08-00000-01

Original Effective Date: 10/01/25

Reviewed: 07/24/25

Subject: Site of Service Review for Select Surgical Procedures

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DESCRIPTION:

Site of service is defined as the location or setting where a surgical procedure will be performed. Settings used include an inpatient hospital, an outpatient hospital, an ambulatory surgical center (ASC), or a doctor's office.

The purpose of this guideline is to review the site of service for select surgical procedures performed in an outpatient department of a hospital to ensure the most safe and appropriate site is used.

Summary and Analysis of Evidence: Patients with significant cardiac arrhythmias, such as atrial fibrillation or ventricular tachycardia, require close monitoring and management of their cardiac condition. Hospital outpatient settings are better equipped to handle potential cardiac complications, such as arrhythmia recurrence or cardiac arrest, which may require immediate intervention (18). Patients with recent coronary interventions are at higher risk for complications, such as stent thrombosis or bleeding. Hospital outpatient departments have the necessary resources and expertise to manage these complications, including access to cardiac catheterization labs and intensive care units. In contrast, ASCs may not have the same level of cardiovascular support, making them less suitable for patients with recent coronary interventions.

Patients who have had a recent CVA (within 3 months) are at increased risk of perioperative stroke and other neurological complications. Hospital outpatient settings can provide closer monitoring and management of these patients, including access to neurology and neurosurgery services if needed. Similar to patients with a recent CVA, those with a recent TIA (within 3 months) are at increased risk of perioperative stroke and other neurological complications. Hospital outpatient settings can provide closer monitoring and management of these patients, including access to neurology and neurosurgery services if needed (28). Patients with severe COPD are at increased risk of perioperative respiratory complications, such as respiratory failure and pneumonia. Hospital outpatient settings can provide closer monitoring and management of these patients, including access to pulmonary services and respiratory therapy if needed. Patients with a history of CAD or PVD are at increased risk of perioperative cardiac complications, such as myocardial infarction and cardiac arrest (18).

Patients with decompensated congestive heart failure require close monitoring and management of their cardiac function, which may not be feasible in an ASC setting. Patients with significant valvular heart disease require close monitoring and management of their cardiac function, which may not be feasible in

an ASC setting. Patients with symptomatic cardiac arrhythmias require close monitoring and management of their cardiac rhythm, which may not be feasible in an ASC setting. Hospital outpatient settings can provide closer monitoring and management of these patients, including access to cardiology services and cardiac catheterization if needed. Patients with poorly controlled diabetes mellitus are at increased risk of perioperative complications, such as hyperglycemia and hypoglycemia. ASCs may not have the necessary resources or expertise to manage these complex conditions.

Patients with significant developmental delays or cognitive impairments may require specialized care and equipment that may not be readily available in an ASC. Hospital outpatient departments are better equipped to handle complex cases, and their staff is trained to manage patients with unique needs. For example, patients with autism spectrum disorder may require specialized anesthesia and perioperative care (39), which is more readily available in a hospital setting.

Patients with end-stage renal disease (ESRD) on dialysis require specialized care and monitoring, particularly during surgical procedures. Hospital outpatient departments have the necessary resources and expertise to manage patients with ESRD, including access to nephrology consultation and dialysis services. ASCs may not have the same level of nephrology support, making them less suitable for patients with ESRD.

Patients with morbid obesity are at higher risk for complications, such as respiratory and cardiac problems, during surgical procedures (16). Hospital outpatient departments have the necessary resources and expertise to manage these complications, including access to bariatric surgery teams and intensive care units. ASCs may not have the same level of bariatric support, making them less suitable for patients with morbid obesity.

Patients with bleeding disorders, such as hemophilia, require close monitoring and access to blood products or special infusion products. Hospital outpatient settings are better equipped to handle these complex cases, as they have on-site blood banks and transfusion services. In contrast, ASCs may not have the necessary resources or expertise to manage bleeding disorders, which can lead to serious complications.

