SITE OF CARE GUIDELINES

Elective Surgical and Endoscopic Procedures

Version 1.0, 2024

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SITE OF CARE: Elective Surgical and Endoscopic Procedures

SOC-1.0: General Information

- This guideline pertains to Elective Surgical and Endoscopic Procedures.
- The purpose of this guideline is to increase access to alternative sites of care for individuals and to decrease health care costs by optimizing non-hospital facilities as a safe and practical option for elective surgical or endoscopic procedures.
- Procedures must meet applicable medical necessity criteria for coverage.
- When coverage criteria are met for the procedure, this policy will be used to determine medical necessity if a hospital outpatient department (HOPD) or inpatient hospital facility is requested.
- For the purposes of this document, sites of service for surgical/endoscopic procedures include the following Place of Service (POS) codes.
  - 19: Off-campus Outpatient Hospital
  - 21: Inpatient Hospital
  - 22: On-Campus Outpatient Hospital (HOPD)
  - 24: Ambulatory Surgical Center (ASC)

SOC-1.1: Administrative Directives

On-Campus Outpatient Hospital (HOPD) (22) or Inpatient Hospital (21) may be considered medically necessary for any of the following:

- Where there are no other geographically accessible appropriate alternative sites for the member to undergo the procedure. This would include the availability of specialized medical resources such as unique staffing and/or equipment at the alternative sites (e.g., endoscopic stents, fluoroscopy, specialized orthopedic tools, implants, etc.).
- When there is no alternative site available at which the individual's physician has privileges.
- When the pre-procedure assessment determines that the individual requires overnight recovery and care following the procedure.
- If the procedure is expected to be immediately followed by inpatient hospitalization.
- The procedure is anticipated to be prolonged (> 3 hours).

SOC-1.2: Condition-specific Guidelines

- The On-Campus Outpatient Hospital (HOPD) (22) or Inpatient Hospital (21) will be deemed medically necessary if any of the following criteria are met:
  - American Society of Anesthesiology class III or greater
    (severe systemic disease impairing function)
  - The procedure requires discontinuing medications (e.g. antiarrhythmics, anti-seizure medication), which necessitate preoperative or postoperative inpatient monitoring or treatment.
  - The individual is using drugs or medications that may interact with the anticipated anesthetic regimen (e.g. cocaine, amphetamines, monoamine oxidase inhibitor) that would result in the need for longer postoperative monitoring or treatment.
  - History of any of the following pulmonary conditions that would increase risk:
    - Abnormal airway
    - Prior difficult intubation
    - Poorly or uncontrolled asthma (i.e., FEV1 < 80% despite medical management)
    - Severe chronic obstructive pulmonary disease (COPD) (i.e., FEV1 < 50%)
    - Dependent on a ventilator or continuous supplemental oxygen
  - History of any of the following gastrointestinal conditions that would increase risk for aspiration:
    - Documented history of achalasia
    - Documented history of delayed gastric emptying disorder or gastroparesis
  - History of any of the following cardiovascular conditions that would increase risk:
    - Implanted cardioverter-defibrillator
    - Implanted pacemaker
    - Myocardial infarction (MI) within three (3) months of the scheduled procedure
    - Recent coronary intervention (e.g. angioplasty within 3 months, bare metal stents placed within 3 months, drug eluting stents placed within one year)
    - Moderate or severe valvular disease and/or cardiomyopathy
    - Severe hypertension (HTN) (e.g., BP > 180/110)
    - Resistant or poorly controlled hypertension (not responsive to 3 antihypertensive agents)
    - Symptomatic/unstable cardiac arrhythmia despite medication
    - Unstable or severe angina [Canadian Class III or IV], uncompensated chronic heart failure [CHF] [NYHA class III or IV])
  - History of any of the following neurological diagnoses that would increase risk:
    - Active multiple sclerosis
    - Cerebrovascular accident (CVA) or transient ischemic attack (TIA) within the last three (3) months
    - Myasthenia gravis
    - Preexisting cognitive dysfunction (e.g., Alzheimer's disease, dementia)
    - Severe motor disorder (e.g. severe Parkinson's, or other severe neurological dysfunction)
    - A condition is present that will require the use of restraints

