

BSC10.01	Place of Service Policy for Outpatient Procedures		
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Section:	10.0 Administration	Page:	Page 1 of 22

Policy Statement

Outpatient Hospital Surgical Facility

- I. The use of an outpatient hospital surgical facility (as reflected in a place of service [POS] code of 19 or 22) may be considered **medically necessary** when **EITHER** of the following criteria are met:
 - A. The individual poses a clinical risk for having the procedure take place in a less intensive setting, such as an ambulatory surgical center (i.e., POS code 24) or an office setting (i.e., POS code 11), due to **ANY** of the following conditions:
 1. Advanced liver disease (MELD score > 8)
 2. Preoperative planning indicates the need for overnight postoperative monitoring or care
 3. Anticipated need for blood transfusion
 4. Bleeding disorder requiring factor replacement, blood products, or specialized infusion therapy
 5. Symptomatic cardiac arrhythmia despite medical therapy
 6. Chronic obstructive pulmonary disease (COPD) with FEV1 < 50%
 7. Ongoing coronary artery disease (CAD) or peripheral vascular disease (PVD) or having a drug-eluting coronary stent placed within the prior 12 months
 8. Developmental stage or cognitive impairment requiring hospital outpatient resources
 9. End-stage renal disease (ESRD), hyperkalemia, or need for peritoneal or hemodialysis
 10. Cerebrovascular accident (CVA) or transient ischemic attack (TIA) within the past 3 months
 11. Myocardial infarction (MI) within the past 3 months
 12. Coronary intervention history such as **EITHER** of the following:
 - a. Drug-eluting stent (DES) within 12 months
 - b. Bare-metal stent (BMS) or percutaneous angioplasty within 90 days, unless continuation of antiplatelet therapy is agreed upon by the surgeon, cardiologist, and anesthesia provider
 13. Ongoing evidence of myocardial ischemia
 14. Poorly controlled asthma (FEV1 < 80% despite optimal medical management)
 15. Pregnancy
 16. Expected operative or anesthesia time greater than 3 hours
 17. Treatment resistant hypertension (refractory hypertension despite at least three antihypertensive medications⁸)
 18. Severe valvular heart disease
 19. Moderate to severe [obstructive sleep apnea \(OSA\)](#)
 20. Uncompensated chronic heart failure (CHF) (NYHA Class III or IV)
 21. Uncontrolled diabetes with recurrent diabetic ketoacidosis (DKA) or severe hypoglycemia
 22. Age under 18 years
 - B. An appropriate ambulatory surgery center (ASC) is not reasonably accessible for the procedure due to **ANY** of the following:

1. The ASC's written clinical guidelines or policies exclude the member due to medical conditions or weight limitations
2. No geographically accessible ASC has the required equipment to safely perform the procedure, including but not limited to:
 - a. Fluoroscopy
 - b. Laser technology
 - c. Ocular surgical equipment
 - d. Operating microscope
 - e. Specialized scopes (e.g., duodenoscope, ureteroscope)
3. No geographically accessible ASC exists at which the treating physician holds the necessary procedural privileges

Ambulatory Surgery Center

- II. The use of an ambulatory surgery center (ASC) may be considered **medically necessary** on an ambulatory basis when **all** of the following criteria are met:
 - A. Immediate access to unique services of a medical center or hospital setting including, but not limited to post-operative recovery in an inpatient facility is not anticipated to be required for the preoperative disease or condition being treated or due to co-morbidities (e.g., infection, coagulopathy, altered mental status, dangerous arrhythmia, hypotension, hypoxemia, tachycardia, tachypnea)
 - B. The treating health care professional has privileges for the requested procedure at an ASC
 - C. In the event of unforeseen complications requiring an inpatient level of care, the requesting provider must either have the ability to care for the patient in the inpatient setting (including privileges) or have a written agreement in place with another qualified provider to accept and care for the patient if a transfer to an inpatient facility is needed
 - D. ASC must be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC)¹ or the Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations [JCAHO])
 - E. Procedure is non-emergent
 - F. Procedure is low-risk or patient is not a high anesthetic risk (or high-risk for surgery; see Policy Guidelines section)
 - G. Cardiac clearance has been done for patients with stents and arrhythmias not considered to be low risk
 - H. There is no significant increased risk related to drugs (see Policy Guidelines section)
 - I. There is no significant risk due to living situation (outpatient care; see Policy Guidelines section)
 - J. Patient is cooperative and able to understand and follow instructions
 - K. Patient has good social support readily available to assist with **any** of the following if needed:
 1. Pre-operative preparatory education
 2. Accompany the patient home
 3. Accompany the patient to their physical therapy and post-operative appointments as needed until the patient is independently mobile
- III. The use of an Ambulatory Surgery Center (ASC), instead of a higher level of care, is considered **not medically necessary** for patients requiring a complex surgical approach or situation, including but not limited to any of the following:
 - A. Open approach is required instead of the usual endoscopic, transcatheter, or other less invasive procedure
 - B. A difficult approach is required due to a previous operation
 - C. Airway monitoring is required after open neck or other procedure

- D. Medical conditions that are commonly associated with a difficult airway (e.g., Pierre Robin, Treacher-Collins, Goldenhar's Syndrome, Epidermolysis Bullosa)
- E. Unusually extensive dissection is needed
- F. Additional complicating factor requiring inpatient care (e.g., complex drain management)

Inpatient Hospital Facility

- IV. Use of an inpatient hospital facility (i.e., POS code 21) solely for a procedure that could safely be performed in an outpatient setting is considered **not medically necessary**.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Out of Scope:

- Services designated by the Centers for Medicare & Medicaid Services (CMS) as "inpatient-only" are considered not appropriate for performance in an outpatient setting. As such, these services fall outside the scope of this policy.
- Medical necessity of the procedure itself may be reviewed separately under applicable medical policy criteria.
- Place-of-service review for radiologic procedures is excluded and is delegated to Evolent under the radiology place-of-service policy (Evolent_POS_2067).
- Emergency procedures that necessitated care in an inpatient setting.

