



CLINICAL MEDICAL POLICY	
Policy Name:	Place of Service
Policy Number:	MP-020-MD-PA
Responsible Department(s):	Medical Management
Provider Notice Date:	09/01/2017
Original Effective Date:	10/01/2017
Annual Approval Date:	08/01/2018
Revision Date:	N/A
Products:	Gateway Health SM Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 7

DISCLAIMER

Gateway HealthSM (Gateway) medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Gateway HealthSM provides coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary services performed as an outpatient.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

(Current applicable Pennsylvania HealthChoices Agreement Section V. Program Requirements, B. Prior Authorization of Services, 1. General Prior Authorization Requirements.)

DEFINITIONS

Prior Authorization Review Panel (PARP) – A panel of representatives from within the Pennsylvania Department of Human Services who have been assigned organizational responsibility for the review, approval and denial of all PH-MCO Prior Authorization policies and procedures. .

Outpatient Surgery Setting – Outpatient surgery is performed in a variety of settings including but not limited to: Ambulatory surgical centers freestanding, ambulatory surgical settings within a hospital setting, or physician office.

PROCEDURES

1. This policy addresses the place of service only and does not address medical necessity of specific procedures. Please refer to the Provider Manual for assistance with the process of determining medical necessity of the procedure.
2. When the services are not covered
Services identified as appropriate in the outpatient setting will not be reimbursed in the inpatient setting without a Gateway HealthSM Medical Director approval.
3. A procedure is considered appropriate in the outpatient setting when:
 - A. The procedure requires the services of the recovery room
 - B. Post-operative care can be managed at home

Note: if services require a higher level setting, supporting medical documentation must be provided at the time of the request.

4. Post-payment Audit Statement
The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Gateway HealthSM at any time pursuant to the terms of your provider agreement.
5. Place of Service
The place of service for procedure codes identified below is appropriate for outpatient.

CODING REQUIREMENTS

Covered Procedure Codes

Hysterectomy

CPT Codes	Description
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal tube(s), and or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 g or less with removal of tubes and/or ovary(s) with repair of enterocele
58270	Vaginal hysterectomy w/colp-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereya type) with or without endoscopic control w/repair of enterocele
58290	Vaginal hysterectomy with uterus greater than 250 g
58291	Vaginal hysterectomy with uterus greater than 250g; with removal of tube(s) or
58292	Vaginal hysterectomy with uterus greater than 250 g; with removal of tube(s) or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy for uterus greater than 250 g with repair of enterocele
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
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
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 greater than 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy , for uterus greater than 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)

Cholecystectomy

CPT Codes	Description
47562	Laparoscopy, surgical; cholecystectomy
47563	Laparoscopy, cholecystectomy with cholangiography
47564	Laparoscopy, cholecystectomy with exploration of common duct

REIMBURSEMENT

Participating facilities will be reimbursed per their Gateway HealthSM contract.

SUMMARY OF LITERATURE

Hysterectomy

The American Congress of Obstetricians and Gynecologists (ACOG) has identified the preferred method for hysterectomies to be vaginal. Per ACOG (2009), “evidence demonstrates that, in general, vaginal hysterectomy is associated with better outcomes and fewer complications than laparoscopic or abdominal hysterectomies.”

Place of Service

Outpatient Setting

- More hysterectomy procedures are being conducted in the outpatient setting
- Lower patient cost
- Benefits to infection incidence and length of stay

Minimally Invasive Techniques

- In hysterectomies, the use of minimally invasive techniques is on the rise within the outpatient setting
- Laparoscopic hysterectomies report a higher cost compared to open or vaginal procedures

Up To Date:

Patients who have laparoscopic hysterectomy without perioperative complication or comorbidities can be discharged home on the same day, or stay in the hospital overnight, typically one night. Observational studies have consistently found the same day discharge is safe and less costly and experience fewer postoperative complications.

As reported by Guta (2011), nineteen laparoscopically assisted vaginal hysterectomies and 17 total laparoscopic hysterectomies were performed. The 2 groups were similar in age, BMI, uterine weight, and surgical time. Comparing the 2 groups, there were no statistically significant differences in pain throughout any time points of the study.

The author concluded there were no statistically significant differences in pain during the postoperative period between the 2 groups. Outpatient hysterectomy is a safe procedure that may improve patient satisfaction surgically and financially, and either approach is well tolerated by patients.

Whiteman reported that gynecologic disorders accounted for 7% of all inpatient hospitalizations among reproductive age women that uterine leiomyoma was the most common diagnosis, and that 80% of women who were hospitalized for uterine leiomyoma, menstrual disorders, or endometriosis underwent hysterectomy. Overall costs and Medicare coinsurance rates are lower in ASCs.

An observational study on a comparison of postoperative outcomes in outpatient and inpatient laparoscopic hysterectomy procedures reported (Khavanin 2013) that overall morbidity was low in both the inpatient and outpatient populations. It was noted that there were significantly fewer 30-day complications observed in the outpatient group compared to the inpatient surgery group. The outpatient group experienced fewer wound complications, lower medical complications and deep vein thrombosis.

