Outpatient Surgical Site of Service

MEDICAL POLICY NUMBER: 420

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial**	☐ **Medicaid/OHP***	☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Notes:

- For definitions or scores referenced in criteria, see the Policy Guidelines immediately following this section.
- In addition to site of service review, codes for rhinoplasties,, spinal cord stimulation and dorsal root ganglion stimulation, small joint surgeries, knee arthroscopy and open procedures, and shoulder arthroscopy and open procedures may also require general medical necessity review for all Plan members, using criteria found in separate medical policies. See Policy Cross-References for links to these policies.
- For Physician Attestation Form, please see Ambulatory Surgery Center Access - Physician Attestation Form

This policy applies to elective, non-emergent cases and does not apply to acute fractures and other emergent conditions.

The following criteria are limited to review of site of service appropriateness for the following procedures:

- *Dorsal Root Ganglion (DRG) Stimulation*
- *Hernia repair*
- *Laparoscopic Cholecystectomy*
- *Plastic procedure on nose (Rhinoplasty)*
- *Spinal cord stimulation*
- *Knee Arthroscopy and Open Procedures (For specific procedures see Policy Guidelines)*
- *Shoulder Arthroscopy and Open Procedures (For specific procedures see Policy Guidelines)*
- *Small Joint Surgery (For specific procedures see Policy Guidelines)*

General Site of Service Criteria

I. The use of a hospital outpatient department instead of an ambulatory surgery center (ASC) or physician office for surgical services may be considered **medically necessary** when **one or more** of the following criteria are met (A.-H.):

A. There is no ASC within 25 miles that can provide the necessary care for the patient due to one of the following (1.-3.):

1. There is no geographically accessible ASC that has the necessary equipment for the procedure; **or**
2. There is no geographically accessible ASC available at which the individual's physician has privileges; **or**
3. An ASC's specific guideline regarding the individual's weight or health conditions prevents the use of an ASC;

B. The procedure requires discontinuing medications (e.g. antiarrhythmics, antiseizure medication), which necessitates preoperative or postoperative inpatient monitoring or treatment;

C. Age 17 years and younger;

D. The service being performed is in conjunction with an additional service that requires the use of a hospital outpatient department and they are being performed in the same operative session;

E. Patient has any of the following anesthesia risk factors (1.-3.):

1. American Society of Anesthesiologists (ASA) Score is 3 or higher; **or**
2. Personal or family history of complication of anesthesia; **or**
3. Documentation of abnormal or high-risk airway; **or**
4. Documentation of use of substances or medications that may interact with anesthesia or cause withdrawal;

F. Patient has any of the following cardiovascular risk factors (1.-7.):

1. Uncompensated chronic heart failure (NYHA class III or IV); **or**
2. Recent history of myocardial infarction (< 3 months); **or**
3. Poorly controlled, resistant hypertension (3 or more drugs to control blood pressure); **or**
4. Recent history of cerebrovascular accident (<3 months); **or**
5. Increased risk for cardiac ischemia (drug eluting stent placed < 1 year, or angioplasty <90 days); **or**
6. Symptomatic cardiac arrhythmia despite medication;
7. Significant valvular heart disease;

G. Patient has **any** of the following pulmonary risk factors (1.-3.):

1. Chronic obstructive pulmonary disease (COPD) (FEV1 <50%); **or**
2. Poorly controlled asthma (FEV1 <80% despite treatment); **or**
3. Moderate to severe obstructive sleep apnea (OSA) (AHI ≥ 15);

H. Patient has **any** of the following (1.-9.):

1. Advanced liver disease with a MELD score >8; **or**
2. Bleeding disorder requiring replacement factor, blood products, or special infusion; product (not including DDAVP-Deamino-Delta-D-Arginine Vasopressin (Desmopressin)); **or**
3. Anticoagulation use, or anticipated need for transfusion; **or**
4. Pregnancy; **or**
5. Morbid obesity (BMI ≥ 40); **or**
6. Uncontrolled diabetes with recurrent DKA or severe hypoglycemia; **or**
7. Neurologic disease increasing perioperative risk; **or**
8. Developmental delay or cognitive status limiting ASC safety; **or**
9. Clinical circumstance requiring restraints or enhanced supervision.

Site of Service Criteria Not Met

II. If the general site of service criteria (criterion I.) is not met, the procedure will be considered **not medically necessary** in the hospital outpatient department setting.

