Site of Service Utilization

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Medical Guideline Disclaimer

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Note: The Site of Service Utilization policy is applied only to members under 75 years of age. There is no impact to members 75 years of age and over.

Background

This Utilization Review Guideline provides assistance in interpreting EmblemHealth benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Utilization Review Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Utilization Review Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Utilization Review Guideline. Other Policies and Guidelines may apply. ConnectiCare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

Benefit Considerations

Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Preauthorization requirements apply to EmblemHealth plans that require services to be medically necessary and conducted in an optimal clinical setting. The medical necessity of the procedure may be separately reviewed against the appropriate criteria. Refer to the member specific benefit plan document to determine if medical necessity applies.

Coverage Rationale

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, an on-campus outpatient hospital or medical center, an ambulatory surgical center, or a doctor's office. Costs for surgical procedures may vary among these different settings. To encourage the use of the most safe and appropriate, 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.

We will review the site of service for medical necessity for certain elective surgical procedures. Site of service is defined as the location where the surgical procedure is performed, such as an off campus-outpatient hospital or medical center, an on campus-outpatient hospital or medical center, an ambulatory surgical center, or an inpatient hospital or medical center or providers office. When there is more than one option for the site of surgery, and in the absence of any clinical contra-indication, the lowest level of site will be approved (i.e., physician office first, then ASC, then hospital outpatient, and last, hospital inpatient).

The following will be considered to determine whether the elective procedure is being performed in an optimal clinical setting:

- Member's specific benefit plan
- Geographic availability of an in-network provider
- Ambulatory surgical care (ASC) capability
- Physician privileging
- Significant member comorbidities (see list of examples of Qualifying Conditions below)
- American Society of Anesthesiologist (ASA) physical status (PS), classification system

Potential Documentation Requirements

- Physician office notes
- Physician privileging
- ASA score

Office Based Procedures

Except for the following qualifying conditions, most elective procedures should be performed in an Office setting (not an all-inclusive list):

- Patient is unable to cooperate with procedure due to mental status, severe anxiety, or extreme pain sensitivity
- Failed office-based procedure attempt due to body habitus, abnormal anatomy, or technical difficulties
- Bleeding disorder that would cause a significant risk of morbidity
- Allergy to local anesthetic
- The following will be considered to determine whether the elective procedure is being performed in an optimal clinical setting:
- The individual has clinical conditions which may compromise the safety of an office-based procedure, including but not limited to:
    - Medical conditions which require enhanced monitoring, medications or prolonged recovery period; or
    - Increased risk for complications due to severe comorbidity, such as that evidenced by an American Society or Anesthesiologist's (ASA) class III or higher physical status.

ASC and Outpatient Surgical Procedures

Except for the qualifying conditions below, many elective procedures should be performed in an Ambulatory Surgical Center (ASC). Some patients may require more complex care due to factors such as age or medical conditions. Also, some ASCs may have specific guidelines that prohibit members who are above a certain weight or have certain health conditions from receiving care in those facilities.

Patients with severe systemic disease and some functional limitation (ASA PS classification III or higher) may be appropriate to have the procedure in an outpatient hospital setting (not an all – inclusive list):

- Morbid obesity (>BMI.40)
- Diabetes (brittle diabetes)
- Resistant hypertension (poorly controlled)
- Chronic obstructive pulmonary disease (COPD) (FEV1 <50%)
- Advance liver disease (MELD Score >8)
- Alcohol dependence (at risk for withdrawal syndrome)
- End stage renal disease (hyperkalemia (above reference range peritoneal or hemodialysis)
- Uncompensated chronic heart failure (CHF) (NYHA class III or IV)
- History of myocardial infarction (MI) (recent event (<3 mo.))
- History of cerebrovascular accident (CVA) or transient ischemic attack (TIA)
- (recent event (<3 mo.))
- Coronary artery disease (CAD/peripheral vascular disease (PVD) (ongoing cardiac ischemia requiring medical management recently placed drug eluting stent (within 1 year))
- Sleep apnea (mode rate to severe obstructive sleep apnea (OSA)
- Implanted pacemaker
- Personal history or family history of complication of anesthesia such as malignant hyperthermia
- Pregnancy
- Bleeding disorder requiring replacement factor or blood products or special infusion
- products to correct a coagulation defect (DDAVP is not blood product and is OK)
- Prolonged surgery (>3 hrs.)
- Anticipated need for transfusion
- Recent history of drug abuse (especially cocaine)
- Patients with drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless acetylsalicylic acid (ASA) and antiplatelet drugs will be continued by agreement of surgeon, cardiologist and anesthesia
- Ongoing evidence of myocardial ischemia
- Poorly controlled asthma (FEV1 <80% despite medical management)
- Significant valvular heart disease
- Cardiac arrhythmia (symptomatic arrhythmia despite medication)
- Potentially difficult airway
- Uncontrolled seizure disorder