- Any of the following other conditions/comorbidities:
  - Advanced liver disease (e.g., MELD score >8 [Model for End-stage Liver Disease] or on the list for a liver transplant)
  - Age < 18 years
  - Current or recent history of substance use disorder (e.g., alcohol and/or drug abuse)
  - End stage renal disease (ESRD),(as evidenced by hyperkalemia above reference range, or receiving peritoneal or hemodialysis)
  - History of a significant hemodynamic instability during a prior surgical procedure and is considered a risk for future procedures
  - History of malignant hyperthermia
  - Individual is awaiting major organ transplant (e.g., heart, liver, lung)
  - Moderate to severe Obstructive Sleep Apnea
    Severity defined as: Moderate for AHI or RDI ≥ 15 and ≤ 30.
    Severe for AHI or RDI > 30/hr.
  - Morbid obesity (BMI ≥40)
  - Pregnancy
  - Sickle cell disease
  - Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect
  - Uncontrolled/difficult to control diabetes manifested by predominant hyperglycemia with recurrent diabetic ketoacidosis, or predominant hypoglycemia with recurrent severe hypoglycemia

Practice Notes

- Diabetic Issues
  - In chronically poorly controlled diabetic patients, the decision to proceed with ambulatory surgery should be made in conjunction with the surgeon or endoscopist while taking into consideration the presence of other comorbidities and the potential risks of the planned procedure.
  - The Society for Ambulatory Anesthesia Consensus issued a guideline statement “Perioperative Blood Glucose Management in Diabetic Patients Undergoing Ambulatory Surgery” (Joshi, et al., 2010). Within this guideline the authors report the following:
    - The American Diabetes Association (ADA) recommends that outpatient management of diabetes should ideally include a combination of a target hemoglobin HgA1c 7% (normal 4%–7%), a preprandial blood glucose level of 90 to 130 mg/dL and a peak postprandial blood glucose level of 180 g/dL (this has not been verified in the ambulatory surgical population).
    - There is no evidence in the literature that any particular blood glucose level is either beneficial or harmful for patients undergoing ambulatory surgical procedures.

- Sleep Apnea
  - In “Preoperative Selection of Adult Patients with Obstructive Sleep Apnea Scheduled for Ambulatory Surgery” (Joshi, et al., 2012) the authors note:
    - Individuals with a known diagnosis of OSA and optimized comorbid medical conditions can be considered for ambulatory surgery, if they are able to use a continuous positive airway pressure device in the postoperative period.
    - Individuals with a presumed diagnosis of OSA, based on screening tools such as the STOP–Bang questionnaire, and with optimized comorbid conditions, can be considered for ambulatory surgery, if postoperative pain can be managed predominantly with non-opioid analgesic techniques.
    - Individuals diagnosed with OSA with non-optimized comorbid medical conditions are not considered good candidates for ambulatory surgery.

- American Society of Anesthesiology Physical Status Classification
  - The American Society of Anesthesiologists (ASA) physical status classification system was developed to offer clinicians a simple categorization of a patient’s physiological status that can be helpful in predicting operative risk. The ASA score is a subjective assessment of a patient’s overall health that is based on five classes.
    - ASA I: A normal healthy patient
    - ASA II: A patient with mild systemic disease
    - ASA III: A patient with severe systemic disease (E.g., Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents)
    - ASA IV: A patient with severe systemic disease that is a constant threat to life (E.g. Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD).
    - ASA V: A moribund patient who is not expected to survive without the operation
    - ASA VI: A declared brain-dead patient whose organs are being removed for donor purposes
  - **The American College of Surgeons (ACS):** The ACS Revised statement on “Patient Safety Principles for Office-based Surgery Utilizing Moderate Sedation/Analgesia” supports the use of the ASA Physical Status Classification System for selection criteria in the office-based/ambulatory surgical setting. The ACS supports that ASA III and above patients should undergo surgical procedures in an accredited surgical center (ACS, 2019).

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