Patients who have had a recent myocardial infarction (MI) require close cardiac monitoring and may need urgent interventions (6). Hospital outpatient settings have the necessary resources, including cardiac catheterization labs and intensive care units, to manage potential complications. Patients with ongoing evidence of myocardial ischemia require close cardiac monitoring and may need urgent interventions (6). Hospital outpatient settings have the necessary resources, including cardiac catheterization labs and intensive care units, to manage potential complications. ASCs may not have the necessary equipment or personnel to handle cardiac emergencies.

Patients who require overnight recovery and care following a surgical procedure may need close monitoring and interventions that are not feasible in an ASC setting. Hospital outpatient settings can provide the necessary level of care, including access to intensive care units and specialized nursing staff. ASCs, by definition, are designed for same-day procedures and may not have the necessary resources or staffing to provide overnight care.

Patients with asthma exacerbation require close monitoring and may need urgent interventions, including access to respiratory therapy and intensive care units. Hospital outpatient settings are better equipped to handle these complex cases, as they have on-site respiratory therapy services and intensive care units. ASCs may not have the necessary resources or expertise to manage asthma exacerbations, which can lead to serious complications.

Patients with poorly controlled hypertension are at increased risk of perioperative cardiovascular complications, such as myocardial infarction, stroke, and cardiac arrhythmias (28). Hospital outpatient settings are better equipped to manage these potential complications, with immediate access to cardiology consultation, invasive monitoring, and intensive care units (ICUs) if needed. In contrast, ASCs typically lack these resources, making them less suitable for patients with poorly controlled hypertension.

Pregnant patients undergoing surgery require careful monitoring and management of both the mother and the fetus. Hospital outpatient settings are better equipped to handle potential obstetric complications, such as preterm labor, fetal distress, or postpartum hemorrhage, with immediate access to obstetric and

neonatal care. ASCs typically lack the necessary resources and expertise to manage these complications, making hospital outpatient settings a safer choice for pregnant patients.

Prolonged surgeries increase the risk of perioperative complications, such as respiratory and cardiac complications, hypothermia, and surgical site infections (6). Hospital outpatient settings are better equipped to manage these potential complications, with access to ICUs, respiratory therapy, and other supportive services. ASCs typically have limited resources and may not be able to provide the necessary level of care for prolonged surgeries.

Patients who are expected to require blood transfusions during surgery require close monitoring and management of their coagulation status (9). Hospital outpatient settings are better equipped to manage these patients, with access to blood banks, coagulation laboratories, and transfusion services. ASCs typically lack these resources, making hospital outpatient settings a safer choice for patients who may require transfusions.

Patients with advanced liver disease are at increased risk of perioperative complications, such as liver failure, coagulopathy, and encephalopathy (22). Hospital outpatient settings are better equipped to manage these potential complications, with access to hepatology consultation, liver transplantation services, and ICUs. ASCs typically lack these resources, making hospital outpatient settings a safer choice for patients with advanced liver disease.

Patients with moderate to severe obstructive sleep apnea (OSA) are at increased risk of respiratory complications during and after surgery (10). Hospital outpatient settings are better equipped to manage patients with OSA, as they have access to respiratory therapy and critical care services.

Patients with these conditions should be treated in a hospital outpatient department rather than an ASC due to the complexity of their conditions and the need for specialized care and resources. Hospital outpatient departments are better equipped to manage these patients and provide the necessary level of care to ensure optimal outcomes.

POSITION STATEMENT:

NOTE: For member contracts that include comparative effectiveness language, the relative cost of procedures performed in an outpatient department of a hospital compared to an ambulatory surgical center may be considered in the medical necessity determination as described in the section below entitled Comparative Effectiveness Analysis.