Definitions:

1. Place of Service (POS): is the code that is applied to claims to describe where a medical procedure was performed. It impacts reimbursement to the provider and determines whether a procedure qualifies for specific programs. The list below reflects the POS codes that are applicable to this policy.
 - a. POS code 21 - Inpatient hospital or medical center
 - A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
 - b. POS code 22 - On campus outpatient hospital or medical center
 - A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
 - Location is within 250 yards of the main building.
 - c. POS code 19 - Off campus outpatient hospital or medical center
 - A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
 - Location is more than 250 yards from the main building.
 - d. POS code 24 - Ambulatory surgical center
 - A freestanding outpatient facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
 - e. POS code 11 - Office
 - Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely

provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Coding

See the [Codes table](#) for details.

Description

This policy helps determine the most appropriate setting for a procedure (such as outpatient, ambulatory surgery center, or hospital). The goal is to ensure care is delivered in a safe and appropriate environment based on the patient's clinical needs, while supporting high-quality outcomes.

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable member health services contract language. To the extent there are conflicts between this Medical Policy and the member health services contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal law may prohibit health plans from denying FDA-approved Healthcare Services as investigational or experimental. In these instances, Blue Shield of California may be obligated to determine if these FDA-approved Healthcare Services are Medically Necessary.

Rationale**Background****Place of Service Codes**

Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.¹² The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry.

This code set is required for use in the implementation guide adopted as the national standard for electronic transmission of professional health care claims under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¹² HIPAA directed the Secretary of HHS to adopt national standards for electronic transactions. These standard transactions require all health plans and providers to use standard code sets to populate data elements in each transaction. The Transaction and Code Set Rule adopted the ASC X12N-837 Health Care Claim: Professional, volumes 1 and 2, version 4010, as the standard for electronic submission of professional claims. This standard names the POS code set currently maintained by CMS as the code set to be used for describing sites of service in such claims. POS information is often needed to determine the acceptability of direct billing of Medicare, Medicaid and private insurance services provided by a given provider.¹²

Difference Between POS 19 and POS 24

Off-campus outpatient hospitals (POS 19) are subject to hospital Conditions of Participation (CoP) and provider-based requirements, including broader patient safety, emergency capability, and

regulatory oversight, compared to ambulatory surgical centers (POS 24), which are limited to same-day surgical services under defined Conditions for Coverage (CfC).¹⁰

Due to these differences in regulatory oversight, patient safety capabilities, and operational complexity, requests for services in POS 19 may require more stringent clinical review to ensure the higher-intensity hospital-based setting is medically necessary when compared to POS 24. In addition, hospital outpatient departments (including POS 19) are generally associated with higher facility costs relative to ambulatory surgical centers.¹¹ Therefore, consistent with Blue Shield of California's utilization management principles, both clinical appropriateness and cost-effectiveness are considered, and the least intensive and least costly setting that can safely and effectively provide the service is expected whenever feasible.

As a part of Blue Shield of California's mission to provide access to quality and affordable care for its members, the health plan may direct members planning to undergo elective procedures to an ambulatory surgery center (ASC) to receive care that is provided by qualified non-hospital-owned surgery centers. This medical policy also allows an eligible member to receive elective procedures at their personal physician's office when performed by a licensed and qualified clinician. Guiding a member to receive care in a setting that best addresses their individual needs may reduce their out-of-pocket cost.

Ambulatory Surgery Centers

Ambulatory surgery centers, or ASCs, are facilities where surgeries that do not require hospital admission are performed. ASCs are facilities that provide surgical procedures exclusively on an outpatient basis. ASCs provide cost-effective services and a convenient environment that is less stressful than what many hospitals can offer. Patients who choose to have surgery in an ASC arrive on the day of their procedure, have their surgery in a fully equipped operating room and recover under the care of highly skilled nurses, all without hospital admission. Whether they are young or old or somewhere in between, patients and their families benefit from the comfortable environment ASCs offer.

ASCs may perform surgeries in several specialties or dedicate their services to one specialty, such as eye care or pain management.

ASCs are *not* physicians' offices, rural health clinics, urgent care centers or ambulatory care centers that provide diagnostic or primary health care services. ASCs treat only patients who have already seen a health care provider and selected surgery as the appropriate treatment for their condition. All ASCs must have at least one dedicated operating room and the equipment needed to perform surgery safely and ensure quality patient care.

The first ASCs were established in the early 1970s, with Medicare first offering coverage for ASC services under Part B in 1982. At that time there were only 30 surgical procedures that met government guidelines for coverage. Since the 1980s, the share of surgeries performed in outpatient settings has grown significantly. In 1981, approximately 81 percent of surgeries were performed in hospitals on an inpatient basis. By 1999, inpatient surgeries represented only 37 percent of all surgeries, compared to 63 percent for outpatient surgeries. These shares have remained stable for the past several years.¹⁶

At the same time, there has been a steady movement of surgery away from hospital outpatient settings toward ASC and physician offices. In 1981, the vast majority (93 percent) of outpatient surgeries were performed in hospital outpatient departments. The share of surgeries performed in hospital outpatient departments (HOPDs) (or hospital-owned facilities) fell to 45 percent by 2005, with the share of surgeries performed in freestanding facilities increasing almost four-fold.¹⁶

