CLINICAL APPROPRIATENESS GUIDELINES

MUSCULOSKELETAL PROGRAM

Appropriate Use Criteria: Level of Care for Musculoskeletal Surgery and Procedures

"Site of Care," "Site of Service" or another term such as "Setting" or "Place of Service" may be terms used in benefit plans, provider contracts, or other materials instead of or in addition to "Level of Care" and, in some plans, these terms may be used interchangeably.

ARCHIVED JANUARY 1, 2021

This document has been archived because it has outdated information. It is for historical information only and should not be consulted for clinical use. Current versions of guidelines are available on the AIM Specialty Health website at http://www.aimspecialtyhealth.com/

EFFECTIVE NOVEMBER 1, 2020

Proprietary

Approval and implementation dates for specific health plans may vary. Please consult the applicable health plan for more details. AIM Specialty Health disclaims any responsibility for the completeness or accuracy of the information contained herein.

AIM SpecialtyHealth®
8600 West Bryn Mawr Avenue
South Tower – Suite 800 Chicago, IL 60631
www.aimspecialtyhealth.com

Table of Contents

Description and Application of the Guidelines

The AIM Clinical Appropriateness Guidelines (hereinafter "the AIM Clinical Appropriateness Guidelines" or the "Guidelines") are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. As used by AIM, the Guidelines establish objective and evidence-based criteria for medical necessity determinations where possible. In the process, multiple functions are accomplished:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To advocate for patient safety concerns
- To enhance the quality of health care
- To promote the most efficient and cost-effective use of services

The AIM guideline development process complies with applicable accreditation standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up-to-date clinical principles and best practices. Relevant citations are included in the References section attached to each Guideline. AIM reviews all of its Guidelines at least annually.

AIM makes its Guidelines publicly available on its website twenty-four hours a day, seven days a week. Copies of the AIM Clinical Appropriateness Guidelines are also available upon oral or written request. Although the Guidelines are publicly-available, AIM considers the Guidelines to be important, proprietary information of AIM, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of AIM.

AIM applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The AIM Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient's condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. Applicable federal and state coverage mandates take precedence over these clinical guidelines. If requested by a health plan, AIM will review requests based on health plan medical policy/guidelines in lieu of the AIM Guidelines.

The Guidelines may also be used by the health plan or by AIM for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

General Clinical Guideline

Clinical Appropriateness Framework

Critical to any finding of clinical appropriateness under the guidelines for a specific diagnostic or therapeutic intervention are the following elements:

- Prior to any intervention, it is essential that the clinician confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This includes a history and physical examination and, where applicable, a review of relevant laboratory studies, diagnostic testing, and response to prior therapeutic intervention.
- The anticipated benefit of the recommended intervention should outweigh any potential harms that may result (net benefit).
- Current literature and/or standards of medical practice should support that the recommended intervention offers the greatest net benefit among competing alternatives.
- Based on the clinical evaluation, current literature, and standards of medical practice, there exists a reasonable likelihood that the intervention will change management and/or lead to an improved outcome for the patient.

If these elements are not established with respect to a given request, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would supersede the requirements set forth above. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account.

Simultaneous Ordering of Multiple Diagnostic or Therapeutic Interventions

Requests for multiple diagnostic or therapeutic interventions at the same time will often require a peer-to-peer conversation to understand the individual circumstances that support the medical necessity of performing all interventions simultaneously. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Additionally, either of the following may apply:

- Current literature and/or standards of medical practice support that one of the requested diagnostic or therapeutic interventions is more appropriate in the clinical situation presented; or
- One of the diagnostic or therapeutic interventions requested is more likely to improve patient outcomes based on current literature and/or standards of medical practice.

Repeat Diagnostic Intervention

In general, repeated testing of the same anatomic location for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study.

Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios:

- Repeated diagnostic testing at the same facility due to technical issues
- Repeated diagnostic testing requested at a different facility due to provider preference or quality concerns
- Repeated diagnostic testing of the same anatomic area based on persistent symptoms with no clinical change, treatment, or intervention since the previous study
- Repeated diagnostic testing of the same anatomic area by different providers for the same member over a short period of time

Repeat Therapeutic Intervention

In general, repeated therapeutic intervention in the same anatomic area is considered appropriate when the prior intervention proved effective or beneficial and the expected duration of relief has lapsed. A repeat intervention requested prior to the expected duration of relief is not appropriate unless it can be confirmed that the prior intervention was never administered.

