

Clinical Policy: Ambulatory Surgery Center Optimization

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[Revision Log](#)

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Description

Ambulatory surgery centers (ASC) operate for the purpose of offering outpatient surgical services to members in an environment appropriate for low-risk procedures on participants with low risk health status. They serve as a high-quality, cost-effective alternative to inpatient surgical services. This policy provides guidance for when surgical services are medically appropriate to be provided in an ASC and can be redirected from an inpatient or outpatient hospital without delaying the services. The goal is not to delay elective procedures and have participants wait if SPU's are available timely and ASC's are not or if the ASC's is available and the SPU is not.

Policy/Criteria

- I. It is the policy of PA Health & Wellness (PHW) that elective procedures performed in an ASC are **medically necessary** when meeting the following indications:
 - A. General guidelines:
 1. Procedure is non-emergent and for a non-life threatening situation;
 2. Requesting surgeon has privileges at an ASC qualified to manage the procedure;
 3. BMI (body mass index) < 40;
 4. Post-operative ventilation is not anticipated;
 5. Operative time expected < 3 hours and combined operative and recovery time is anticipated to be < 23 hours;
 6. Procedure is not expected to result in extensive blood loss or directly involves major blood vessels;
 7. Major or prolonged body cavity invasion is not anticipated;
 8. Health status is American Society of Anesthesiologist (ASA) physical status (PS) class I, II, or III; or if class IV, meets the following:
 - a. Only local anesthetic with minimal sedation is planned;
 - b. No respiratory distress is present;
 - c. No internal cardioverter-defibrillator in a patient requiring electrocautery;
 - i. Emergency Transportation to a nearby hospital is available if needed.
 9. Evaluation of the airway does not identify non-modifiable physical characteristics that may indicate the potential for a difficult airway (examination may include assessment of facial features [e.g., mouth opening, head and neck mobility, prominent upper incisors, presence of a beard and the upper lip bite test] and assessment of anatomical measurements and landmarks [e.g., Mallampati and modified Mallampati scores, neck circumference, and hyomental distance]);
 10. Non-obstetric surgery during pregnancy meets the following (in addition to other general guidelines):
 - a. Procedure is not elective;
 - b. Primary obstetric provider has been consulted regarding aspects of maternal anatomy and physiology that could affect intraoperative maternal-fetal wellbeing;

- c. Corticosteroid administration considered for fetal benefit in patients with fetuses at viable premature gestational ages;
 - d. Screened for venous thromboembolism risk and appropriate perioperative prophylaxis administered;
 - e. If the fetus is considered pre-viable, ascertainment of fetal heart rate by Doppler at least before and after the procedure (in select circumstances, intraoperative fetal monitoring may be considered to facilitate positioning or oxygenation interventions);
 - f. If the fetus is viable (greater than 23 to 24 weeks of gestation), intraoperative electronic fetal monitoring, meets all of the following:
 - i. It is physically possible to perform intraoperative electronic fetal monitoring;
 - ii. An obstetric care provider with cesarean delivery privileges will be readily available during the procedure;
 - iii. Informed consent has been obtained that allows for emergency cesarean delivery for fetal indications;
 - iv. The nature of the planned surgery will allow the safe interruption or alteration of the procedure to provide access to perform emergency delivery;
 - g. A qualified individual will be readily available to interpret fetal heart rate patterns;
 - h. Neonatal and pediatric services are available on an emergent basis;
 - i. Blood products access onsite;
11. All Anesthesia staff will meet licensing and supervision requirements of Pennsylvania.
- B.** Does not have any of the following disqualifying conditions that would indicate a hospital setting is more appropriate (not an all-inclusive list):
- 1. Brittle diabetes (instable diabetes that results in disruption of life and often recurrent/prolonged hospitalization);
 - 2. Resistant hypertension (poorly controlled despite use of 3 antihypertensive agents of different classes);
 - 3. Chronic obstructive pulmonary disease (COPD) (FEV1 < 50%);
 - 4. Advanced liver disease (MELD Score > 8);
 - 5. Alcohol dependence who is at risk for withdrawal syndrome;
 - 6. End stage renal disease (on peritoneal or hemodialysis)
 - 7. Uncompensated chronic heart failure (NYHA class III or IV)
 - 8. History of myocardial infarction in past 3 months;
 - 9. History of cerebrovascular accident or transient ischemic attack in past 3 months;
 - 10. Coronary artery disease with ongoing cardiac ischemia requiring ongoing medical management, placement of drug eluting stent in past year, or non-drug eluting stent or plain angioplasty in past 3 months unless aspirin and antiplatelet drugs will be continued by agreement of surgeon, cardiologist, and anesthesia;
 - 11. Moderate to severe uncontrolled obstructive sleep apnea;
 - 12. Implanted pacemaker;
 - 13. Personal history or family history of complication of anesthesia such as malignant hyperthermia;

