Clinical Policy: Ambulatory Surgery Center Optimization

Reference Number: NV.CP.MP.158
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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 and outpatient hospital site of care. This policy provides guidance for when surgical services are medically appropriate to be provided in an ASC and under what clinical conditions or circumstances members are not redirected from an inpatient or outpatient hospital setting.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that elective low risk surgeries and/or procedures can be performed in an ASC setting. **Contraindications** to performing surgeries and/or procedures in an ASC setting are as follows:

Contraindications to ASC:

1. Procedure is emergent or for a life threatening situation;
2. BMI (body mass index) > 50
3. Health status is American Society of Anesthesiologist (ASA) physical status (PS) class 4 or higher,
4. Personal history or family history of severe complication of anesthesia including but not limited to malignant hyperthermia
5. Member has severe uncontrolled obstructive sleep apnea
6. Operative time expected >3 hours and combined operative and recovery time is anticipated to be > 23 hours.
7. Procedure is expected to result in extensive blood loss or need special infusion products to correct a coagulation defect (DDAVP is not a blood product and is not a contraindication)
8. Member is Pregnant and member or provider declines procedure in ASC
9. Uncompensated chronic heart failure (NYHA class III or IV);
10. History of myocardial infarction in past 6 months
11. Coronary artery disease with ongoing cardiac ischemia requiring ongoing medical management, or placement of a STENT in last 6 months
12. Significant uncompensated valvular heart disease
13. Symptomatic cardiac arrhythmia despite medication;
14. Cardiomyopathy with EF <30%
15. Poorly controlled asthma (FEV1 < 80% despite medical management)
16. Advanced liver disease (MELD Score > 8);

Procedures appropriate for an ASC (*see Table 1*) should be redirected from an outpatient hospital setting when the above contraindications are not present. These procedures should be considered

medically necessary per nationally recognized clinical decision support tools (i.e., InterQual® or MCG).

17. 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.[4] 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.[5] Outpatient surgery in ACSs provide safe, cost-effective alternatives for a variety of surgical procedures with low complication rates. 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.[6] Furthermore, a retrospective study of Medicare beneficiaries reported a 7% decline in hospital-based outpatient surgery rates after an ASC opened in the hospital service area without any increases noted in mortality or admission rates.[12]

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 others 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 2022, 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

CPT® Codes	Description
19120	Exc Cyst/Aberrant Breast Tissue Open 1/> Lesion
19380	Revision Of Reconstructed Breast
20680	Removal Implant Deep

CPT® Codes	Description
27792	29806: Surgical Arthroscopy Shoulder Capsulorrhaphy
36558	Insj Tunneled Cvc W/O Subq Port/Pmp Age 5 Yr/>
36589:	Rmvl Tun Cvc W/O Subq Port/Pmp
41899	Unlisted Procedure Dentoalveolar Structures
43235	Esophagogastroduodenoscopy Transoral Diagnostic
43239	Egd Transoral Biopsy Single/Multiple
45378	Colonoscopy
45380	Colonoscopy W/Biopsy Single/Multiple
47562	Laparoscopy Surg Cholecystectomy
49650	Laparoscopy Surg Rpr Initial Inguinal Hernia
54161	Circumcision Age >28 Days
54300	Penis Straightening Chordee
54304	Penis Corrj Chordee/1st Stage Hypospadias Rpr
54360	Plastic Rpr Penis Correct Angulation
57288	Sling Operation Stress Incontinence
58558	Hysteroscopy Bx Endometrium&/Polypc W/Wo D&C
58662	Laps Fulg/Exc Ovary Viscera/Peritoneal Surface
64721	Neuroplasty &/Transpos Median Nrv Carpal Tunne
66984:	Xcapsl Ctrc Rmvl Insj Io Lens Prosth W/O Ecp

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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 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.

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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 for additional information.

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