Inpatient Surgical Procedures

Certain specific complex surgeries can only be performed in an inpatient setting due to the needed level of involvement of specialized staff and technical equipment necessary to safely perform the procedure. Examples include organ transplants, most oncology procedures and many cardiac procedures.

Coding

CPT/HCPCS Code	Description
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11602	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm
11604	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm
11622	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11750	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;
11772	Excision of pilonidal cyst or sinus; complicated
12031	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
12032	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)
20694	Removal, under anesthesia, of external fixation system
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater
21315	Closed treatment of nasal bone fracture with manipulation; without stabilization
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
24071	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater

CPT/HCPCS Code	Description
24105	Excision, olecranon bursa
25000	Incision, extensor tendon sheath, wrist (eg, deQuervains disease)
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments
26055	Tendon sheath incision (eg, for trigger finger)
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm
26160	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone
26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater
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)
28005	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot
28010	Tenotomy, percutaneous, toe; single tendon
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater
28090	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); foot
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
28295	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal metatarsal osteotomy, any method
28296	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with distal metatarsal osteotomy, any method
28299	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with double osteotomy, any method
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])

CPT/HCPCS Code	Description
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
30130	Excision inferior turbinate, partial or complete, any method
30140	Submucous resection inferior turbinate, partial or complete, any method
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope
31571	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)
42820	Tonsillectomy and adenoidectomy; younger than age 12
42825	Tonsillectomy, primary or secondary; younger than age 12
42826	Tonsillectomy, primary or secondary; age 12 or over
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
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
44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)
44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple
44386	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple

CPT/HCPCS Code	Description
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45390	Colonoscopy, flexible; with endoscopic mucosal resection
46040	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)
46255	Hemorrhoidectomy, internal and external, single column/group;
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple
47562	Laparoscopy, surgical; cholecystectomy
47563	Laparoscopy, surgical; cholecystectomy with cholangiography
49322	Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)
49505	Repair initial inguinal hernia, age 5 years or older; reducible
49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49650	Laparoscopy, surgical; repair initial inguinal hernia
49651	Laparoscopy, surgical; repair recurrent inguinal hernia
50590	Lithotripsy, extracorporeal shock wave
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block
55040	Excision of hydrocele; unilateral
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
56405	Incision and drainage of vulva or perineal abscess
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
56605	Biopsy of vulva or perineum (separate procedure); 1 lesion
57288	Sling operation for stress incontinence (eg, fascia or synthetic)
57452	Colposcopy of the cervix including upper/adjacent vagina;
57454	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision

CPT/HCPCS Code	Description
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)
64718	Neuroplasty and/or transposition; ulnar nerve at elbow
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
65756	Keratoplasty (corneal transplant); endothelial
65855	Trabeculoplasty by laser surgery
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
67028	Intravitreal injection of a pharmacologic agent (separate procedure)
67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)
67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
67113	Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens
67145	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation
67210	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
67228	Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation
67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle
67400	Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy
68811	Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia
68815	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction

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Revision History

Aug 1, 2025	Policy updated: – Four codes removed effective 8/1/2025: 19120, 19125, 19307 and 44970 – Policy corrected to include applicable codes effective 8/1/2025 Policy reinstated with: – Clarification to member age applicability – Updated coding and Place of Service column-removal from Coding Table
Apr 14, 2023	Policy retired
May 27, 2022	Added note communicating that the policy is applied only to members between 18–74 years of age
Jan. 10, 2020	Expanded from Commercial and Medicaid only to include Medicare applicability eff. Feb 1, 2020