



## Kaiser Foundation Health Plan of Washington

### Clinical Review Criteria

#### Elective Surgical Procedures (Level of Care Policy)

- Bariatric
- Cardiac Catheterization
- ENT
- General Surgery
- Gynecology
- Orthopedic
- Pacemaker
- Spine
- Urology

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### Criteria

#### For Medicare Members

Source	Policy
Code of Federal Regulations (CFR)	<a href="#">42 CFR 412.3</a>
CMS Coverage Manuals	<a href="#">Hospital Outpatient Regulations and Notices</a>
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article (LCA)	None
Kaiser Permanente Medical	Due to the absence of an active NCD, LCD, or other coverage guidance, Kaiser Permanente has chosen to use their own Clinical Review Criteria, " <b>Elective Surgical Procedures</b> " for <i>level of care medical necessity determinations</i> . Refer to the Non-Medicare criteria below.

#### For Non-Medicare Members

When requesting Inpatient Level of Care for certain *elective* surgical procedures (not those typically done in an ambulatory surgery center), the request will be reviewed for coverage in the most appropriate, safe, and cost-effective level of care. A member's clinical presentation may be appropriate for an alternate level of care such as a hospital-based outpatient setting.

Examples include but are not limited to Pacemaker Placement or Cardiac Catheterization, Bariatric Surgery Procedures, and General Surgery Procedures.

Some elective surgical procedures may also be subject to medical necessity review in addition to level of care criteria below:

- [Bariatric Surgery](#)
- [Cardiac Defibrillators](#)
- [Cardiac Pacemakers](#)
- [Cervical Fusion](#)
- [Lumbar Fusion](#)

[Minimally Invasive Lumbar Decompression](#)  
[Total Hip Arthroplasty](#)  
[Total Knee Arthroplasty](#)

A planned elective admission for certain surgeries or procedures is considered medically necessary at an inpatient level of care when any of the following criteria is met:

- Medical conditions increasing the risk of major post-operative complications:
  - Advanced liver disease (MELD Score >8)
  - Cognitive status that warrants inpatient stay
  - Severe renal disease (GFR  $\leq$  30mL/min)
  - Severe valvular heart disease
  - Stroke or TIA within the last 3 months
  - Symptomatic chronic lung disease (e.g., asthma, COPD)
  - Symptomatic coronary artery disease or heart failure
  - Unstable medical condition (e.g., poorly controlled diabetes)
- Procedure related factors that may increase the risk of complications:
  - Anesthetic risk
    - [American Society of Anesthesiologists class III or greater](#)
    - Age 85 years or older
    - High risk for thromboembolism
    - [Moderate \(AHI 15-30\) to severe \(AHI >30\) sleep apnea](#)
    - Persistent electrolyte abnormalities unresponsive to treatment (e.g., hyperkalemia, hyponatremia)
    - Risk of postoperative airway compromise (e.g., open neck procedure, airway surgery)
  - Complexity of surgical procedure
    - Complex surgical approach (e.g., unusually extensive dissection needed)
    - Complex post-operative wound care (e.g., complex drain management, open wound, previous local tissue injury resulting from factors such as radiation, previous surgery, impaired circulation, sustained pressure)
    - Difficult approach because of previous operation
    - Extensive or prolonged (longer than the usual time frame) surgery
- The need for preoperative diagnostic studies that cannot be performed as an outpatient
- Procedural related event that may require an inpatient stay as indicated by the following:
  - [Acute Kidney Injury](#)
  - Altered mental status that is severe or persistent
  - Ambulatory or appropriate activity level status is not achieved
  - Conversion to open or complex procedure that requires inpatient care
  - Excessive drainage or bleeding from the operative site
  - [Hemodynamic instability](#)
  - Longer postoperative monitoring or treatment is needed due to preoperative use of drugs (e.g., cocaine, amphetamines)
  - Pain, fever, or vomiting not appropriate for ambulatory or observation level of care
  - Severe complications of procedure (e.g., bowel injury, airway compromise, vascular injury)
  - Unstable clinical status

### **Definitions**

**ASA physical Status Classification System Risk Scoring tool:** 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. Current Definitions and ASA-Approved examples found [HERE](#).

