Medical Policy: Site of Service Utilization (Commercial)

POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
M20190010v3	01/14/2022	MPC (Medical Policy Committee)

Note: The Site of Service Utilization policy is applied only to members between 18–74 years of age. There is no impact to members under 18 or over 75.

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.

Applicable Procedure Codes for Office Based Procedures

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
19000	Puncture aspiration of cyst of breast;
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscopy
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
46922	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical

55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)

Applicable Procedure Codes for Outpatient Surgical Procedures

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
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
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)
21320	Closed treatment of nasal bone fracture; with stabilization
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
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
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
47000	Biopsy of liver, needle; percutaneous
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
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 (eg, Gibbons or double-J type)
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic
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 (eg, Gibbons or double-J type)
55040	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)
55700	Biopsy, prostate; needle or punch, single or multiple, any approach
57288	Sling operation for stress incontinence (eg, fascia or synthetic)
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
65426	Excision or transposition of pterygium; with graft
65730	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)
65855	Trabeculoplasty by laser surgery

66170	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, 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 (eg, irrigation and aspiration or phacoemulsification)
67028	Intravitreal injection of a pharmacologic agent (separate procedure)
67036	Vitrectomy, mechanical, pars plana approach;
67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal
67228	Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy),
67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle
67312	Strabismus surgery, recession or resection procedure; 2 horizontal muscles
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

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Revision history

DATE	REVISION
05/27/2022	• Added note communicating that the policy is applied only to members between 18–74 years of age
08/2021	• Coding Section: Removed paperclips and added code lists • References updated
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