Level of Care Guidelines for Musculoskeletal Surgery and Procedures

"Site of Care," "Site of Service" or another term such as "Setting" or "Place of Service" may be terms used in benefit plans, provider contracts, or other materials instead of or in addition to "Level of Care" and, in some plans, these terms may be used interchangeably.

Scope

Evidence is growing that supports the safety and effectiveness of the outpatient surgery setting for many orthopedic and spine surgical procedures. Procedures that have historically been performed in the inpatient setting are now being successfully performed in the outpatient surgery setting. Factors that have contributed to this movement include:

- Equal or better outcomes compared to inpatient setting
- Minimal invasive techniques and improved surgical technologies
- Improved anesthesia techniques and more effective postoperative pain management
- Lower costs and operational efficiency

Appropriate patient selection for the outpatient setting is paramount. It may be medically necessary for patients with certain risk factors and undergoing certain procedures to have their procedures performed in the inpatient setting.

The intent of this guideline is to assist in determining the appropriate level of care necessary to safely and effectively perform the intended surgical procedure. Provider should submit the required supporting medical documentation to include but not limited to the following:

- Provider office notes detailing preoperative medical optimization
- List of managed or unmanaged comorbidities and/or other surgical risk factors
- If requested, the specific reason for an inpatient preoperative day
- Copies of medical consultations or clearances
- American Society of Anesthesiologists (ASA) physical status (see Appendix), Charlson Comorbidity Index score, or other validated surgical risk score if necessary, to support the requested level of care

This guideline does not address the medical necessity of the procedure itself. The prior authorization process for medical necessity of the surgical procedure is completed separately and precedes the level of care determination. The procedure must meet the respective AIM Musculoskeletal Surgery guideline for clinical appropriateness prior to level of care determination.

Definitions

Outpatient Surgical Setting

An outpatient surgical procedure is defined as one where a patient arrives and is registered at a setting other than the acute inpatient hospital setting, undergoes the procedure, and is discharged the same day or within the timeframe for observation defined by patient's health plan contract and/or local government regulatory agency. Such settings may include Observation Care, Hospital Outpatient Department (on or off campus), Ambulatory Surgical Center or Physician Office. For the purposes of this guideline, procedures performed in a Physician Office are out of scope.

Observation Surgical Setting

Observation is a special form of hospital outpatient care that provides interim services in place of an inpatient admission to allow for a reasonable period of time to evaluate and determine the need for further treatment or for inpatient admission. There is evidence that the characteristics of observation care in clinical practice differ from the Centers for Medicare and Medicaid Services definition and that use of observation care is growing with short

inpatient stays being the third most common reason to admit for observation. Individual cases admitted to Observation Care may undergo concurrent clinical review to assess the need for transfer to acute inpatient setting. Maximum length of stay in Observation Care is governed by the patient's health plan contract and/or local government regulatory agency.

Surgeons who request inpatient admission for an outpatient musculoskeletal procedure and who decline Observation Care will need to provide clinical documentation to support the need for direct admission to an acute inpatient setting.

Inpatient Surgical Setting

The inpatient surgical setting, rather than the outpatient setting, is required only if the patient's safety or health would be significantly and directly threatened if care were provided in a less intensive setting. The selection of surgical setting is not justified when it is solely for the convenience of the patient, the patient's family, or the provider.

Guidelines

Acute Inpatient Surgical Setting

The acute inpatient surgical setting may be considered medically necessary when at least **ONE** of the following requirements are met:

- Current postoperative care requirements are of such intensity and/or duration that they cannot be met in an observation or outpatient surgical setting.
- Anticipated postoperative care requirements cannot be met, even initially, in an observational surgical setting due to the complexity, duration, or extent of the planned procedure and/or substantial preoperative patient risk.

Observation Outpatient Surgical Setting

The observation surgical setting may be considered medically necessary in patients with **ONE** or more preprocedural clinical risk factors that increase the likelihood of inpatient admission.

Note: The presence of medical and/or psychiatric comorbidities alone may not always justify an observation surgical setting, but consideration should be given if poorly controlled, unstable, untreated, or anticipated to require treatment postoperatively.