Link to Evidence Summary

POLICY CROSS REFERENCES

- Inpatient Surgical Site of Service (Company)
- Rhinoplasty and Other Nasal Surgeries (Company)
- Implantable Spinal Cord and Dorsal Root Ganglion Stimulation (Company)
- Implantable Loop Recorder (Company)
- Shoulder Arthroscopy and Open Procedures (Company)
- Knee Arthroscopy and Open Procedures (Company)
- Small Joint Surgery (Company)
- Inpatient Hospital Admission and Length of Stay Reviews (Reimbursement Policy)
- Ambulatory Surgery Center (ASC) Payment Structure (Reimbursement Policy)

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request:

- Medical records to include documentation of all of the following:
  - History
  - Physical examination including patient weight and co-morbidities
  - Surgical plan
  - American Society of Anesthesiologists Physical Classification (ASA-PS) score

DEFINITIONS

Body Mass Index (BMI)[1]

Metric BMI Formula: BMI= weight (kg) ÷ height^2 (m^2)
Imperial BMI Formula: BMI= weight (lb) ÷ height^2 (in^2) x 703

- Obesity is defined as a BMI of 30.0 kg/m^2 or higher.
- Obesity is frequently divided into categories:
  - Class I: BMI of 30 kg/m^2 to < 35 kg/m^2
  - Class II: BMI of 35 kg/m^2 to < 40 kg/m^2
  - Class III: BMI of 40 kg/m^2 or higher
    - A BMI of 40-49.9 kg/m^2 is considered morbidly obese.
    - A BMI of 50 kg/m^2 or more is considered superobesity or super morbid obesity.

American Society of Anesthesiologists (ASA) Physical Status Classification System (ASA-PS)[2]

Current Definitions and ASA-Approved Examples

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): 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, premature infant PCA < 60 weeks, 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	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction

**The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)*

New York Heart Association (NYHA) Classification[3]

1. Class I – No symptoms and no limitation in ordinary physical activity, eg, shortness of breath when walking, climbing stairs etc.
2. Class II – Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.
3. Class III – Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g., walking short distances (20–100 m). Comfortable only at rest.
4. Class IV Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients.

Model for End-Stage Liver Disease (MELD)[4]

MELD calculator found here. The MELD score calculation uses:

- Serum Creatinine (mg/dL)*
- Bilirubin (mg/dL)
- INR
- Serum Sodium (mEq/L)

*For patients who have had dialysis twice within the last week, or 24 hours of CVVHD, the creatinine value will be automatically set to 4 mg/dL.

BACKGROUND

From the Noridian web page for Ambulatory Surgical Center (ASC):[5,6]

> "An ASC is defined as an entity that operates exclusively for furnishing outpatient surgical services to patients. To receive coverage of and payment for its services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS."

Several factors are considered when determining the appropriateness for the site of care including an individual's health status, facility and geographic availability, specialty requirements, and physician privileges. The American Society of Anesthesiologist (ASA) physical status classification system and/or significant comorbidities may be taken into account.

Procedures

Currently, the scope of this policy is limited to review of site of service appropriateness for the following procedures *shown below.*

Procedures other than these services may be added for site of service appropriateness review in the future.