Select surgical procedures performed in an outpatient department of a hospital **meet the definition of medically necessity** for a member with any of the following conditions: (not an all-inclusive list)

- Significant cardiac arrhythmias
- History of cerebrovascular accident (CVA) < 3 months
- History of transient ischemic attack (TIA) < 3 months
- Chronic obstructive pulmonary disease (COPD)
- History of coronary artery disease (CAD)/peripheral vascular disease (PVD)
- Developmental stage or cognitive status necessitating use of outpatient department of a hospital
- History of drug eluting stent placed within 1-year, bare metal stents or plain angioplasty within 90 days
- End stage renal disease on dialysis

- Less than 19 years of age
- Morbid obesity with BMI ≥ 40
- Bleeding disorder (requiring blood products or special infusion product)
- History of myocardial infarction, event < 3 months
- Advance surgical planning determines overnight recovery and care following surgical procedure is necessary
- Ongoing evidence of myocardial ischemia
- Asthma with exacerbation
- Poorly controlled hypertension
- Pregnancy
- Prolonged surgery (> 3 hours)
- Expected need for transfusion
- Advanced liver disease (MELD Score > 8)
- Significant valvular heart disease
- Moderate to severe obstructive sleep apnea (OSA)
- Symptomatic cardiac arrhythmias
- Decompensated congestive heart failure
- Poorly controlled diabetes mellitus.

Select surgical procedures performed in an outpatient department of a hospital **meet the definition of medical necessity** if an ASC can't be accessed for a procedure due to any of the following situations:

- No geographically accessible ASC has the necessary equipment for the procedure
- No geographically accessible ASC is available where the member's physician has privileges
- The ASC's guidelines regarding the member's health conditions prevent the use of an ASC
- For Medicare Advantage Members, procedure not on Medicare's ASC list of covered procedures.

Select surgical procedures performed in an outpatient department of a hospital **do not meet the definition of medical necessity** when the criteria above are not met.

Comparative Effectiveness Analysis:

This section only applies to member contracts that contain a comparative effectiveness analysis within the definition of Medical Necessity. This may apply to member contracts that were issued or renewed on or after January 1, 2014.

It has been shown that services in ASC settings are equally safe and have similar or higher quality outcomes compared to hospital-based outpatient sites of service.

If a service meets the medical necessity criteria set forth above in the Position Statement, then an analysis under this comparative effectiveness section should be applied, solely for coverage and payment purposes. Initially, this analysis should determine if: 1.) There is an alternate service available that produces the same or similar outcomes and/or 2.) The same service as requested or performed can be rendered at a different location of service. If there is no alternative service that produces the same or similar outcomes nor is there a different location at which the services could be rendered, then no further comparative effectiveness analysis need be completed, and the service will be deemed to have met the definition of medical necessity. If, however, there are alternative services that produce the same or similar outcomes and/or there is a different location of service at which the services can be rendered, then a comparative effectiveness analysis must be conducted to determine if: a.) The same service rendered at a different location, or b.) An alternate service(s) is/are less costly. If the answer is yes, then the requested service does satisfy the requirements of this comparative effectiveness analysis and does not meet the medical necessity requirements for coverage and payment purposes.

Analysis

Several research studies have compared the clinical results of procedures performed at ambulatory surgery centers (ASCs) and outpatient hospital departments (OHDs). The findings suggest that ASCs have comparable or even slightly superior outcomes for certain types of procedures.

Summary of results:

1. **Lower readmission rates: ASCs had lower readmission rates compared to OHDs for procedures such as total hip arthroplasty (THA) and total knee arthroplasty (TKA) (Puri et al, 2025).**

   Puri et al (2025) examined readmissions, emergency room (ER) visits, periprosthetic joint infection (PJI), fracture, and dislocation after primary total hip arthroplasty (THA) or total knee arthroplasty (TKA) across sites. Primary TJAs [total joint arthroplasties] between July 1, 2021, and June 30, 2022 were reviewed. It was concluded that, "Primary TJA performed at ASCs had the lowest readmission rates and ER visits compared to HOPDs and hospitals with essentially similar rates of PJI, periprosthetic hip fracture, and prosthetic hip dislocation."