In 2008, there were approximately 5,149 Medicare-certified ASCs in the United States, excluding 23 ASCs located in Puerto Rico and 2 in Guam. This number has increased steadily over the past ten years. The vast majority of ASCs remain under private ownership. The number of HOPDs, on the other hand, has remained fairly stable over the years, despite an overall increasing trend in the number of outpatient surgeries. There were slightly more than 4,800 HOPDs in 2008. ASCs are concentrated heavily in California, Florida, and Texas, with 694, 387, and 347 facilities in each state in 2008, respectively.¹⁶

Literature Review

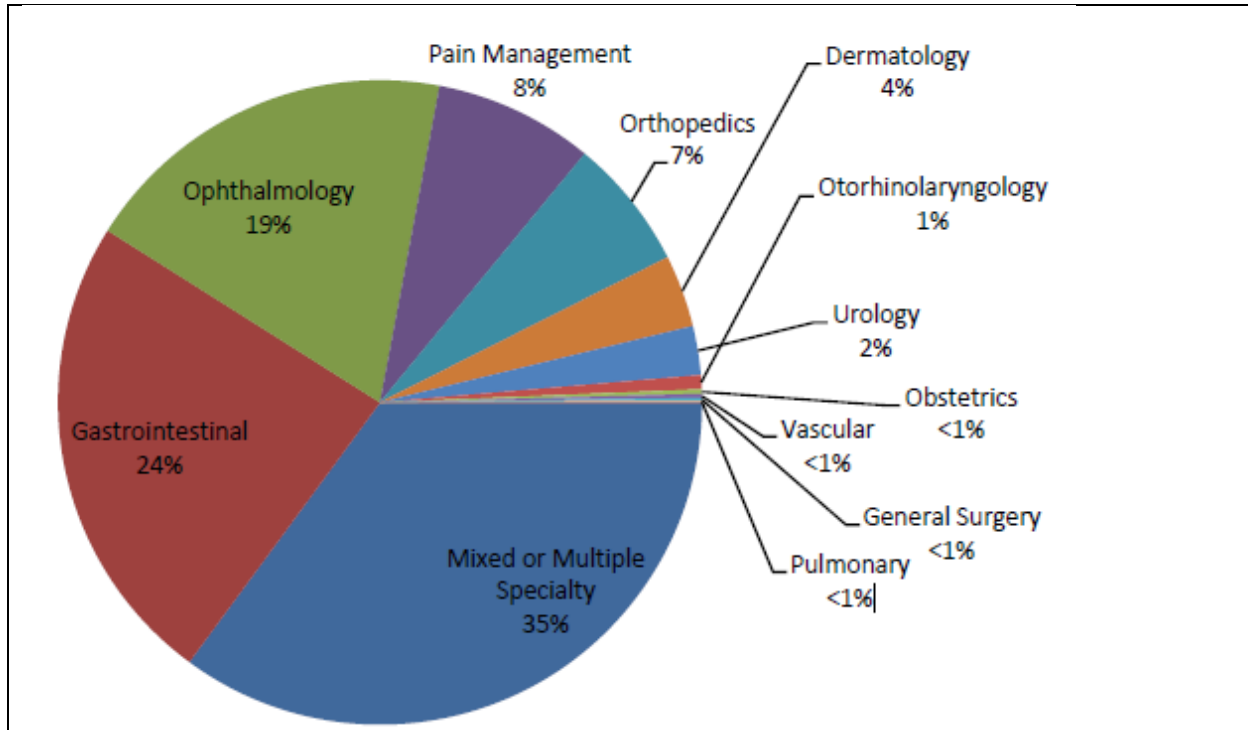
Appropriate Level of Care

Outpatient surgical procedures should be performed at the lowest appropriate level of care consistent with patient safety. According to the Centers for Medicare & Medicaid Services (CMS), ASC-covered surgeries are those that do not pose significant safety risk and typically do not require active monitoring beyond the day of surgery. Procedures with a high likelihood of major bleeding, invasive intra-abdominal or intra-thoracic involvement, emergent nature, or other factors necessitating overnight medical observation are excluded from Medicare's ASC list. This federal standard underpins Blue Shield's policy that certain high-complexity or high-risk surgeries are not appropriate in a free-standing ASC setting⁶.

National specialty consensus further indicates that stringent patient selection is critical for ambulatory surgery. Patients with limited systemic disease (e.g., ASA Physical Status I or II) – or carefully selected III – and whose procedure is of moderate complexity are generally suitable for an ASC. In contrast, patients with severe comorbid conditions (e.g., ASA class IV or unstable III) or those requiring potential hospital-level post-operative care should have their surgery in a hospital outpatient facility³. This approach is supported by guidelines from anesthesiology and surgical societies, which call for matching the surgical setting to the patient's health status and needs⁵. Thus, the policy criteria (e.g., regarding ASA class, cardiac/pulmonary risk factors, or need for overnight monitoring) reflect evidence-based best practices to ensure patient safety and optimal outcomes.