Procedures:	Information:
Dorsal Root Ganglion (DRG) Stimulation	Dorsal root ganglion stimulation is a pain therapy indicated for individuals with complex regional pain syndrome types 1 or 2. "Rather than working through the spinal cord, this therapy is applied to the dorsal root ganglion, a group of specialized nerves near the spinal cord at the base of each branching spinal nerve."[7] The DRG stimulator consists of electrical leads and an implanted pulse generator. The electrical leads are threaded through the epidural space and attached over the DRG. The pulse generator is also implanted subcutaneously. Patients can switch between stimulation settings using an external hand-held controller.[8]
Hernia Repair	Hernia repair is a surgical intervention performed to correct a protrusion of tissue or organ through a weakened area in a muscle or connective tissue. =Most hernias form in your abdomen or groin. The procedure may be conducted via open, laparoscopic, or robotic techniques and typically involves repositioning the herniated contents and reinforcing the defect with sutures or surgical mesh.
Laparoscopic Cholecystectomy	Laparoscopic cholecystectomy is a minimally invasive surgical technique used to remove a diseased gallbladder. Indications for laparoscopic cholecystectomy include acute and chronic cholecystitis, symptomatic cholelithiasis, biliary dyskinesia (either hypo- or hyperfunctional), acalculous cholecystitis, gallstone pancreatitis, and gallbladder polyps or masses.
Plastic procedure on nose (Rhinoplasty)	Rhinoplasty is a procedure performed on the external or internal structures of the nose, septum, or turbinate. This surgery may be performed to improve abnormal function, reconstruct congenital or acquired deformities, or to enhance appearance.
Spinal cord stimulation	Spinal cord stimulation (SCS) is a treatment designed to help suppress pain in specific areas for individuals suffering from chronic, refractory, neuropathic pain; most commonly, failed back surgery syndrome, complex regional pain syndrome type 1, and diabetic peripheral neuropathy. The SCS device works by delivering electrical currents through the spinal column in order to disrupt the transmission of pain signals. SCS consists of a generator that is implanted subcutaneously and directly connects to electrodes implanted in the epidural space. SCS implantation is conducted in two phases: the trial phase and the permanent implantation phase. During the trial phase, electrodes are implanted temporarily and connected to the generator. The generator is then programmed with stimulation parameters customized to the specific areas of pain.[9]
KNEE ARTHROSCOPY AND OPEN PROCEDURES	
Meniscal Repair	Resection or repair of meniscal tear involves either removing the damaged part of the meniscus (resection) or stitching the torn edges together (repair). The goal is to restore knee function and alleviate pain. Meniscal repair is often preferred to preserve the meniscus's shock-absorbing function.
Cartilage Restoration Procedures (Microfracture or drilling or abrasion knee arthroplasty (with chondroplasty))	• Microfracture, drilling, or abrasion arthroplasty are techniques aimed at repairing damaged cartilage by creating small holes or abrasions in the bone. This stimulates the growth of new cartilage by promoting blood flow to the area.

	• Chondroplasty is a surgical procedure to smooth and repair damaged cartilage in the knee. It is often performed arthroscopically, allowing the surgeon to trim rough cartilage and promote healthy tissue growth.
Synovectomy	• Synovectomy (limited) involves removing a portion of the inflamed synovial membrane lining the joint. It is typically used to treat conditions like rheumatoid arthritis and aims to reduce pain and swelling. • Synovectomy (major) is similar to limited synovectomy but involves the complete removal of the synovial membrane. This is usually done when the inflammation is severe and widespread.
Debridement	• Removal of loose or foreign body • Lavage of joint • Arthroscopically assisted lysis of adhesions
SHOULDER ARTHROSCOPY AND OPEN PROCEDURES	
Labral Tear Repair	Labral tear repair is a surgical procedure aimed at addressing tears in the labrum, a fibrocartilaginous structure that encircles the glenoid cavity of the shoulder joint. This procedure typically involves the reattachment of the torn labrum to the glenoid rim using specialized sutures or suture anchors. The goal is to restore the anatomical integrity and stability of the shoulder joint, thereby alleviating pain and improving function that conservative treatments have failed to achieve.
Debridement	Debridement of the shoulder is a surgical procedure aimed at removing damaged tissue, loose fragments of tendon, thickened bursa, and other debris from the shoulder joint. This procedure can be performed arthroscopically, using small incisions and an arthroscope to visualize and clear the joint, or through open surgery with a larger incision. The goal is to alleviate pain, improve joint function, and provide a clearer view of the extent of the injury, which may help determine if further surgical intervention is needed.
Capsulorrhaphy	Capsulorrhaphy is a surgical procedure aimed at tightening a torn or stretched joint capsule to restore stability and prevent recurrent dislocations. This procedure is commonly performed on the shoulder joint, where it involves suturing the capsule or using thermal shrinking techniques to reinforce the joint's stability. The goal is to restore the anatomical integrity and functional capacity of the joint, thereby alleviating pain and improving range of motion.
Partial Claviculectomy (including Mumford Procedure)	The Mumford procedure, also known as distal clavicle excision or distal clavicle resection, is a minimally invasive orthopedic surgery aimed at alleviating shoulder pain and discomfort. This procedure involves the removal of the distal (lateral) end of the clavicle, which is closest to the acromioclavicular (AC) joint. By excising this portion of the clavicle, the procedure helps decompress the joint, reducing friction and alleviating symptoms associated with shoulder impingement or osteoarthritis.
Arthroscopic Capsular Release, Lysis of Adhesions, and Manipulation under Anesthesia	Lysis of adhesions of the shoulder is a surgical procedure aimed at breaking down and removing adhesions, which are bands of scar tissue that restrict movement and cause pain in the shoulder joint. These adhesions often form as a result of previous surgeries, injuries, or conditions like adhesive capsulitis (frozen shoulder). The procedure can be performed arthroscopically, using small incisions and an arthroscope to visualize and remove the adhesions, or through open surgery with a larger incision. The goal is to restore the shoulder's range of motion and alleviate pain.