2. **Comparable safety: ASCs had comparable safety profiles to OHDs for procedures such as total shoulder arthroplasty (TSA) (Mastrokostas et al, 2025), lumbar laminectomies (Rana et al, 2024), and total joint arthroplasties (Altman et al, 2024).**

   Mastrokostas et al (2025) compared the safety and cost-effectiveness of outpatient total shoulder arthroplasty (TSA) in ambulatory surgical centers (ASCs) versus hospital-based centers (HSCs). Patients undergoing primary TSA in ASCs or HSCs, assessing medical complications, readmissions, implant issues, and costs were identified. ASCs showed lower odds of pulmonary embolism, total medical complications, prosthetic joint dislocation, and total implant-related complications, but a higher 90-day readmission rate. It was concluded that, "Outpatient primary TSA in ASCs offers comparable safety with substantially lower costs than HSCs. Despite higher readmission rates, ASCs represent a viable, cost-effective alternative."

   Rana et al (2024) compared the cost-effectiveness and patient outcomes of lumbar laminectomies performed in hospital settings vs ASCs. A retrospective analysis was conducted on 771 patients who underwent 1 or 2-level outpatient laminectomy between 2019 and 2023. "The findings support the safety and one-year cost effectiveness of ASCs for appropriately selected patient populations undergoing lumbar laminectomy."

   Altman et al (2024) compared patient outcomes following an outpatient total knee arthroplasty (TKA) or a total hip arthroplasty (THA) in a hospital setting versus an ambulatory surgical center. The study was a prospective study of patients receiving either a TKA or THA, with results up to one year. At one-year follow-up, no statistical differences in any PROMs [Patient-Reported Outcome Measures] between the ASC and hospital cohorts was found. The study concluded, "We believe that this study confirms that same day discharge, outpatient total joint procedures can be performed safely and effectively from either the hospital or ASC setting. While there were some differences in perceived outcomes at 3-months for some subgroups, these were not statistically significant at the 1-year after follow-up."

3. **Lower complication rates: ASCs had lower complication rates compared to OHDs for procedures such as GI endoscopy (Lin et al, 2022) and hand and upper-extremity surgical cases (Goyal et al, 2016).**

Lin et al (2022) compared the incidence of unplanned hospital visits after GI endoscopy performed in ASCs versus HOPDs during 2014 to 2017. It was found that, "Unplanned hospital visits after outpatient GI endoscopy were not uncommon. However, ASC patients consistently had less frequent hospital-based acute care encounters, indicating that GI endoscopy could be performed safely in ASCs for select patients."

Goyal et al (2016) reviewed 28,737 hand and upper-extremity surgical cases performed at a single, freestanding ambulatory surgery center over an eleven-year period. The study concluded that, "with a selected patient population, a very low adverse event rate (0.20%) can be achieved. Our review showing few adverse events, no deaths, and no wrong-site surgical procedures supports our view that hand and upper-extremity surgical procedures can be completed safely in the outpatient setting at a freestanding ambulatory surgery center."

4. **Shorter operative time: ASCs had shorter operative times compared to OHDs for procedures such as laparoscopic-assisted myomectomy (LAM) (Danilyants et al, 2020).**

   Danilyants et al (2020) compared the safety protocols and operative outcomes of patients undergoing laparoscopic-assisted myomectomy (LAM) at an ASC versus a hospital outpatient setting. 816 LAM cases were reviewed. Surgeries reviewed were performed between 2013 and 2017 in an ASC and 2011-2013 in an outpatient hospital setting. It was found the rate of complications was comparable across settings, as was the average myoma weight. Operative time was significantly shorter at the ASC. Conclusion: "Laparoscopic-assisted myomectomy can be performed safely and effectively by skilled surgeons at a freestanding ASC, even in patients with morbid obesity or large leiomyoma."

5. **Higher patient satisfaction: ASCs had higher patient satisfaction rates compared to OHDs for procedures such as total hip arthroplasty (THA) (Davey et al, 2024).**

   Davey et al (2024) compared outcomes between patients undergoing total hip arthroplasty (THA) at an ASC versus hospital-based center (HBC) while controlling for medical comorbidities. Patients undergoing primary THA with same-day discharge (SDD) from a single HBC or ASC from December 2020 to 2021 were identified. Conclusions: "No notable difference was observed in patient-reported outcomes at any time point for SDD after THA performed at an ASC or an HBC when controlling for age and comorbidities. This study suggests noninferiority of stand-alone ASCs for outpatient THA, regarding patient satisfaction and patient-reported outcomes."

