Clinical Policy: Ambulatory Surgery Center Optimization

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Ambulatory surgery centers (ASC) operate for the purpose of offering outpatient surgical services to members/enrollees in an environment appropriate for low risk procedures on members/enrollees 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 setting.

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® 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;
   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;
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10. Coronary artery disease with ongoing cardiac ischemia requiring ongoing medical management, placement of drug eluding stent in past year, or non-drug eluding 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;
14. Pregnancy;
15. 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);
16. Recent history of drug abuse;
17. Poorly controlled asthma (FEV1 < 80% despite medical management);
18. Significant valvular heart disease;
19. 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 Health Plan’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 ACSs 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 hand surgeons reported performing hand procedures at ASCs.5

The Health Plan may also use tools developed by third parties, such as the InterQual™ Guidelines, MCG, 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
Table 1: Codes that will be redirected from an outpatient hospital when criteria are met

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>24342</td>
<td>Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft</td>
</tr>
<tr>
<td>24359</td>
<td>Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment</td>
</tr>
<tr>
<td>26160</td>
<td>Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger</td>
</tr>
<tr>
<td>27385</td>
<td>Suture of quadriceps or hamstring muscle rupture; primary</td>
</tr>
<tr>
<td>27792</td>
<td>Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed</td>
</tr>
<tr>
<td>27822</td>
<td>Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip</td>
</tr>
<tr>
<td>28285</td>
<td>Correction, hammertoe (eg, interphalangeal fusion, partial or total phalanectomy)</td>
</tr>
<tr>
<td>28299</td>
<td>Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method</td>
</tr>
<tr>
<td>28308</td>
<td>Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each</td>
</tr>
<tr>
<td>28750</td>
<td>Arthrodesis, midtarsal or tarsometatarsal, single joint</td>
</tr>
<tr>
<td>29848</td>
<td>Endoscopy, wrist, surgical, with release of transverse carpal ligament</td>
</tr>
<tr>
<td>31253</td>
<td>Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed</td>
</tr>
<tr>
<td>31254</td>
<td>Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)</td>
</tr>
<tr>
<td>47562</td>
<td>Laparoscopy, surgical; cholecystectomy</td>
</tr>
<tr>
<td>49650</td>
<td>Laparoscopy, surgical; repair initial inguinal hernia</td>
</tr>
<tr>
<td>50590</td>
<td>Lithotripsy, extracorporeal shock wave</td>
</tr>
<tr>
<td>52234</td>
<td>Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)</td>
</tr>
<tr>
<td>52352</td>
<td>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)</td>
</tr>
<tr>
<td>52601</td>
<td>Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)</td>
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<tr>
<td>67108</td>
<td>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</td>
</tr>
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</table>
| 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
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<tr>
<td></td>
<td>silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens</td>
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<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>Policy developed</td>
<td>01/18</td>
<td>01/18</td>
</tr>
<tr>
<td>References reviewed and updated</td>
<td>01/19</td>
<td>01/19</td>
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<tr>
<td>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.</td>
<td>09/20</td>
<td>09/20</td>
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<td>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.”</td>
<td>01/21</td>
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<tr>
<td>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, 28485, 28615, 28740, 43264, 51102, 52260, 52276, 52310, 52317, 65820.</td>
<td>02/21</td>
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</tr>
</tbody>
</table>

References

2. Guidelines for Ambulatory Anesthesia and Surgery; Committee on Ambulatory Surgery Care; American Society of Anesthesiologists, October 2013. Reaffirmed Oct 17, 2018
3. 2017.1 InterQual List of Inpatient Procedures

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted
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standards of medical practice; peer-reviewed medical literature; government agency/program
approval status; evidence-based guidelines and positions of leading national health professional
organizations; views of physicians practicing in relevant clinical areas affected by this clinical
policy; and other available clinical information. The Health Plan makes no representations and
accepts no liability with respect to the content of any external information used or relied upon in
developing this clinical policy. This clinical policy is consistent with standards of medical
practice current at the time that this clinical policy was approved. “Health Plan” means a health
plan that has adopted this clinical policy and that is operated or administered, in whole or in part,
by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a
component of the guidelines used to assist in making coverage decisions and administering
benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage
decisions and the administration of benefits are subject to all terms, conditions, exclusions and
limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,
contract of insurance, etc.), as well as to state and federal requirements and applicable Health
Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting
may not be the effective date of this clinical policy. This clinical policy may be subject to
applicable legal and regulatory requirements relating to provider notification. If there is a
discrepancy between the effective date of this clinical policy and any applicable legal or
regulatory requirement, the requirements of law and regulation shall govern. The Health Plan
retains the right to change, amend or withdraw this clinical policy, and additional clinical
policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is
not intended to dictate to providers how to practice medicine. Providers are expected to exercise
professional medical judgment in providing the most appropriate care, and are solely responsible
for the medical advice and treatment of members/enrollees. This clinical policy is not intended
to recommend treatment for members/enrollees. Members/enrollees should consult with their
treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent
judgment and over whom the Health Plan has no control or right of control. Providers are not
agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and
distribution of this clinical policy or any information contained herein are strictly prohibited.
Providers, members/enrollees and their representatives are bound to the terms and conditions
expressed herein through the terms of their contracts. Where no such contract exists, providers,
members/enrollees and their representatives agree to be bound by such terms and conditions by
providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict
with the coverage provisions in this clinical policy, state Medicaid coverage provisions take
precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members/enrollees,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at [http://www.cms.gov](http://www.cms.gov) for additional information.

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