Cholecystectomy

One of the most common abdominal surgical procedures is cholecystectomy. In the United States, 90% are performed laparoscopically. Given the success with this operative approach, laparoscopic cholecystectomy is considered the gold standard for the surgical treatment of gallstone disease.

In 1999, Lillemoe, et al. reported on a retrospective analysis of 130 consecutive patients that underwent laparoscopic cholecystectomy in an outpatient surgery unit. A total of eight patients were admitted to the hospital following postanesthesia care, six of these eight patients were discharged on the first postoperative day. The authors concluded that laparoscopic cholecystectomy can be performed as true outpatients within hours of completion of the procedure. Less than 10% of patients will fail this protocol and another 5% may require hospitalization after returning to their homes.

Patients undergoing uncomplicated laparoscopic cholecystectomy for symptomatic cholelithiasis may be discharged home on the day of surgery (Tenconi, et al. 2008). Control of postoperative pain, nausea, and vomiting are important to successful same day discharge, and admission rates despite planned same day discharge are reported to be 1-39%; patients older than age 50 may be at increased risk for admission (Kasem, et al. 2006). Readmission rates range from 0-8%; common causes for readmission after same day discharge include pain, intra-abdominal fluid collections, bile leaks, and bile duct stones (Sherigar, et al. 2006). Time to discharge after surgery for patients with acute cholecystitis, bile duct stones, or in patients converted to an open procedure should be determined on an individual basis.

Per the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) in 2010, the length of stay guidelines for laparoscopic cholecystectomy includes:

- Patients undergoing uncomplicated laparoscopic cholecystectomy for symptomatic cholelithiasis may be discharged home on the day of surgery; control of postoperative pain, nausea, and vomiting are important to successful same day discharge. (Level II, Grade B)
- Patients older than age 50 may be at increased risk for admission. (Level II, Grade B).
- Time to discharge after surgery for patients with acute cholecystitis, bile duct stones, or in patients converted to an open procedure should be determined on an individual basis. (Level III, Grade A).

In 2013, Vaughan et al. performed a review of randomized clinical trials comparing day-surgery versus overnight stay surgery for laparoscopic cholecystectomy. It was reported that day-surgery seems to be as safe as overnight stay surgery. There was no improvement in any patient-oriented outcomes such as a return to normal activity or earlier return to work. The authors stated that more randomized clinical trials are needed to assess the impact of day-surgery laparoscopic cholecystectomy on the quality of life and other patient outcomes.

Vaughan et al. (2013) reported that most otherwise healthy, reliable patients with good home support can leave the hospital six hours after surgery. Cochrane reviews have found no significant differences for important clinical outcomes for patients discharged the same day versus admitted overnight following laparoscopic cholecystectomy.

POLICY SOURCE(S)

Kisic-Trope J, Qvigstad E, Ballard K. A randomized trial of day-case vs inpatient laparoscopic supracervical hysterectomy. *Am J Obstet Gynecol* 2011; 204:307.e1-8. Accessed on May 17, 2016, and abstract available at: <http://www.sciencedirect.com/science/article/pii/S0002937810022684>.

Alperin M, Kivnick S, Poon, KYT. Outpatient laparoscopic hysterectomy for large uteri. *Journal Minim Invasive Gynecol*. Dec 2012;19(6): 689-694. Accessed on May 17, 2016 and available at: https://www.researchgate.net/publication/232530152_Outpatient_Laparoscopic_Hysterectomy_for_Large_Uteri.

Hospital Outpatient Prospective Payment System Rulemaking. Centers for Medicare & Medicaid Services. Accessed on May 17, 2016 and available at: <https://www.gov/cms/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>.

Additions to List of ASC Covered Surgical Procedures for CY 2016. Table 68. *Federal Register* 80(219), November 13, 2015: p 70490. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/html/2015-27943.htm>.

Guta G. Outpatient laparoscopic hysterectomy: evaluation of pain. *Journal Society Laparoendoscopic Surgeon*. 2011 Jul-Sep, 15(3): 346-349. Accessed on May 17, 2016 and available at: <http://europepmc.org/articles/PMC3183569>.

Whiteman MK, Kuklina E, Jamieson DJ, Hillis SD, Marchbanks PA. Inpatient hospitalization for gynecologic disorders in the United States. *Am J Obstet Gynecol*. 2010; 541–543 [PubMed]. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20132921>.

Medicare co-insurance rates are lower in ASCs than in hospitals. MedPAC, Report to the Congress: Medicare Payment Policy, March 2014. Available at: http://www.medpac.gov/docs/default-source/reports/mar14_ch05.pdf?sfvrsn=0.

Tsai LJ, Kahn, BS. Should you offer outpatient hysterectomy? *Contemporary OB/GYN*. Oct 2011; 56:10; 49-55. Accessed on May 17, 2016 and available at: <http://contemporaryobgyn.modernmedicine.com/contemporary-obgyn/news/modernmedicine/modern-medicine-now/should-you-offer-outpatient-hysterectomy?page=full>.