Arthroscopic or Open Biceps Tenodesis and Tenotomy	• Biceps tenodesis is a surgical procedure designed to treat tears or damage to the long head of the biceps tendon, which connects the biceps muscle to the shoulder. This procedure involves detaching the damaged tendon from its original attachment at the superior labrum and reattaching it to the humerus (upper arm bone) using sutures or anchors. The goal is to alleviate pain, restore shoulder function, and prevent further damage to the tendon. • Biceps tenotomy is a surgical procedure in which the long head of the biceps tendon is intentionally severed from its attachment at the shoulder joint. This procedure is typically performed arthroscopically Page 9 of 13 MP436 and is often chosen when the biceps tendon is irreversibly damaged or inflamed. By releasing the tendon, the procedure aims to alleviate pain and improve shoulder function. However, it may result in a cosmetic deformity known as "Popeye" sign, where the biceps muscle bulges in the upper arm.
SMALL JOINT SURGERY	
Bunionette Surgery	Bunionette surgery involves removing a bony bump on the outside of the foot near the base of the little toe. Depending on the severity, the procedure may include shaving the bone (exostectomy), realigning the bone (osteotomy), or adjusting soft tissues to relieve pain and correct deformity.
Hallux Valgus	Hallux valgus surgery corrects the misalignment of the big toe, commonly known as a bunion. The procedure may involve cutting and realigning bones (osteotomy), removing bony growths, and adjusting tendons or ligaments to restore proper toe alignment and relieve pain
Lesser Toe Deformity Surgery	Lesser toe deformity surgery addresses deformities of the smaller toes—such as hammer toe, claw toe, or mallet toe—caused by muscle imbalance, arthritis, or ill-fitting shoes. Surgical correction may involve tendon release, joint resection, or bone realignment to restore toe function and reduce discomfort.
Hallux Rigidus Surgery	Hallux rigidus surgery addresses arthritis of the big toe joint, which causes stiffness and pain due to cartilage degeneration. Surgical options depend on the severity of the condition and include cheilectomy (removal of bone spurs), osteotomy (realignment), arthroplasty (joint replacement), or arthrodesis (fusion). Early-stage disease may benefit from less invasive procedures, while advanced cases often require fusion or replacement. The goal is to relieve pain, restore function, and improve quality of life. Recovery varies by procedure but typically includes rest, limited activity, and physical therapy.
Sesamoidectomy	A sesamoidectomy is the surgical removal of one or both small sesamoid bones under the big toe joint, performed to alleviate chronic pain, fractures, or infections that fail to respond to conservative treatments.
First Metatarsophalangeal Joint Arthrodesis	First MTP joint arthrodesis, or fusion, is a surgical procedure that permanently joins the bones of the big toe joint to eliminate motion and pain caused by arthritis or deformity. It is commonly used for severe hallux rigidus or failed previous surgeries. The surgeon removes the joint cartilage and uses screws or plates to hold the bones together until they fuse. This procedure provides excellent pain relief and stability but sacrifices joint movement. Recovery involves a period of non-weight-bearing followed by gradual rehabilitation. It is often preferred for patients with high physical demands or significant joint degeneration.

First Metatarsophalangeal Joint Arthroplasty	First metatarsophalangeal (MTP) joint arthroplasty is a surgical procedure that replaces the damaged surfaces of the big toe joint with artificial components. It is typically performed to treat severe arthritis (hallux rigidus) when joint preservation is no longer viable. The goal is to relieve pain and maintain joint motion. The procedure involves removing arthritic bone and cartilage and inserting a prosthetic implant. While it preserves mobility, it may not be suitable for highly active individuals due to implant wear over time. Recovery includes rest, gradual weight-bearing, and physical therapy to restore function and range of motion.
Metatarsal Osteotomy	Metatarsal osteotomy is a surgical procedure used to correct deformities of the foot, particularly hallux valgus (bunion). It involves cutting and realigning one or more of the metatarsal bones to restore proper alignment and function. The procedure may involve removing a wedge of bone, shifting the bone, and securing it with screws or pins. It is often performed when conservative treatments fail to relieve pain or correct the deformity. Recovery includes limited weight-bearing and physical therapy. The goal is to relieve pain, improve foot mechanics, and prevent further joint damage or deformity progression.