Demographic/constitutional

- Age 65 and above
- BMI greater than 40 kg/m^2
- Pregnancy

Medical risk factors

- Charlson Comorbidity Index score greater than 2, ASA class greater than 2, or other attestation of comorbid status
- Recent venous thromboembolic event
- Severe or uncontrolled diabetes
- Severe anemia (e.g., hemoglobin ≤ 10)
- Coagulopathy
- Recent unexplained weight loss
- Malnutrition
- Chronic pulmonary disease

    - COPD, severe and/or oxygen dependent
    - Respiratory distress
- Obstructive sleep apnea
- Liver disease including but not limited to cirrhosis
- Vascular
    - Cardiovascular disease
        - Myocardial infarction within 6 months of intended surgery
        - Angina pectoris with severe functional limitation
        - Cardiac arrhythmia
        - Implantable cardiac device (defibrillator, pacemaker)
        - Congestive heart failure
    - Cerebrovascular disease
        - Recent stroke or transient ischemic attack
    - Uncontrolled preoperative pain
    - Prior complication of anesthesia
    - Prior postoperative complication
        - Ileus
        - Urinary retention

Psychiatric/cognitive

- Ongoing substance abuse
- Cognitive impairment

Functional status

- Patient unable to care for individual needs
- Functional impairment likely to necessitate inpatient rehabilitation after surgery (example: moderate to severe myelopathy)
- Patient is at high risk for falls

Outpatient Surgical Setting (excluding Observation)

The nonobservation surgical setting includes Ambulatory Surgery Center or Hospital-based Outpatient Department and may be considered medically necessary for elective spine and joint surgery in low risk patients and procedures as follows:

Note: These requirements do not prohibit providers from performing these procedures in Ambulatory Surgery Center for carefully selected higher risk patients (e.g., physiologic age < biological age, medically optimized, uneventful prior procedure) according to their professional medical judgement.

Hospital-based Outpatient Department

Patient meets **ALL** of the following:

- Age less than 65
- BMI less than or equal to 40 kg/m^2
- Low medical comorbidity risk
- Safe post surgical disposition

All necessary staff, equipment, and resources are available to safely and effectively perform the requested procedure in an ambulatory surgical center.

- Cervical
  - One- or two-level anterior cervical discectomy and fusion (ACDF) between C3 and C7
  - One- or two-level cervical disc arthroplasty between C3 and C7
  - One- or two-level foraminotomy
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Thoracic
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Lumbar
  - One- or two-level discectomy and/or decompression (laminectomy, laminotomy, or foraminotomy)
  - One- or two-level posterior or posterolateral with posterior interbody fusion
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Sacral
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Vertebroplasty
- Kyphoplasty
- Joint
  - Total or partial primary knee arthroplasty for unilateral osteoarthritis
  - Total or partial primary hip arthroplasty for unilateral osteoarthritis

Ambulatory Surgery Center with 23-hour observation

Patient meets **ALL** of the following:

- Age less than 65
- BMI less than or equal to 40 kg/m^2
- Low medical comorbidity risk
- Safe post surgical disposition

All necessary staff, equipment, and resources are available to safely and effectively perform the requested procedure in the ambulatory surgical center.

- Cervical
  - One- or two-level anterior cervical discectomy and fusion (ACDF) between C3 and C7
  - One- or two-level cervical disc arthroplasty between C3 and C7
  - One- or two-level foraminotomy
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Thoracic
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Lumbar
  - One- or two-level discectomy and/or decompression (laminectomy, laminotomy, or foraminotomy)
  - One- or two- level posterior or posterolateral with posterior interbody fusion
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural

- Sacral
  - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Vertebroplasty
- Kyphoplasty
- Joint
  - Total or partial primary knee arthroplasty for unilateral osteoarthritis
  - Total or partial primary hip arthroplasty for unilateral osteoarthritis

Facility has the capability for minimum of 23-hour observation.