Specialties Served in Ambulatory Surgery Centers

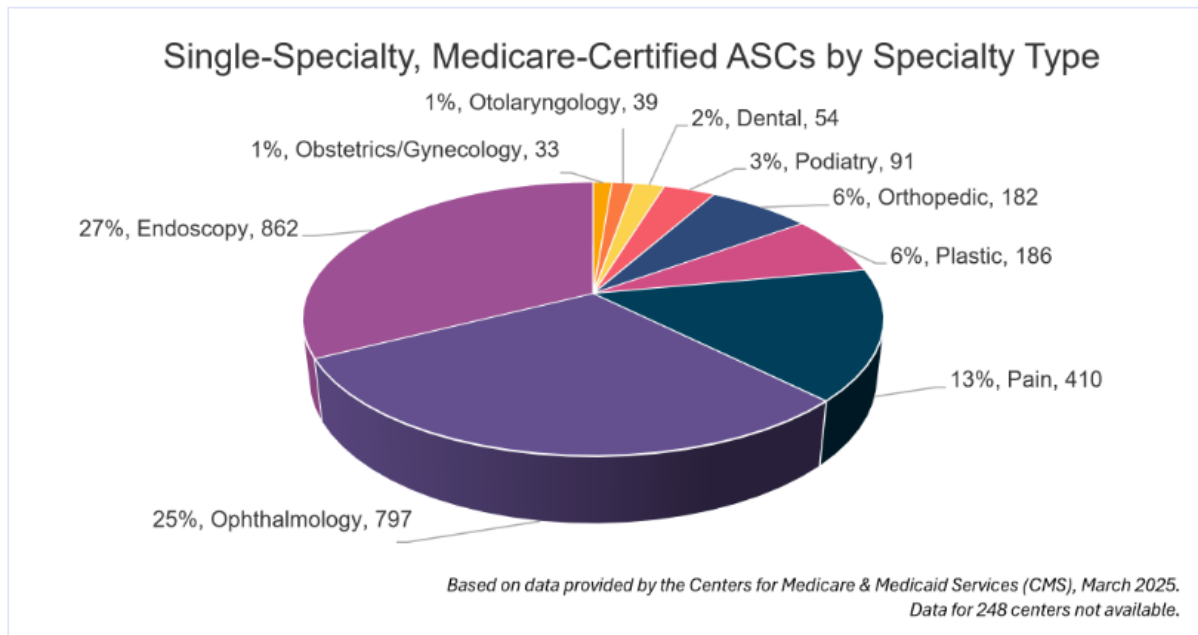
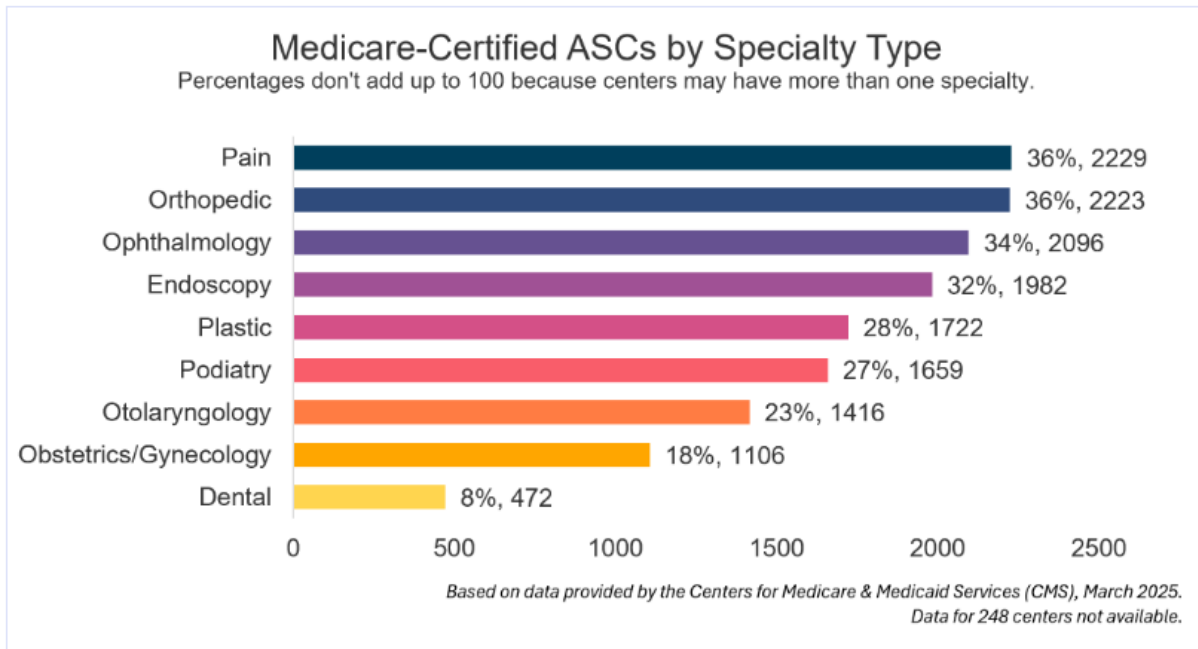
ASCs offer a variety of surgical services (see Table 1). In 2007 Medicare reported thirty-five percent of ASCs are multi-specialty providers in that they provide a mix of surgical services. A number of facilities were identified as specializing in either gastrointestinal procedures or ophthalmology.¹⁶