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

CLINICAL EVIDENCE AND LITERATURE REVIEW

CLINICAL PRACTICE GUIDELINES

American Society of Anesthesiologists (ASA)

The American Society of Anesthesiologists (ASA) maintains a Physical Status Classification System with definitions and ASA-approved examples.[2] This system is intended to be used in conjunction with other factors to aid in predicting perioperative risks. The system was originally proposed in 1942, and the current version was published in 2014 with the inclusion of examples, and was most recently updated in 2020.

EVIDENCE SUMMARY

A procedure reviewed under this policy may be considered medically necessary in the hospital outpatient department instead of an ambulatory surgical center (ASC) setting when criteria are met (see separate medical policies for general medical necessity criteria). Due to a lack of evidence and clinical practice guidelines based on evidence, the use of a hospital outpatient department instead of an ASC for surgical services is considered not medically necessary when the policy criteria are not met including

when the procedure can be safely performed in a less intensive setting, an ASC where the physician has privileges is geographically available, or the specific service requires prior authorization and the individual does not meet applicable policy criteria.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online here.

BILLING GUIDELINES AND CODING

CODES*		
Rhinoplasty		
CPT	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	Rhinoplasty, primary; including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
	30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
Spinal Cord Stimulator		
	0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed
	0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator
	63650	Percutaneous implantation of neurostimulator electrode array, epidural
	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

	63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
	63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
	63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
	63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array
Hernia Repair		
	43281	Laparoscopy, Surgical, Repair of Paraesophageal Hernia, Includes Fundoplasty, When Performed; w/o Implantation of Mesh
	43282	Laparoscopy, Surgical, Repair of Paraesophageal Hernia, Includes Fundoplasty, When Performed; with Implantation of Mesh
	49505	Repair initial inguinal hernia, age 5 years or older; reducible
	49520	Repair recurrent inguinal hernia, any age; reducible
	49525	Repair inguinal hernia, sliding, any age
	49550	Repair initial femoral hernia, any age; reducible
	49555	Repair recurrent femoral hernia; reducible
	49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
	49613	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
	49650	Laparoscopy, surgical; repair initial inguinal hernia
	49651	Laparoscopy, surgical; repair recurrent inguinal hernia
Laparoscopic Cholecystectomy		
	47562	Laparoscopy; cholecystectomy
	47563	Laparoscopy; cholecystectomy with cholangiography
	47564	Laparoscopy; cholecystectomy with exploration of common duct
Knee Arthroscopy and Open Procedures		
	29873	Arthroscopy, knee, surgical; with lateral release
	29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
	29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)
	29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)

	29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
	29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
	29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
	29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
	29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
	29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
Shoulder Arthroscopy and Open Procedures		
	23430	Tenodesis of long tendon of biceps
	29806	Arthroscopy, Shoulder, Surgical; Capsulorrhaphy
	29807	Arthroscopy, Shoulder, Surgical; Repair of Slap Lesion
	29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
	29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
	29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
	29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
	29827	Arthroscopy, Shoulder, Surgical; with Rotator Cuff Repair
	29828	Arthroscopy, shoulder, surgical; biceps tenodesis
Small Joint Surgery		
	28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
	28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)
	28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
	28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant
	28292	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method

	28295	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal metatarsal osteotomy, any method
	28296	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with distal metatarsal osteotomy, any method
	28297	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method
	28299	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with double osteotomy, any method
	28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal
	28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, eac
	28315	Sesamoidectomy, first toe (separate procedure)
	28750	Arthrodesis, great toe; metatarsophalangeal joint

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
1/2025	New policy.
11/2025	Annual update. No criteria or coding changes.
1/2026	Interim update. Removed criterion 1.E.4. Added codes for Laparoscopic Cholecystectomy and Hernia Repair
2/2026	Interim update. No changes to criteria.
5/2026	Interim update. Addition of new musculoskeletal codes. Removal of one code.
11/2026	Annual update. No criteria or coding changes.