**Apnea Hypopnea Index (AHI):** The number of apneas plus the number of hypopneas during the entire sleeping period, times 60, divided by total sleep time in minutes; unit: event per hour

**Acute Kidney Injury:** Acute Kidney Injury is defined as any of the following:

- Increase in the serum creatinine value of  $\geq$  0.3 mg/dL (26.52 micromol/L) in 48 hours

- Increase in serum creatinine of  $\geq 1.5$  times baseline within the prior 7 days
- Reduction of more than 50% in estimated glomerular filtration rate from baseline
- Urine volume  $< 0.5$  mL/kg/hour for 6 hours (KDIGO, 2021)

**Hemodynamic Instability:**

Hemodynamic instability, as indicated by **1 or more** of the following:

- Vital sign abnormality not readily corrected by appropriate treatment, as indicated by **1 or more** of the following:
  - Tachycardia that persists despite appropriate treatment (eg, volume repletion, treatment of pain, treatment of underlying cause)
  - Hypotension: systolic blood pressure  $< 90$  mm hg or decrease in systolic blood pressure  $> 40$  mm hg
  - Mean arterial pressure less than 70 mm Hg
  - Orthostatic hypotension that persists despite appropriate treatment (eg, volume repletion)
  - Altered level of consciousness
  - Shortness of breath

**If requesting these services, for inpatient level of care, please send the following documentation to support medical necessity:**

- Last 6 months of clinical notes from requesting provider &/or specialist
- Attending provider must provide documentation in the prior authorization request that supports the need to have an overnight stay of greater than 2 midnights.

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

**Background**

Surgery may safely be performed in various settings. Some of the common settings used are an inpatient hospital or medical center, an off-campus outpatient hospital or medical center, or an on campus outpatient hospital. Costs for surgical procedures may vary among these different settings. To encourage the use of the most safe and appropriate, cost effective sites of service for certain medically necessary outpatient surgical procedures, prior authorization is required for the site of service for the surgical procedures listed below.

**Applicable Codes**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific contract and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

**Bariatric Surgery codes—**

**Non-Medicare:** Requires review when submitted as an inpatient level of care

**Medicare:** Medicare inpatient only procedures indicated with an “X” below, and this policy does not apply

CPT® or HCPCS Codes	Description	Medicare <i>IP Only List</i>
<b>Laparoscopic Roux-en-Y</b>		
<i>*Requires separate medical necessity review with <a href="#">Bariatric Surgery criteria</a></i>		
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	X

43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	X
<b>Lap Band Procedure</b>		
<i>*Requires separate medical necessity review with <a href="#">Bariatric Surgery criteria</a></i>		
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	X
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	
<b>Laparoscopic Gastric Sleeve</b>		
<i>*Requires separate medical necessity review with <a href="#">Bariatric Surgery criteria</a></i>		
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	X

**Cardiac Procedure Codes—****Non-Medicare:** Requires review when submitted as an inpatient level of care**Medicare:** Medicare inpatient only procedures indicated with an “X” below, and this policy does not apply

CPT® or HCPCS Codes	Description	Medicare  IP Only List
<b>Cardiac Catheterization</b>		
0523T	Intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded FFR values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention (List separately in addition to code for primary procedure)	
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	
92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	
92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)	
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	
92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)	

92978	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)	
92979	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	
93505	Endomyocardial biopsy	
93563	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	
93564	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during	

	congenital heart catheterization, when performed (List separately in addition to code for primary procedure)	
93565	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)	
93566	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	
93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supra-avalvular aortography (List separately in addition to code for primary procedure)	
93568	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)	
93569	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)	
93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)	
93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)	
93573	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)	
93574	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization (List separately in addition to code for primary procedure)	
93575	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel (List separately in addition to code for primary procedure)	
93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	
93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	
93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	
93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	
93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections	
93598	Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)	
<b>Pacemaker Placement</b>		
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	

33210	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)	
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	
33212	Insertion of pacemaker pulse generator only; with existing single lead	
33213	Insertion of pacemaker pulse generator only; with existing dual leads	
33214	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	
33223	Relocation of skin pocket for implantable defibrillator	
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	
33233	Removal of permanent pacemaker pulse generator only	
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	
33235	Removal of transvenous pacemaker electrode(s); dual lead system	
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	
33243	Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy	X
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction	
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed <i>*Requires separate medical necessity review with <a href="#">Pacemaker Clinical Review Policy</a></i>	
33271	Insertion of subcutaneous implantable defibrillator electrode <i>*Requires separate medical necessity review with <a href="#">Pacemaker Clinical Review Policy</a></i>	

