Office-Based Procedures - Site of Service

Policy Number: MP.12.16
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Ü Instructions for Use

Table of Contents **Page**

Related Commercial/Individual Exchange Policies

- Ablative Treatment for Spinal Pain
- Epidural Steroid Injections for Spinal Pain
- Facet Joint and Medial Branch Block Injections for Spinal Pain
- Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)

Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans. Some state-specific exclusions may apply; refer to UnitedHealthcare Commercial Advance Notification/Prior Authorization Requirements > Site of Service (SOS) – Office-Based Program for details.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado and Texas.

Coverage Rationale

UnitedHealthcare members may choose to receive surgical procedures in an office setting or other locations. We are conducting site of service medical necessity reviews, however, to determine whether the ambulatory surgical center (ASC) is medically necessary, in accordance with the terms of the member's benefit plan. If the ambulatory surgical center is not considered medically necessary, this location will not be covered under the member's plan.

Certain elective procedures performed in an ambulatory surgical center are considered medically necessary for an individual who meets any of the following criteria:

- Allergy to local anesthetic
- Bleeding disorder that would cause a significant risk of morbidity
- Developmental stage or cognitive status warranting use of an ambulatory surgical center
- Failed office-based procedure attempts due to body habitus, abnormal anatomy, or technical difficulties
- Presence of complications and comorbid disease that would cause office-based procedure to be unsafe or unsuitable

An elective surgical procedure performed in an ambulatory surgical center is considered medically necessary if there is an inability to access an office setting for the procedure due to the following:

- There is no geographically accessible office 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, ureteroscope)*; or

- There is no geographically accessible in-network provider

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

Elective Procedures List

Prior authorization is required for procedures listed in the Applicable Codes section if not performed in an office setting.

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.

CPT/HCPCS Codes*	Required Clinical Information
Service Category/Situation	
11402, 11403, 11404,11406, 11420, 11421, 11422, 11426, 11442, 11423, 11424, 19000, 20552, 20553, 27096, 31579, 57460, 62270, 62321, 64479, 64490, 64493, 64633, 64635	Medical notes documenting the following, when applicable: • History • Physical examination including patient weight and co-morbidities • Surgical plan • 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 20552 and 20553, refer to the Medical Policy titled Temporomandibular Joint Disorders. • For CPT code 64633, refer to the Medical Policies titled Ablative Treatment for Spinal Pain and Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache). For CPT code 64635, refer to the Medical Policy titled Ablative Treatment for Spinal Pain

*For code descriptions, refer to the Applicable Codes section.

Applicable Codes

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 policy 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.

CPT Code	Description
Dermatology	
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

CPT Code	Description
Dermatology	
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
General Surgery	
19000	Puncture aspiration of cyst of breast
Muscular/Skeletal	
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
Neurologic	
62270	Spinal puncture, lumbar, diagnostic
62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
Obstetrics & Gynecology	
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
Respiratory	
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscopy (only flexible to be performed in office setting)

Clinical Evidence

American College of Surgeons (ACS) and American Society of Anesthesiologists (ASA)

In a 2019 ACS statement on patient safety principles for office-based surgery utilizing moderate sedation/analgesia and a 2019 ASA guideline for office-based anesthesia the following recommendations on patient and procedure selection were made:

- The anesthesiologist should be satisfied that the procedure to be undertaken is within the scope of practice of the health care practitioners and the capabilities of the facility
- The procedure should be of a duration and degree of complexity that will permit the patient to recover and be discharged from the facility
- Individual who by reason of pre-existing medical or other conditions may be at undue risk for complications should be referred to an appropriate facility for performance of the procedure and the administration of anesthesia (ASC, 2019 and ASA, 2019)

References

American College of Surgeons. Patient safety principles for office-based surgery. March 17, 2003.

American College of Surgeons (ACS). Statement on patient safety principles for office-based surgery utilizing moderate sedation/analgesia. September 1, 2019.

American Society of American Society of Anesthesiologists. Guidelines for office-based anesthesia. October 21, 2009. Amended on October 23, 2019.

Federation of State Medical Boards of the United States, Inc. Report of the Special Committee on outpatient (office-based) surgery. 2002.

Policy History/Revision Information

Date	Summary of Changes
10/01/2023	**Application** ***Individual Exchange Plans*** • Revised language indicating this Medical Policy applies to all Individual Exchange benefit plans in all states except for Colorado and Texas **Supporting Information** • Archived previous policy version MP.12.15

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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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.