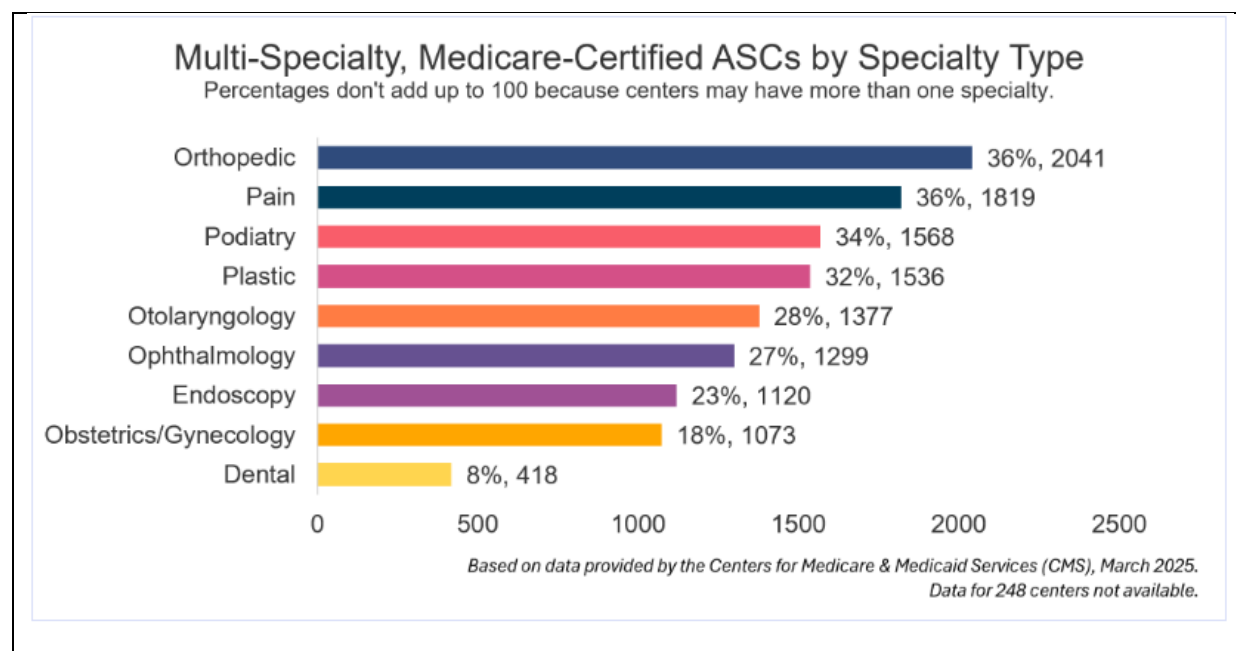
Table 1. Specialties Performed in Medicare-Certified ASCs (2007)

Source: 2007 Medicare Physician/Supplier Procedure Summary (PSPS) file.¹⁷

More recently, the following specialties are typically performed in Medicare-Certified ASCs (see Table 2)¹⁸:

- Dental
- Endoscopy
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic
- Other
- Otolaryngology
- Pain
- Plastic
- Podiatry

Table 2. Specialties Served in Medicare-Certified ASCs 2025¹⁸



Hollenbeck et al (2014) performed a retrospective cohort study of Medicare beneficiaries undergoing outpatient surgery between 2001 and 2010. The literature compared population-based rates of outpatient surgery in Hospital Service Areas (HSAs) with freestanding ASCs to those without. After adjusting for differences using multiple propensity score methods, the impact of ASC opening in a HSA previously without one on rates of outpatient surgery were assessed. Adjusted outpatient surgery rates increased from 2,806 to 3,940 per 10,000 and the number of ASC operating rooms grew from 7,036 to 11,223 (both $p < 0.001$ for trend). By the 4th year after opening, rates of outpatient surgery increased by 10.9% (from 3,338 to 3,701 per 10,000) in HSAs adding an ASC for the first time. In contrast, outpatient surgery rates grew by only 2.4% and 0.6% in HSAs where an ASC was always or never present, respectively ($p < 0.001$ for test between 3 slopes). Rather than redistributing patients from one setting to another, the opening of ASCs increases outpatient surgery use. However, the 10.9% increase is more modest than previously suggested by state-level data.¹⁹

Over the last decade, the rate of outpatient surgery among Medicare Beneficiaries increased by 40%. Concurrent with this trend, the capacity for delivering these procedures grew by nearly 60% with the addition of 4,187 new operating rooms in freestanding ASCs. Rates of outpatient surgery in HSAs with ASCs were approximately 10% higher relative to those without them in every year of the 2014 retrospective cohort study mentioned above. When an ASC was added to a market previously without one, rates of outpatient surgery quickly caught up to those in markets where an ASC was always present. Specifically, at four years after opening, rates grew by approximately 11% in markets where an ASC was added for the first time. Similar trends were evident in procedure groups representing specialties that commonly use ASCs.¹⁹

Anesthesia in the Ambulatory Surgery Center Setting

Prabhakar et al (2017) published a review noting that ambulatory surgery has grown in recent decades in volume and represents a significant number of anesthetics delivered throughout the United States of America. Preoperative anesthetic assessment in the ambulatory setting has become important because patients with numerous complex comorbidities are now commonplace in this arena. Disease states involving the lungs, the heart, the kidneys, and subpopulations including those who are obese and the elderly commonly receive anesthetics in an ambulatory setting. The review presented key aspects of current thinking with regard to preoperative assessment and considerations for different critical disease states and subpopulations that are now being managed under ambulatory surgery. Same day surgery centers require patient safety, and expectations are high for patient satisfaction. Advancements in surgical and anesthetic technique have allowed for

more complex patients to partake in ambulatory surgery. Anesthesiologists must be familiar with guidelines, state-of-the-art pain management, and standards of preoperative patient evaluation to accurately stratify patient risk and to advocate for patient safety.²⁰

Medicare National Coverage

The Centers for Medicare & Medicaid Services (2009) implemented Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) for Ambulatory Surgical Centers (ASCs) which contain the health and safety standards that all ASCs must meet. Covered topics include, but are not limited to: requirements for the ASC's governing body and management; the provision of surgical services; patient rights; infection control; and patient admission, assessment and discharge.²¹

Appendix 1

American Society of Anesthesiologists (ASA): The ASA developed the ASA Physical Status Classification System, last amended October 2019, to assess and communicate an individual's pre-anesthesia co-morbidities. The ASA acknowledges the classification system alone does not predict perioperative risk, however when used with other factors (e.g., type of surgery, frailty, level of deconditioning), it can be helpful in predicting perioperative risks. ASA Classification is defined as follows⁴:

- ASA I - normal, healthy patient (healthy, non-smoking, no or minimal alcohol use)
- ASA II - patient with mild systemic disease (Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity ($30 < \text{BMI} < 40$), well-controlled diabetes mellitus (DM)/HTN, mild lung disease)
- ASA III - patient with severe systemic disease (substantive functional limitations; one or more moderate to severe diseases; examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity ($\text{BMI} \geq 40$), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or coronary artery disease (CAD)/stents) Page 6 of 11 Medical Coverage Policy: 0553
- ASA IV - patient with severe systemic disease that is a constant threat to life (examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, disseminated intravascular coagulation (DIC), acute respiratory distress (ARD) or ESRD not undergoing regularly scheduled dialysis)
- ASA V - a moribund patient who is not expected to survive without the operation (examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction)
- ASA VI - a declared brain-dead patient whose organs are being removed for donor purposes

The ASA Physical Status Classification System is one means to determine risk and whether or not a patient should have surgery. Other factors to consider include age, obesity, nature and severity of the procedure, type of anesthetic, and duration of anesthesia or surgery.