6. **Cost-effectiveness: ASCs were found to be cost-effective for procedures such as lumbar laminectomies (Rana et al, 2024) and total shoulder arthroplasty (TSA) (Mastrokostas et al, 2025).**

   Rana et al (2024) compared the cost-effectiveness and patient outcomes of lumbar laminectomies performed in hospital settings vs ASCs. A retrospective analysis was conducted on 771 patients who underwent 1 or 2-level outpatient laminectomy between 2019 and 2023. "The findings support the safety and one-year cost effectiveness of ASCs for appropriately selected patient populations undergoing lumbar laminectomy."

   Mastrokostas et al (2025) compared the safety and cost-effectiveness of outpatient total shoulder arthroplasty (TSA) in ambulatory surgical centers (ASCs) versus hospital-based centers (HSCs). Patients undergoing primary TSA in ASCs or HSCs, assessing medical complications, readmissions, implant issues, and costs were identified. ASCs showed lower odds of pulmonary embolism, total medical complications, prosthetic joint dislocation, and total implant-related complications, but a higher 90-day readmission rate. It was concluded that, "Outpatient primary TSA in ASCs offers comparable safety with substantially lower costs than HSCs. Despite higher readmission rates, ASCs represent a viable, cost-effective alternative."

7. **Lower risk of surgical site infections: ASCs had lower rates of surgical site infections (SSI) compared to OHDs for orthopedic procedures (Edmonston et al, 2010).**

   Edmonston et al (2010) conducted a study to find the rate of infection and identify patient and technical risk factors for surgical site infections (SSI) in an orthopedic ambulatory surgical center. Over 11,000 surgeries for a 5-year period were reviewed for SSI as well as demographic, medical, and surgical risk factors. "The overall infection rate was 0.33%, which compares favorably to previous studies of outpatient surgery and appears to be substantially lower than SSI rates previously reported for inpatient orthopaedic surgery."

8. **Equivalent 30-day postoperative safety profiles: ASCs had equivalent 30-day postoperative safety profiles compared to OHDs for procedures such as transforaminal interbody fusion (TLIF) (Schlesinger et al, 2023).**

   Schlesinger et al (2023) collected baseline characteristics, perioperative variables, and 30-day postoperative safety outcomes to determine the comparative 30-day safety profile for patients treated with transforaminal interbody fusion (TLIF) in the ASC versus the hospital setting. Conclusions: "There were equivalent 30-day postoperative safety profiles for patients undergoing a minimally invasive TLIF irrespective of surgical setting. For appropriately selected surgical candidates, the ASC offers a viable and attractive option for their TLIF procedure with the advantage of same-day discharge and at-home recovery."

Overall, the studies suggest that ASCs can provide safe, effective, and cost-efficient care for a range of procedures, with comparable or superior outcomes to OHDs.

BILLING/CODING INFORMATION:

Site of service reviews will be conducted for the procedures listed below when performed in an outpatient department of a hospital.

CPT Coding:

11770	Excision of pilonidal cyst or sinus; simple
11772	Excision of pilonidal cyst or sinus; complicated
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)
21320	Closed treatment of nasal bone fracture with manipulation; with stabilization
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater
21933	Excision, tumor, soft tissue of back or flank, subfascial (e.g., intramuscular); 5 cm or greater
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance: lumbar
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater
23430	Tenodesis of long tendon of biceps
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed
24071	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
25000	Incision, extensor tendon sheath, wrist (e.g., deQuervains disease)
25111	Excision of ganglion, wrist (dorsal or volar); primary