Khavanin N, Mlodinow A, Milad MP, Bilimoria KY, Kim JY. Comparison of perioperative outcomes in outpatient and inpatient laparoscopic hysterectomy. *J Minim Invasive Gynecol*. 2013 Sep; 20(5):604-10. Epub 20136 May 11. Accessed on May 17, 2016 and available at: <http://www.uptodate.com/contents/laparoscopic-hysterectomy/abstract/53?utdPopup=true>.

Vaughan J, Gurusamy KS, Davidson BR. Day-surgery versus overnight stay surgery for laparoscopic cholecystectomy. *Cochrane Database Syst Rev*. 2013; 7:CD006798. Accessed on May 17, 2016 and available at: <http://www.uptodate.com/contents/laparoscopic-cholecystectomy/abstract/89?utdPopup=true>.

Lillemoe KD, Lin JW, Talamini MA, Yeo CJ, Snyder DS, Parker SD. Laparoscopic cholecystectomy as a “true” outpatient procedure: initial experience in 130 consecutive patients. *J Gastrointest Surg*. 199 Jan-Feb; 3(1): 44-9. Accessed on May 17, 2016, and abstract available at: <http://www.ncbi.nlm.nih.gov/pubmed/10457323>.

Lam D, Miranda R, Hom SJ. Laparoscopic cholecystectomy as an outpatient. *J AM Coll Surg*. 1997 Aug; 185(2):152-5. Accessed on May 19, 2016 and available at: <http://www.ncbi.nlm.nih.gov/pubmed/9249082>.

Psaila J, Agrawal S, Fountain U, et al. Day-surgery laparoscopic cholecystectomy: factors influencing same-day discharge. *World J Surg* 2008; 32:76-81. Accessed on May 25, 2016 and available at: http://www.aslcn1.it/fileadmin/Formazione_corso_base/G/Tonelli_Eliana/articolo_2.pdf.

Tenconi SM, Boni L, Colombo EM, Dionigi G, Rovera F, Cassinotti E. Laparoscopic cholecystectomy as day-surgery procedure: current indications and patients’ selection. *Int J Surg* 2008; 6 Suppl 1:S86-8. Accessed on May 25, 2016 and available at: [http://www.journal-surgery.net/article/S1743-9191\(08\)00208-2/pdf](http://www.journal-surgery.net/article/S1743-9191(08)00208-2/pdf).

Kasem A, Paix A, Grandy-Smith S, El-Hasani S. Is laparoscopic cholecystectomy safe and acceptable as a day case procedure? *J Laparoendosc Adv Surg Tech A* 2006; 16:365-8. Accessed on May 19, 2016 and available at: [http://www.journal-surgery.net/article/S1743-9191\(16\)30182-0/pdf](http://www.journal-surgery.net/article/S1743-9191(16)30182-0/pdf).

Sherigar JM, Irwin GW, Rathore MA, Khan A, Pillow K, Brown MG. Ambulatory laparoscopic cholecystectomy outcomes. *JSL* 2006; 10:473-8. Accessed on May 25, 2016 and available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3015767/>.

Society of American Gastrointestinal Endoscopic Surgeons (SAGES). Statement on: Guidelines for the clinical application of laparoscopic biliary tract surgery. Jan 2010. Accessed on May 19, 2016 and available at: <http://www.sages.org/publications/guidelines/guidelines-for-the-clinical-application-of-laparoscopic-biliary-tract-surgery/>.

Richardson WS, Fuhrman GS, Burch E, Bolton JS, Bowen JC. Outpatient laparoscopic cholecystectomy. *Surgical Endoscopy* Feb 2001; 15(2):193-195. Accessed on May 19, 2016 and available at: <http://link.springer.com/article/10.1007/s004640000301>.

Csikesz NG, Singla A, Murphy MM, et al. Surgeon volume metrics in laparoscopic cholecystectomy. *Dig Dis Sci* 2010; 55:2398. Accessed on May 19, 2016 and abstract available at: <http://link.springer.com/article/10.1007/s10620-009-1035-6>.

Wier LM, Steiner CA, Owens PL. Surgeries in hospital-owned outpatient facilities, 2012. Statistical Brief #188. Healthcare Cost and Utilization Project (HCUP). May 2016. Agency for Healthcare Research and Quality, Rockville, MD. Accessed on May 25, 2016 and available at: <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb188-Surgeries-Hospital-Outpatient-Facilities-2012.jsp>.

American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion No. 444: Choosing the route of hysterectomy for benign disease. Obstet Gynecol 2009; 114:1156-1158. (Reaffirmed 2011). Accessed on May 19, 2016 and available at: <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Choosing-the-Route-of-Hysterectomy-for-Benign-Disease>.

Policy History

Date	Activity
06/15/2016	QI/UM Committee Approval
06/20/2016	PARP approval of UM InterQual Changes on Place of Service
09/01/2016	Provider effective date
01/01/2017	Annual Review. Policy revised: Added Policy History box; Changed Operational Guidelines from post-service to preservice
08/02/2017	PARP approval annual review: Revision of language in #2 criteria of Procedures stating inpatient requests must be approved by medical director.
10/01/2017	Revised Provider Effective Date