Table 1. ASA Physical Status Classification System

ASA PS Classification	Definition	Adult Examples, Including, but not limited to:	Pediatric Examples, Including, but not limited to:	Obstetric Examples, Including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use	Healthy (no acute or chronic disease), normal BMI percentile for age	
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations or end organ involvement. Current smoker, social alcohol drinker, pregnancy, obesity ($30 < \text{BMI} < 40$), well-controlled DM or HTN, mild lung disease, CHF NYHA Class 1, mild cognitive dysfunction, isolated mild/moderate obstructive sleep apnea with compliance with CPAP as prescribed.	Asymptomatic non cyanotic congenital cardiac disease, well controlled dysrhythmias, asthma without exacerbation, well controlled epilepsy, non-insulin dependent DM, abnormal BMI percentile for age, mild/moderate OSA, oncologic state in remission, autism with mild limitations, malignant hyperthermia risk (family history or patient with history)	Normal pregnancy,*well controlled gestational HTN, diet-controlled gestational DM
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. COPD, morbid obesity ($\text{BMI} \geq 40$), active hepatitis, compensated cirrhosis, alcohol dependence or abuse, functional implanted pacemaker, moderate reduction of ejection fraction or CHF NYHA class 2 or 3, ESRD undergoing regularly scheduled dialysis, history (> 3 months) of MI, CVA, TIA, PE, or CAD/stents, significant cognitive dysfunction, isolated severe OSA regardless of CPAP compliance or any severity of obstructive sleep apnea with CPAP noncompliance. Poorly controlled DM or HTN with or without end organ dysfunction.	Uncorrected stable congenital cardiac abnormality, asthma with exacerbation, poorly controlled epilepsy, insulin dependent diabetes mellitus, morbid obesity, malnutrition, severe OSA, oncologic state, renal failure, muscular dystrophy, cystic fibrosis, history of organ transplantation, brain/spinal cord malformation, symptomatic hydrocephalus, premature infant PCA < 60 weeks, autism with severe limitations, metabolic disease, difficult airway, long term parenteral nutrition. Full term infants < 6 weeks of age.	Preeclampsia with or without severe features, gestational diabetes poorly controlled or with complications or high insulin requirements, a thrombophilic disease requiring anticoagulation.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (< 3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction or CHF NYHA class 4, shock, sepsis, DIC, ARDS, ESRD not undergoing regularly scheduled dialysis, uncompensated cirrhosis, severe cognitive dysfunction	Symptomatic congenital cardiac abnormality, congestive heart failure, active sequelae of prematurity, acute hypoxic-ischemic encephalopathy, shock, sepsis, disseminated intravascular coagulation, automatic implantable cardioverter-defibrillator, ventilator dependence, endocrinopathy, severe trauma, severe respiratory	Preeclampsia with severe features complicated by HELLP or other adverse event, peripartum cardiomyopathy, uncorrected/dec ompensated heart disease.

ASA PS Classification	Definition	Adult Examples, Including, but not limited to:	Pediatric Examples, Including, but not limited to:	Obstetric Examples, Including, but not limited to:
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal or thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction	distress, advanced oncologic state. Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension with hypertensive crisis, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.	Uterine rupture, amniotic fluid embolism
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes			

*Although pregnancy is not a disease, the patient's physiologic state is significantly altered from when the woman is not pregnant, hence the assignment of ASA PS II for a woman with uncomplicated pregnancy.

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

ARDS, acute respiratory distress syndrome; ASA, American Society of Anesthesiologists; BMI, body mass index; CAD, coronary artery disease; CHF NYHA, congestive heart failure, New York Heart Association classification; COPD, chronic obstructive pulmonary disease; CPAP, continuous positive airway pressure; CVA, cerebrovascular accident; DIC, disseminated intravascular coagulation; DM, diabetes mellitus; ECMO, extracorporeal membrane oxygenation; ESRD, end-stage renal disease; HELLP, hemolysis, elevated liver enzymes, low platelets; HTN, hypertension; MI, myocardial infarction; OSA, obstructive sleep apnea; PCA, post-conceptual age; PE, pulmonary embolism; PS, physical status; TIA, transient ischemic attack

Appendix 2

Hypertension Classification Reference

For the purposes of medical policy interpretation and application, blood pressure categories may be referenced using the classification framework established by the American College of Cardiology (ACC) and the American Heart Association (AHA) for adults. These categories are defined based on systolic and diastolic blood pressure measurements as follows²:

- **Normal:** systolic less than 120 mm Hg and diastolic less than 80 mm Hg
- **Elevated:** systolic between 120-129 mm Hg and diastolic less than 80 mm Hg
- **Stage 1 Hypertension:** systolic between 130-139 mm Hg or diastolic between 80-89 mm Hg
- **Stage 2 Hypertension:** systolic at least 140 mm Hg or diastolic at least 90 mm Hg

These definitions may be used as a reference standard when assessing clinical documentation, risk stratification, or medical necessity criteria within applicable policies.