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14. 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);
15. Recent history of drug abuse;
16. Poorly controlled asthma (FEV1 < 80% despite medical management);
17. Significant valvular heart disease;
18. Symptomatic cardiac arrhythmia despite medication;

C. Procedures appropriate for an ASC (see Table 1) should be redirected from an outpatient hospital setting when the above criteria are met. These procedures should be considered medically necessary per nationally recognized clinical decision support tools (i.e. InterQual™ or MCG).

II. It is the PHW's policy that procedures medically appropriate for an ASC per the criteria listed in section I above, that are performed in an inpatient or outpatient hospital setting, are considered to not be provided in the most appropriate care setting. Providers who request these services will be directed to the most appropriate care setting when the requesting physician has privileges at a qualified ASC capable of providing the requested procedure.

Background

Ambulatory surgery centers (ASCs) are distinct entities that operate to furnish outpatient surgical services to patients. These facilities are either independent (i.e., not a part of a provider of services or any other facility) or operated by a hospital. According to a recent analysis in the 2010 Hospital Ambulatory Medical Care Survey, there were over 22 million surgical and nonsurgical procedures performed at ambulatory surgical centers.⁴ Outpatient surgery in ASCs provide safe, cost-effective alternatives for a variety of surgical procedures with low complication rates.⁵ For example, a survey of the American Society for Surgery of the Hand noted that over 65% of surgeons reported performing hand procedures at ASCs.⁵

The Health Plan may also use tools developed by third parties, such as the InterQual™ Guidelines, and other consensus guidelines and evidence-based medicine, to assist us in administering health benefits. The InterQual™ Care Guidelines and other 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.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Table 1: Codes that will be redirected from an outpatient hospital when criteria are met

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CPT® Codes	Description
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24359	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
26160	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger
27385	Suture of quadriceps or hamstring muscle rupture; primary
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each
28750	Arthrodesis, great toe; metatarsophalangeal joint
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
47562	Laparoscopy, surgical; cholecystectomy
47563	Laparoscopy, surgical; cholecystectomy with cholangiography
49650	Laparoscopy, surgical; repair initial inguinal hernia
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
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (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)
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

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CPT® Codes	Description
55700	Biopsy, prostate; needle or punch, single or multiple, any approach
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy
60240	Thyroidectomy, total or complete
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; without endoscopic cyclophotocoagulation
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
67028	Intravitreal injection of a pharmacologic agent (separate procedure)
67113	Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	01/18	
References reviewed and updated.	02/19	
References reviewed and updated	10/19	
In I.C, added reference to procedures in Table 1 and added MCG as an additional option for conducting medical necessity reviews of the procedure. Added table of CPT codes that will be redirected to an ASC from an outpatient hospital when meeting criteria. References reviewed and updated. Replaced “members’ with “members/enrollees” in all instances. Added additional verbiage to criteria II. noting that inpatient or outpatient hospital setting requests will not be considered appropriate “when the requesting physician has privileges at a qualified ASC capable of providing the requested procedure.” CPT codes removed due to the lack of InterQual criteria that can be utilized for medical necessity determination: 11603, 21501, 21552, 23430, 26418, 27328, 28119,	06/2021	

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
28485, 28615, 28740, 43264, 51102, 52260, 52276, 52310, 52317, 65820.		
Annual review completed; Added codes to Table 1: 43270, 45330, 47562, 47563, 49654, 49655, 50590, 52356, 55700, 58571, 60220, 60240, and 67028. Updated references. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Removed pregnancy as a disqualifying condition. Added Evaluation of the airway does not identify non-modifiable physical characteristics that may indicate the potential for a difficult airway. Added to general guidelines, criteria for when non-obstetric surgery during pregnancy could be performed at an ASC. Minor rewording with no clinical significance. Added codes 66982 and 66984 as appropriate for an ASC. Clarified code description for CPT code 28750. References reviewed and updated. Specialist reviewed.	10/23/2022	

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