33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed <i>*Requires separate medical necessity review with <a href="#">Pacemaker Clinical Review Policy</a></i>	
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed <i>*Requires separate medical necessity review with <a href="#">Pacemaker Clinical Review Policy</a></i>	

**ENT Procedure Codes—**

**Non-Medicare:** Requires review when submitted as an inpatient level of care

**Medicare:** Medicare inpatient only procedures indicated with an “X” below, and this policy does not apply

CPT® or HCPCS Codes	Description	Medicare <i>IP Only List</i>
<b><i>Thyroidectomy</i></b>		
60200	Excision of cyst or adenoma of thyroid, or transection of isthmus	
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	
60212	Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	
60225	Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	
60240	Thyroidectomy, total or complete	
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	
60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	X
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	
60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach	X
60271	Thyroidectomy, including substernal thyroid; cervical approach	
<b><i>Parathyroidectomy</i></b>		
60500	Parathyroidectomy or exploration of parathyroid(s);	
60502	Parathyroidectomy or exploration of parathyroid(s); re-exploration	

**General Surgery Codes—**

**Non-Medicare:** Requires review when submitted as an inpatient level of care

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CPT® or HCPCS Codes	Description	Medicare <i>IP Only List</i>
<b><i>Laparoscopic Appendectomy</i></b>		
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	X
44970	Laparoscopy, surgical, appendectomy	
<b><i>Laparoscopic Cholecystectomy</i></b>		
47562	Laparoscopy, surgical; cholecystectomy	
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	
47570	Laparoscopy, surgical; cholecystoenterostomy	X
<b><i>Hernia Repair (non-hiatal)—Femoral, inguinal, and umbilical</i></b>		
49505	Repair initial inguinal hernia, age 5 years or older; reducible	
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	
49520	Repair recurrent inguinal hernia, any age; reducible	



49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	
49525	Repair inguinal hernia, sliding, any age	
49550	Repair initial femoral hernia, any age; reducible	
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	
49555	Repair recurrent femoral hernia; reducible	
49557	Repair recurrent femoral hernia; incarcerated or strangulated	
49650	Laparoscopy, surgical; repair initial inguinal hernia	
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	
<b>Lumpectomy; Partial or Complete Mastectomy</b>		
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	
19303	Mastectomy, simple, complete	
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	
<b>Laparoscopic Nissen Fundoplication or Esophagogastric Fundoplasty</b>		
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	
<b>Lysis of adhesions by laparoscopy (without bowel ischemia, systemic toxicity) Laparotomy is Inpatient procedure</b>		
44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)	
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	X

**Gynecology Procedure Codes—**

**Non-Medicare:** Requires review when submitted as an inpatient level of care

**Medicare:** Medicare inpatient only procedures indicated with an “X” below, and this policy does not apply

CPT® or HCPCS Codes	Description	Medicare <i>IP Only List</i>
<b>Laparoscopic Hysterectomy</b>		
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less	
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g	
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less	
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g	
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g	
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	

58575	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed	X
<b><i>Vaginal Hysterectomy</i></b>		
58260	Vaginal hysterectomy, for uterus 250 g or less	
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	X
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	
58275	Vaginal hysterectomy, with total or partial vaginectomy	X
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	X
58290	Vaginal hysterectomy, for uterus greater than 250 g	
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	
<b><i>Anterior or Posterior Colporrhaphy</i></b>		
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	
57260	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;	
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	
<b><i>Laparoscopic Surgical Myomectomy, Oophorectomy, and/or Salpingectomy</i></b>		
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g	
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	
58672	Laparoscopy, surgical; with fimbrioplasty	
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)	
58679	Unlisted laparoscopy procedure, oviduct, ovary	
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	
59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	

**Orthopedic Procedure Codes—****Non-Medicare:** Requires review when submitted as an inpatient level of care**Medicare:** Medicare inpatient only procedures indicated with an “X” below, and this policy does not apply

