenced by an American Society or Anesthesiologist's (ASA) class III or higher physical status.

ASC and Outpatient Surgical Procedures

With the exception of the qualifying conditions below, many elective procedures should be performed in an Ambulatory Surgical Center (ASC). 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 (mode rate 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)
- Potentially difficult airway
- Uncontrolled seizure disorder

Inpatient Surgical Procedures

Certain specific complex surgeries can only be performed in an inpatient setting due to the needed level of involvement of specialized staff and technical equipment necessary to safely perform the procedure. Examples include organ transplants, most oncology procedures and many cardiac procedures.

CODING

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 guideline 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 and Guidelines may apply.

To access the codes, please download the policy ***to your computer, and click on the paperclip icon within the policy***

📎	**Applicable Procedure Codes for Office-Based Procedures**
📎	**Applicable Procedure Codes for Outpatient Surgical Procedures**

References

American Heart Association. Classes of Heart Failure. Available at: http://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure. Accessed November 7, 2018.

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Epstein LJ, Kristo D, Strollo PJ Jr, et al. Clinical guideline for the evaluation, management and long - term care of obstructive sleep apnea in adults. JClin Sleep Med. 2009 Jun 15; 5(3):263-76. Available at: http://www.aasmnet.org/Resources/clinicalguidelines/OSA_Adults.pdf. Accessed November 7, 2018.

Friedman L S. Surgery in the Patient with Liver Disease. Trans Am Clin Climatol Assoc. 2010; 121: 192–205. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2917124/. Accessed November 7, 2018.

National Kidney Foundation. Clinical update on hyperkalemia. A chronic risk for CKD patients and a potential barrier to recommended CKD treatment. https://www.kidney.org/sites/default/files/02-10-6785_HBE_Hyperkalemia_Bulletin.pdf. Accessed November 7, 2018.

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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. http://www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf. Accessed on November 7, 2018

Revision history

DATE	REVISION
10/2019	• OB/GYN codes: 57522, 58353, 58558, 58563, 58565 removed from Outpatient Surgical Procedures Coding Criteria retroactive to 8/1/2019.
9/2019	• Added clarification that policy is applicable to all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals. No other changes to policy criteria.
04/2019	• New policy