Ambulatory Surgery Center with or without 23-hour observation

The following procedure can be safely performed in the Ambulatory Surgical Center with or without 23 hours of observation

- Arthroscopy

Selected References

Joint Surgery

1. Adamson, T, Godil, SS, Mehrlich, M, et al. Anterior cervical discectomy and fusion in the outpatient ambulatory surgery setting compared with the inpatient hospital setting: analysis of 1000 consecutive cases. J Neurosurg Spine. 2016;24(6):878-84.
2. Basques, BA, Erickson, BJ, Leroux, T, et al. Comparative outcomes of outpatient and inpatient total shoulder arthroplasty: an analysis of the Medicare dataset. Bone Joint J. 2017;99-B(7):934-8.
3. Berstock, JR, Beswick, AD, Lenguerrand, E, et al. Mortality after total hip replacement surgery: A systematic review. Bone & joint research. 2014;3(6):175-82.
4. Best, NM, Sasso, RC. Outpatient lumbar spine decompression in 233 patients 65 years of age or older. Spine. 2007;32(10):1135-9; discussion 40.
5. Bradley, B, Middleton, S, Davis, N, et al. Discharge on the day of surgery following unicompartmental knee arthroplasty within the United Kingdom NHS. Bone Joint J. 2017;99-B(6):788-92.
6. Brolin, TJ, Mulligan, RP, Azar, FM, et al. Neer Award 2016: Outpatient total shoulder arthroplasty in an ambulatory surgery center is a safe alternative to inpatient total shoulder arthroplasty in a hospital: a matched cohort study. J Shoulder Elbow Surg. 2017;26(2):204-8.
7. Cancienne, JM, Brockmeier, SF, Gulotta, LV, et al. Ambulatory Total Shoulder Arthroplasty: A Comprehensive Analysis of Current Trends, Complications, Readmissions, and Costs. J Bone Joint Surg Am. 2017;99(8):629-37.
8. Centers for Medicare and Medicaid Services Hospital Outpatient Prospective Payment CMS-1678-FC Addendum E: HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2018 (2017). Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending Accessed January 11, 2018.
9. Colvin, AC, Egorova, N, Harrison, AK, et al. National trends in rotator cuff repair. J Bone Joint Surg Am. 2012;94(3):227-33.
10. Courtney, PM, Boniello, AJ, Berger, RA. Complications Following Outpatient Total Joint Arthroplasty: An Analysis of a National Database. J Arthroplasty. 2017;32(5):1426-30.
11. De Beule, J, Vandenneucker, H, Claes, S, et al. Can anterior cruciate ligament reconstruction be performed routinely in day clinic? Acta Orthop Belg. 2014;80(3):391-6.
12. Goyal, N, Chen, AF, Padgett, SE, et al. Otto Aufranc Award: A Multicenter, Randomized Study of Outpatient versus Inpatient Total Hip Arthroplasty. Clin Orthop. 2017;475(2):364-72.
13. Hofstede, SN, Gademan, MG, Vliet Vlieland, TP, et al. Preoperative predictors for outcomes after total hip replacement in patients with osteoarthritis: a systematic review. BMC Musculoskelet Disord. 2016;17:212.
14. Huang, A, Ryu, JJ, Dervin, G. Cost savings of outpatient versus standard inpatient total knee arthroplasty. Can J Surg. 2017;60(1):57-62.
15. Iyengar, JJ, Samagh, SP, Schairer, W, et al. Current trends in rotator cuff repair: surgical technique, setting, and cost. Arthroscopy. 2014;30(3):284-8.
16. Kadhim, M, Gans, I, Baldwin, K, et al. Do Surgical Times and Efficiency Differ Between Inpatient and Ambulatory Surgery Centers That are Both Hospital Owned? J Pediatr Orthop. 2016;36(4):423-8.