CPT® or HCPCS Codes	Description	Medicare IP Only List
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<b>Total Knee Arthroplasty</b>		
<i>*Requires separate medical necessity review with <a href="#">Total Knee Arthroplasty Criteria</a></i>		
<b>27438</b>	Arthroplasty, patella; with prosthesis	
<b>27446</b>	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	
<b>27447</b>	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	
<b>27486</b>	Revision of total knee arthroplasty, with or without allograft; 1 component	X
<b>27487</b>	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	X
<b>27488</b>	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	X
<b>Total Hip Arthroplasty</b>		
<i>*Requires separate medical necessity review with <a href="#">Total Hip Arthroplasty Criteria</a></i>		
<b>27130</b>	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	
<b>27132</b>	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	X
<b>27134</b>	Revision of total hip arthroplasty; both components, with or without autograft or allograft	X
<b>27137</b>	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	X
<b>27138</b>	Revision of total hip arthroplasty; femoral component only, with or without allograft	X
<b>Total Shoulder Arthroplasty</b>		
<b>23335</b>	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	X
<b>23470</b>	Arthroplasty, glenohumeral joint; hemiarthroplasty	
<b>23472</b>	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	
<b>23473</b>	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	
<b>23474</b>	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	X

**Spine Procedure Codes—****Non-Medicare:** Requires review when submitted as an inpatient level of care**Medicare:** Medicare inpatient only procedures indicated with an “X” below, and this policy does not apply

<b>CPT® or HCPCS Codes</b>	<b>Description</b>	<b>Medicare IP Only List</b>
<b><i>Lumbar Discectomy, Foraminotomy, or Laminotomy (when elective and not at multiple levels)</i></b>		
<b>62380</b>	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar <i>*Requires separate medical necessity review with <a href="#">Minimally Invasive Lumbar Decompression</a> criteria</i>	
<b>63030</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	
<b>63035</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	

<b>63042</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	
<b>63044</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)	
<b><i>Cervical Discectomy or Microdiscectomy, foraminotomy, laminotomy</i></b>		
<b>63020</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	
<b>63040</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical	
<b>63043</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)	
<b>63075</b>	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace	
<b>63076</b>	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	
<b><i>Cervical Laminectomy</i></b>		
<b>0274T</b>	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic <i>*Requires separate medical necessity review with <a href="#">Minimally Invasive Lumbar Decompression criteria</a></i>	
<b>63045</b>	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	
<b>63050</b>	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;	X
<b>63051</b>	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)	X
<b>63081</b>	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	X
<b>63082</b>	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)	X
<b>63185</b>	Laminectomy with rhizotomy; 1 or 2 segments	X
<b>63190</b>	Laminectomy with rhizotomy; more than 2 segments	X
<b>63191</b>	Laminectomy with section of spinal accessory nerve	X
<b>63250</b>	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical	X
<b>63300</b>	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical	X
<b>63304</b>	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical	X
<b><i>Lumbar Laminectomy (when elective and without significant comorbid conditions)</i></b>		
<b>0275T</b>	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy	

	and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar <i>*Requires separate medical necessity review with <a href="#">Minimally Invasive Lumbar Decompression</a> criteria</i>	
<b>63005</b>	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	
<b>63012</b>	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)	
<b>63017</b>	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar	
<b>63047</b>	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	
<b>63048</b>	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	
<b>63056</b>	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	
<b>63057</b>	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)	
<b>63087</b>	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment	X
<b>63088</b>	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)	X
<b>63090</b>	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment	X
<b>63091</b>	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)	X
<b>63185</b>	Laminectomy with rhizotomy; 1 or 2 segments	X
<b>63190</b>	Laminectomy with rhizotomy; more than 2 segments	X
<b>63200</b>	Laminectomy, with release of tethered spinal cord, lumbar	X
<b>63252</b>	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar	X
<b>63267</b>	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	
<b>63272</b>	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar	X
<b><i>Cervical Fusion—Anterior</i></b>		
<b>22551</b>	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below C2 <i>*Requires separate medical necessity review with <a href="#">Cervical Fusion (Anterior or Posterior)</a> criteria</i>	
<b>22552</b>	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below	