Appendix 3

Obstructive Sleep Apnea Severity Classification Reference

For medical policy purposes, obstructive sleep apnea (OSA) severity may be categorized using standardized sleep study indices, including the apnea-hypopnea index (AHI), respiratory disturbance index (RDI), or respiratory event index (REI), as documented in adult sleep studies.

The following are generally accepted measures of OSA severity in adults⁹:

- **None/minimal:** AHI, RDI, or REI less than 5 events/hour
- **Mild:** AHI, RDI, or REI greater than or equal to 5 events/hour but less than 15 events/hour.
- **Moderate:** AHI, RDI, or REI greater than or equal to 15 events/hour but less than 30 events/hour.
- **Severe:** AHI, RDI, or REI greater than or equal to 30 events/hour.

These thresholds may be referenced to support determinations related to disease severity, treatment eligibility, or coverage considerations, in accordance with the applicable policy.

Appendix 4

Model for End-Stage Liver Disease (MELD) Score Reference

The Model for End-Stage Liver Disease (MELD) score is a validated prognostic model used to estimate severity of liver disease and short-term mortality risk in individuals with advanced hepatic disease. The MELD scoring system has been adopted by the United Network for Organ Sharing (UNOS) for prioritization of candidates awaiting liver transplantation in the United States.

The MELD score is calculated using objective laboratory parameters, which include⁷:

- Serum bilirubin
- Serum creatinine
- International normalized ratio (INR)

The MELD score may be used as an objective reference when evaluating disease severity or clinical urgency for transplant-related or liver disease-related coverage determinations, when applicable under the relevant policy.

Appendix 5

New York Heart Association (NYHA) Functional Classification Reference

For purposes of medical policy interpretation and application, functional capacity related to cardiac disease may be referenced using the New York Heart Association (NYHA) Functional Classification system. This classification categorizes individuals based on the degree of limitation experienced during physical activity, as it relates to symptoms such as shortness of breath, fatigue, palpitations, or angina.

The NYHA Functional Classification is defined as follows¹:

- **Class I** - Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- **Class II** - Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.

- **Class III** - Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- **Class IV** - Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

References

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Clinical findings (i.e., pertinent symptoms and duration)
 - Comorbidities
 - Clinical risk factors
 - Activity and functional limitations
 - Reason for procedure/test/device, when applicable
 - Pertinent past procedural and surgical history
 - Past and present diagnostic testing and results
 - Treatment plan (i.e., planned surgical procedure and anticipated operative duration)
- Consultation and medical clearance report(s), when applicable
- Preoperative evaluations such as radiology report(s) and interpretation (i.e., MRI, CT, discogram)
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable
- Evidence of ASC access limitations, when applicable

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed
- Procedure report(s)

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
	45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
	45380	Colonoscopy, flexible; with biopsy, single or multiple
	45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
04/01/2020	New policy
04/01/2021	Annual review. No change to policy statement. Policy guidelines updated.
05/01/2022	Annual review. No change to policy statement. Literature review updated.
04/01/2023	Annual review. No change to policy statement.
04/01/2024	Annual review. No change to policy statement. Policy guidelines updated.
04/01/2025	Annual review. Policy statement, guidelines and literature updated.
06/01/2026	Annual review. No change to policy statement.
08/01/2026	Annual review. Policy statement, guidelines and literature updated. Policy title changed from Ambulatory Surgery Center to current one. Coding update.

Feedback

Blue Shield of California is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/provider.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health

services contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE <u>Red font: Verbiage removed</u>	AFTER <u>Blue font: Verbiage Changes/Additions</u>
Ambulatory Surgery Center BSC10.01 Policy Statement:	Place of Service Policy for Outpatient Procedures BSC10.01 Policy Statement: Outpatient Hospital Surgical Facility I. The use of an outpatient hospital surgical facility (as reflected in a place of service [POS] code of 19 or 22) may be considered medically necessary when EITHER of the following criteria are met: A. The individual poses a clinical risk for having the procedure take place in a less intensive setting, such as an ambulatory surgical center (i.e., POS code 24) or an office setting (i.e., POS code 11), due to ANY of the following conditions: 1. Advanced liver disease (MELD score > 8) 2. Preoperative planning indicates the need for overnight postoperative monitoring or care 3. Anticipated need for blood transfusion 4. Bleeding disorder requiring factor replacement, blood products, or specialized infusion therapy 5. Symptomatic cardiac arrhythmia despite medical therapy 6. Chronic obstructive pulmonary disease (COPD) with FEV1 < 50% 7. Ongoing coronary artery disease (CAD) or peripheral vascular disease (PVD) or having a drug-eluting coronary stent placed within the prior 12 months 8. Developmental stage or cognitive impairment requiring hospital outpatient resources 9. End-stage renal disease (ESRD), hyperkalemia, or need for peritoneal or hemodialysis 10. Cerebrovascular accident (CVA) or transient ischemic attack (TIA) within the past 3 months 11. Myocardial infarction (MI) within the past 3 months 12. Coronary intervention history such as EITHER of the following:

