KAISER PERMANENTE®

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

Criteria

For Medicare Members

Source	Policy
Code of Federal Regulations (CFR)	42 CFR 412.3
CMS Coverage Manuals	Hospital Outpatient Regulations and Notices
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, "***Elective Surgical Procedures"*** for *level of care medical necessity determinations*. 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

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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 ≤ 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 ≥ 0.3 mg/dL (26.52 micromol/L) in 48 hours

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- Increase in serum creatinine of ≥ 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 this 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 *IP Only List*
Laparoscopic Roux-en-Y **Requires separate medical necessity review with Bariatric Surgery criteria*		
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	X

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43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	X
Lap Band Procedure **Requires separate medical necessity review with Bariatric Surgery criteria*		
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	
Laparoscopic Gastric Sleeve **Requires separate medical necessity review with Bariatric Surgery criteria*		
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*
Cardiac Catheterization		
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)	

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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	

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	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 supravalvular 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)	
Pacemaker Placement		
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	

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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-leadless	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 **Requires separate medical necessity review with Leadless Pacemaker Clinical Review Policy*	

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33271-leadless	Insertion of subcutaneous implantable defibrillator electrode **Requires separate medical necessity review with Leadless Pacemaker Clinical Review Policy*	
33274-leadless	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 **Requires separate medical necessity review with Leadless Pacemaker Clinical Review Policy*	
33275-leadless	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed **Requires separate medical necessity review with Leadless Pacemaker Clinical Review Policy*	

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 *IP Only List*
Thyroidectomy		
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	
Parathyroidectomy		
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
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*
Laparoscopic Appendectomy		
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	X
44970	Laparoscopy, surgical, appendectomy	
Laparoscopic Cholecystecomy		
47562	Laparoscopy, surgical; cholecystectomy	
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	

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47570	Laparoscopy, surgical; cholecystoenterostomy	X
Hernia Repair (non-hiatal)—Femoral, inguinal, and umbilical		
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	
Lumpectomy; Partial or Complete Mastectomy		
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	
Laparoscopic Nissen Fundoplication or Esophagogastric Fundoplasty		
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	
Lysis of adhesions by laparoscopy (without bowel ischemia, systemic toxicity) Laparotomy is Inpatient procedure		
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 *IP Only List*
Laparoscopic Hysterectomy		
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)	

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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
Vaginal Hysterectomy		
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-urethrocystopexy (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	
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	
Anterior or Posterior Colporrhaphy		
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	
Laparoscopic Surgical Myomectomy, Oophorectomy, and/or salpingectomy		
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	
Bladder Sling—vaginal approach		
51840	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple	X
51841	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair)	X

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51845	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)	
51990	Laparoscopy, surgical; urethral suspension for stress incontinence	
51992	Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)	
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	
57289	Pereyra procedure, including anterior colporrhaphy	

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

CPT® or HCPCS Codes	Description	Medicare *IP Only List*

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Lumbar Discectomy, Foraminotomy, or Laminotomy (when elective and not at multiple levels)		
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar **Requires separate medical necessity review with Minimally Invasive Lumbar Decompression criteria*	
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	
63035	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)	
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	
63044	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)	
Cervical Discectomy or Microdiscectomy, foraminotomy, laminotomy		
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical	
63043	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)	
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	
Cervical Laminectomy		
0274T	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 **Requires separate medical necessity review with Minimally Invasive Lumbar Decompression criteria*	
63045	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	
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;	X
63051	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
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	X
63082	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

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63185	Laminectomy with rhizotomy; 1 or 2 segments	X
63190	Laminectomy with rhizotomy; more than 2 segments	X
63191	Laminectomy with section of spinal accessory nerve	X
63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical	X
63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical	X
63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical	X
Lumbar Laminectomy (when elective and without significant comorbid conditions)		
0275T	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 **Requires separate medical necessity review with Minimally Invasive Lumbar Decompression criteria*	
63005	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	
63012	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)	
63017	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	
63047	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	
63048	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)	
63056	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)	
63057	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)	
63087	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
63088	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
63090	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
63091	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
63185	Laminectomy with rhizotomy; 1 or 2 segments	X
63190	Laminectomy with rhizotomy; more than 2 segments	X
63200	Laminectomy, with release of tethered spinal cord, lumbar	X
63252	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar	X

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63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar	X
Cervical Fusion—Anterior		
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 **Requires separate medical necessity review with Cervical Fusion (Anterior or Posterior) criteria*	
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure) **Requires separate medical necessity review with Cervical Fusion (Anterior or Posterior) criteria*	
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 **Requires separate medical necessity review with Cervical Fusion (Anterior or Posterior) criteria*	
22585	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) **Requires separate medical necessity review with Cervical Fusion (Anterior or Posterior) criteria*	X
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	
Cervical Fusion—Posterior **Requires separate medical necessity review with Cervical Fusion (Anterior or Posterior) criteria*		
22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	X
22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	
Single Level Lumbar Fusion **Requires separate medical necessity review with Lumbar Fusion criteria*		
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	X
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	X
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace **Requires separate medical necessity review with Medically necessary services criteria*	X
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar	
22632	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)	
22633	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	
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace	

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	(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
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CPT® or HCPCS Codes	Description	Medicare *IP Only List*
Percutaneous Nephrostomy		
50080	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)	
50081	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)	
50432	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	
50433	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	
50695	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	
52334	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	
Transurethral Resection of the Prostate (TURP)		
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	
52630	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)	
Orchiectomy **May require separate medical necessity review with Gender Affirming Surgeries criteria*		
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	
54522	Orchiectomy, partial	
54530	Orchiectomy, radical, for tumor; inguinal approach	
54535	Orchiectomy, radical, for tumor; with abdominal exploration	
54690	Laparoscopy, surgical; orchiectomy	
Laparoscopic Nephrectomy **May require separate medical necessity review with Kidney/Pancreas Transplant OR Kidney Transplant criteria*		
50543	Laparoscopy, surgical; partial nephrectomy	

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50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	X
50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	X
50547	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	X
50548	Laparoscopy, surgical; nephrectomy with total ureterectomy	X
Pyeloplasty		
50544	Laparoscopy, surgical; pyeloplasty	
Vesicovaginal Fistula Repair		
57330	Closure of vesicovaginal fistula; transvesical and vaginal approach	
Prostatectomy		
55810	Prostatectomy, perineal radical	X
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	X
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	X
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy	X
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	X
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	

***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**.

Date Created	Date Reviewed	Date Last Revised
11/1/2022	11/01/2022 MPC	07/11/2023

MPC 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 25th, 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.

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