25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed
26055	Tendon sheath incision (e.g., for trigger finger)
26123	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)
26160	Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus
28285	Correction, hammertoe (e.g., 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
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
28298	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal phalanx osteotomy, any method
28299	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with double osteotomy, any method
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (e.g., 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 (e.g., 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
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
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)
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29893	Endoscopic plantar fasciotomy
29914	Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)
29916	Arthroscopy, hip, surgical; with labral repair
30140	Submucous resection inferior turbinate, partial or complete, any method
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
31535	Laryngoscopy, direct, operative, with biopsy
31536	Laryngoscopy, direct, operative, with biopsy; with operating microscope or telescope
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis

	segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein
38500	Biopsy or excision of lymph node(s); open, superficial
38510	Biopsy or excision of lymph node(s); open, deep cervical node(s)
42440	Excision of submandibular (submaxillary) gland
42826	Tonsillectomy, primary or secondary; age 12 or over
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45380	Colonoscopy, flexible; with biopsy, single or multiple
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45390	Colonoscopy, flexible; with endoscopic mucosal resection
45990	Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic
46200	Fissurectomy, including sphincterotomy, when performed
46255	Hemorrhoidectomy, internal and external, single column/group
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
49505	Repair initial inguinal hernia, age 5 years or older; reducible
49650	Laparoscopy, surgical; repair initial inguinal hernia
50590	Lithotripsy, extracorporeal shock wave
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
52000	Cystourethroscopy (separate procedure)
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
52204	Cystourethroscopy, with biopsy(s)
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy

52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age
54360	Plastic operation on penis to correct angulation
54530	Orchiectomy, radical, for tumor; inguinal approach
54640	Orchiopexy, inguinal or scrotal approach
55040	Excision of hydrocele; unilateral
56620	Vulvectomy simple; partial
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58561	Hysteroscopy, surgical; with removal of leiomyomata
58562	Hysteroscopy, surgical; with removal of impacted foreign body
58563	Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
64718	Neuroplasty and/or transposition; ulnar nerve at elbow
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
65426	Excision or transposition of pterygium; with graft
65756	Keratoplasty (corneal transplant); endothelial

66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation
67036	Vitrectomy, mechanical, pars plana approach
67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation
67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (e.g., macular pucker)
67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil)
67108	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
67113	Repair of complex retinal detachment (e.g., 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 silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens
67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle
67312	Strabismus surgery, recession or resection procedure; 2 horizontal muscles
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material

REIMBURSEMENT INFORMATION:

The following information may be required documentation to support medical necessity: Physician history and physical exam including comorbidities and weight; ASA score if applicable; surgical treatment plan; physician privileging information for the use of the outpatient department of the hospital.

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products: The following was reviewed on the last guideline reviewed date: Claims Processing Manual. Chapter 14 - Ambulatory Surgical Centers; accessed at cms.gov.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

Poorly controlled diabetes mellitus: Blood glucose levels not adequately controlled resulting in fasting blood glucose ≥ 180 mg/dL; Hemoglobin A1c (HbA1c) ≥ 9%; or postprandial blood glucose ≥ 250 mg/dL.

Poorly controlled hypertension: Blood pressure levels not adequately controlled, resulting in systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg, despite treatment with antihypertensive medications.

Significant cardiac arrhythmias: Characterized by alterations in heart rate, disruptions in cardiac conduction, or hemodynamic instability. Examples of significant cardiac arrhythmias include ventricular fibrillation, ventricular tachycardia, atrial fibrillation, supraventricular tachycardia, bradyarrhythmia, and Torsades de pointes.

Symptomatic cardiac arrhythmias: Characterized by symptoms such as abnormal heart rhythm, palpitations, dyspnea, angina, and syncope. Examples of symptomatic cardiac arrhythmias include atrial fibrillation, ventricular tachycardia, supraventricular tachycardia, and bradyarrhythmia.

RELATED GUIDELINES:

None applicable.

OTHER:

Medicare ASC Procedures List: https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 07/24/25.

GUIDELINE UPDATE INFORMATION:

10/01/25	New Medical Coverage Guideline.
01/01/26	Annual CPT/HCPCS Coding Update. Code 55700 deleted.