POLICY STATEMENT	
BEFORE <u>Red font: Verbiage removed</u>	AFTER <u>Blue font: Verbiage Changes/Additions</u>
	a. Drug-eluting stent (DES) within 12 months b. Bare-metal stent (BMS) or percutaneous angioplasty within 90 days, unless continuation of antiplatelet therapy is agreed upon by the surgeon, cardiologist, and anesthesia provider 13. Ongoing evidence of myocardial ischemia 14. Poorly controlled asthma (FEV1 < 80% despite optimal medical management) 15. Pregnancy 16. Expected operative or anesthesia time greater than 3 hours 17. Treatment resistant hypertension (refractory hypertension despite at least three antihypertensive medications⁸) 18. Severe valvular heart disease 19. Moderate to severe <u>obstructive sleep apnea (OSA)</u> 20. Uncompensated chronic heart failure (CHF) (NYHA Class III or IV) 21. Uncontrolled diabetes with recurrent diabetic ketoacidosis (DKA) or severe hypoglycemia 22. Age under 18 years B. An appropriate ambulatory surgery center (ASC) is not reasonably accessible for the procedure due to ANY of the following: 1. The ASC's written clinical guidelines or policies exclude the member due to medical conditions or weight limitations 2. No geographically accessible ASC has the required equipment to safely perform the procedure, including but not limited to: a. Fluoroscopy b. Laser technology c. Ocular surgical equipment d. Operating microscope e. Specialized scopes (e.g., duodenoscope, ureterscope) 3. No geographically accessible ASC exists at which the treating physician holds the necessary procedural privileges

POLICY STATEMENT	
BEFORE <u>Red font: Verbiage removed</u>	AFTER <u>Blue font: Verbiage Changes/Additions</u>
I. The use of an ambulatory surgery center (ASC) may be considered medically necessary on an ambulatory basis when all of the following criteria are met: A. Immediate access to unique services of a medical center or hospital setting including, but not limited to post-operative recovery in an inpatient facility is not anticipated to be required for the preoperative disease or condition being treated or due to co-morbidities (e.g., infection, coagulopathy, altered mental status, dangerous arrhythmia, hypotension, hypoxemia, tachycardia, tachypnea) B. The treating health care professional has privileges for the requested procedure at an ASC C. In the event of unforeseen complications requiring an inpatient level of care, the requesting provider must either have the ability to care for the patient in the inpatient setting (including privileges) or have a written agreement in place with another qualified provider to accept and care for the patient if a transfer to an inpatient facility is needed D. ASC must be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC)¹ or the Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations [JCAHO]) E. Procedure is non-emergent F. Procedure is low-risk or patient is not a high anesthetic risk (or high-risk for surgery; see Policy Guidelines section) G. Cardiac clearance has been done for patients with stents and arrhythmias not considered to be low risk H. There is no significant increased risk related to drugs (see Policy Guidelines section) I. There is no significant risk due to living situation (outpatient care; see Policy Guidelines section) J. Patient is cooperative and able to understand and follow instructions	<u>Ambulatory Surgery Center</u> II. The use of an ambulatory surgery center (ASC) may be considered medically necessary on an ambulatory basis when all of the following criteria are met: A. Immediate access to unique services of a medical center or hospital setting including, but not limited to post-operative recovery in an inpatient facility is not anticipated to be required for the preoperative disease or condition being treated or due to co-morbidities (e.g., infection, coagulopathy, altered mental status, dangerous arrhythmia, hypotension, hypoxemia, tachycardia, tachypnea) B. The treating health care professional has privileges for the requested procedure at an ASC C. In the event of unforeseen complications requiring an inpatient level of care, the requesting provider must either have the ability to care for the patient in the inpatient setting (including privileges) or have a written agreement in place with another qualified provider to accept and care for the patient if a transfer to an inpatient facility is needed D. ASC must be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC)¹ or the Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations [JCAHO]) E. Procedure is non-emergent F. Procedure is low-risk or patient is not a high anesthetic risk (or high-risk for surgery; see Policy Guidelines section) G. Cardiac clearance has been done for patients with stents and arrhythmias not considered to be low risk H. There is no significant increased risk related to drugs (see Policy Guidelines section) I. There is no significant risk due to living situation (outpatient care; see Policy Guidelines section) J. Patient is cooperative and able to understand and follow instructions

POLICY STATEMENT

BEFORE <u>Red font: Verbiage removed</u>	AFTER <u>Blue font: Verbiage Changes/Additions</u>
K. Patient has good social support readily available to assist with any of the following if needed: 1. Pre-operative preparatory education 2. Accompany the patient home 3. Accompany the patient to their physical therapy and post-operative appointments as needed until the patient is independently mobile II. The use of an ASC is considered not medically necessary for patients requiring a complex surgical approach or situation, including but not limited to any of the following: A. Open approach is required instead of the usual endoscopic, transcatheter, or other less invasive procedure B. A difficult approach is required due to a previous operation C. Airway monitoring is required after open neck or other procedure D. Medical conditions that are commonly associated with a difficult airway (e.g., Pierre Robin, Treacher-Collins, Goldenhar's Syndrome, Epidermolysis Bullosa) E. Unusually extensive dissection is needed F. Additional complicating feature requiring inpatient care (e.g., complex drain management) III. The use of an ASC is considered not medically necessary for all other indications outside of the medically necessary criteria.	K. Patient has good social support readily available to assist with any of the following if needed: 1. Pre-operative preparatory education 2. Accompany the patient home 3. Accompany the patient to their physical therapy and post-operative appointments as needed until the patient is independently mobile III. The use of an Ambulatory Surgery Center (ASC), instead of a higher level of care, is considered not medically necessary for patients requiring a complex surgical approach or situation, including but not limited to any of the following: A. Open approach is required instead of the usual endoscopic, transcatheter, or other less invasive procedure B. A difficult approach is required due to a previous operation C. Airway monitoring is required after open neck or other procedure D. Medical conditions that are commonly associated with a difficult airway (e.g., Pierre Robin, Treacher-Collins, Goldenhar's Syndrome, Epidermolysis Bullosa) E. Unusually extensive dissection is needed F. Additional complicating factor requiring inpatient care (e.g., complex drain management) Inpatient Hospital Facility IV. Use of an inpatient hospital facility (i.e., POS code 21) solely for a procedure that could safely be performed in an outpatient setting is considered not medically necessary.