	C2, each additional interspace (List separately in addition to code for separate procedure) <i>*Requires separate medical necessity review with <a href="#">Cervical Fusion (Anterior or Posterior)</a> criteria</i>	
<b>22554</b>	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 <i>*Requires separate medical necessity review with <a href="#">Cervical Fusion (Anterior or Posterior)</a> criteria</i>	
<b>22585</b>	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure) <i>*Requires separate medical necessity review with <a href="#">Cervical Fusion (Anterior or Posterior)</a> criteria</i>	
<b>22858</b>	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	
<b>Cervical Fusion—Posterior</b> <i>*Requires separate medical necessity review with <a href="#">Cervical Fusion (Anterior or Posterior)</a> criteria</i>		
<b>22600</b>	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	X
<b>22614</b>	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	
<b>Single Level Lumbar Fusion</b> <i>*Requires separate medical necessity review with <a href="#">Lumbar Fusion</a> criteria</i>		
<b>22533</b>	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	X
<b>22558</b>	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	X
<b>22586</b>	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace <i>*Requires separate medical necessity review with <a href="#">Medically necessary services</a> criteria</i>	X
<b>22612</b>	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	
<b>22630</b>	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar	
<b>22632</b>	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)	
<b>22633</b>	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar	
<b>22634</b>	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)	

**Urology Procedure Codes—**

**Non-Medicare:** Requires review when submitted as an inpatient level of care

**Medicare:** Medicare inpatient only procedures indicated with an “X” below, and this policy does not apply

CPT® or HCPCS Codes	Description	Medicare
		<i>IP Only List</i>

<b>Percutaneous Nephrostomy</b>		
<b>50080</b>	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	
<b>50081</b>	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	
<b>50432</b>	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	
<b>50433</b>	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	
<b>50695</b>	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	
<b>52334</b>	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	
<b>Transurethral Resection of the Prostate (TURP)</b>		
<b>52601</b>	Transurethral electro-surgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	
<b>52630</b>	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	
<b>Orchiectomy</b>		
<i>*May require separate medical necessity review with <a href="#">Gender Affirming Surgeries</a> criteria</i>		
<b>54520</b>	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	
<b>54522</b>	Orchiectomy, partial	
<b>54530</b>	Orchiectomy, radical, for tumor; inguinal approach	
<b>54535</b>	Orchiectomy, radical, for tumor; with abdominal exploration	
<b>54690</b>	Laparoscopy, surgical; orchiectomy	
<b>Laparoscopic Nephrectomy</b>		
<i>*May require separate medical necessity review with <a href="#">Kidney/Pancreas Transplant</a> OR <a href="#">Kidney Transplant</a> criteria</i>		
<b>50543</b>	Laparoscopy, surgical; partial nephrectomy	
<b>50545</b>	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	X
<b>50546</b>	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	X
<b>50547</b>	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	X
<b>50548</b>	Laparoscopy, surgical; nephrectomy with total ureterectomy	X
<b>Pyeloplasty</b>		
<b>50544</b>	Laparoscopy, surgical; pyeloplasty	
<b>Vesicovaginal Fistula Repair</b>		
<b>57330</b>	Closure of vesicovaginal fistula; transvesical and vaginal approach	
<b>Prostatectomy</b>		
<b>55810</b>	Prostatectomy, perineal radical	X

<b>55812</b>	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	X
<b>55815</b>	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	X
<b>55842</b>	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	X
<b>55845</b>	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	X
<b>55866</b>	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	
<b>Bladder Sling—vaginal approach</b>		
<b>51840</b>	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple	X
<b>51841</b>	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair)	X
<b>51845</b>	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)	
<b>51990</b>	Laparoscopy, surgical; urethral suspension for stress incontinence	
<b>51992</b>	Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)	
<b>57288</b>	Sling operation for stress incontinence (eg, fascia or synthetic)	
<b>57289</b>	Pereyra procedure, including anterior colporrhaphy	
<b>57287</b>	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	
<b>53440</b>	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	
<b>53442</b>	Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)	

**\*Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

\*\*To verify authorization requirements for a specific code by plan type, please use the [Pre-authorization Code Check](#).

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Date Created	Date Reviewed	Date Last Revised
11/1/2022	11/01/2022 <sup>MPC</sup> , 11/07/2023 <sup>MPC</sup>	07/11/2023

<sup>MPC</sup> Medical Policy Committee

Revision History	Description
11/01/2022	MPC approved the new Elective Surgical Procedures (Level of Care) criteria. Cardiac Catheterization/Pacemaker is the first approved elective procedure to be done on an outpatient basis. 60-day notice is required; effective April 1, 2023.
03/22/2023	Updated effective date to April 25 <sup>th</sup> , 2023.
07/11/2023	MPC approved to expand the scope of our current policy which has been restricted to two procedures to date. Requires 60-day notice. Effective date 12/01/2023
10/06/2023	Effective date changed to 12/05/2023.