17. Klapwijk, LC, Mathijssen, NM, Van Egmond, JC, et al. The first 6 weeks of recovery after primary total hip arthroplasty with fast track. Acta Orthop. 2017;88(2):140-4.
18. Kolisek, FR, McGrath, MS, Jessup, NM, et al. Comparison of outpatient versus inpatient total knee arthroplasty. Clin Orthop. 2009;467(6):1438-42.
19. Kunutsor, SK, Whitehouse, MR, Blom, AW, et al. Patient-Related Risk Factors for Periprosthetic Joint Infection after Total Joint Arthroplasty: A Systematic Review and Meta-Analysis. PLoS ONE. 2016;11(3):e0150866.
20. Lang, SS, Chen, HI, Koch, MJ, et al. Development of an outpatient protocol for lumbar discectomy: our institutional experience. World Neurosurg. 2014;82(5):897-901.
21. Lee, DK, Kim, HJ, Lee, DH. Incidence of Deep Vein Thrombosis and Venous Thromboembolism following TKA in Rheumatoid Arthritis versus Osteoarthritis: A Meta-Analysis. PLoS ONE. 2016;11(12):e0166844.
22. Lefevre, N, Klouche, S, de Pamphilis, O, et al. Postoperative discomfort after outpatient anterior cruciate ligament reconstruction: a prospective comparative study. Orthop Traumatol Surg Res. 2015;101(2):163-6.
23. Leroux, TS, Basques, BA, Frank, RM, et al. Outpatient total shoulder arthroplasty: a population-based study comparing adverse event and readmission rates to inpatient total shoulder arthroplasty. J Shoulder Elbow Surg. 2016;25(11):1780-6.
24. Lovald, ST, Ong, KL, Malkani, AL, et al. Complications, mortality, and costs for outpatient and short-stay total knee arthroplasty patients in comparison to standard-stay patients. J Arthroplasty. 2014;29(3):510-5.
25. Lovecchio, F, Alvi, H, Sahota, S, et al. Is Outpatient Arthroplasty as Safe as Fast-Track Inpatient Arthroplasty? A Propensity Score Matched Analysis. J Arthroplasty. 2016;31(9 Suppl):197-201.
26. Lyman, S, Koulouvaris, P, Sherman, S, et al. Epidemiology of anterior cruciate ligament reconstruction: trends, readmissions, and subsequent knee surgery. J Bone Joint Surg Am. 2009;91(10):2321-8.
27. Maletis, GB, Inacio, MC, Reynolds, S, et al. Incidence of symptomatic venous thromboembolism after elective knee arthroscopy. J Bone Joint Surg Am. 2012;94(8):714-20.
28. Mall, NA, Chalmers, PN, Moric, M, et al. Incidence and trends of anterior cruciate ligament reconstruction in the United States. Am J Sports Med. 2014;42(10):2363-70.
29. McGirt, MJ, Godil, SS, Asher, AL, et al. Quality analysis of anterior cervical discectomy and fusion in the outpatient versus inpatient setting: analysis of 7288 patients from the NSQIP database. Neurosurg. 2015;39(6):E9.
30. Nelson, SJ, Webb, ML, Lukasiewicz, AM, et al. Is Outpatient Total Hip Arthroplasty Safe? J Arthroplasty. 2017;32(5):1439-42.
31. Observation or inpatient? get it right up front. Hospital case management: the monthly update on hospital-based care planning and critical paths. 2012;20(1):1-3.
32. Overman, RA, Freburger, JK, Assimon, MM, et al. Observation stays in administrative claims databases: underestimation of hospitalized cases. Pharmacoepidemiology and drug safety. 2014;23(9):902-10.
33. Parcells, BW, Giacobbe, D, Macknet, D, et al. Total Joint Arthroplasty in a Stand-alone Ambulatory Surgical Center: Short-term Outcomes. Orthopedics. 2016;39(4):223-8.
34. Schuttler, S, Andjelkov, N. Articular cartilage surgery in outpatients: a pilot study. J Knee Surg. 2011;24(2):125-7.
35. Schwappach, DL, Strasmann, TJ. Does location matter? A study of the public's preferences for surgical care provision. J Eval Clin Pract. 2007;13(2):259-64.
36. Sheehy, AM, Graf, B, Gangireddy, S, et al. Hospitalized but not Admitted: Characteristics of Patients with “Observation Status” at an Academic Medical Center. JAMA internal medicine. 2013;173(21):1991-8.
37. Si, HB, Zeng, Y, Shen, B, et al. The influence of body mass index on the outcomes of primary total knee arthroplasty. Knee Surg Sports Traumatol Arthrosc. 2015;23(6):1824-32.
38. Simon, CB, Coronado, RA, Greenfield, WH, 3rd, et al. Predicting Pain and Disability After Shoulder Arthroscopy: Rotator Cuff Tear Severity and Concomitant Arthroscopic Procedures. The Clinical journal of pain. 2016;32(5):404-10.
39. Springer, BD, Odum, SM, Vegari, DN, et al. Impact of Inpatient Versus Outpatient Total Joint Arthroplasty on 30-Day Hospital Readmission Rates and Unplanned Episodes of Care. Orthop Clin North Am. 2017;48(1):15-23.
40. Stieber, JR, Brown, K, Donald, GD, et al. Anterior cervical decompression and fusion with plate fixation as an outpatient procedure. Spine J. 2005;5(5):503-7.
41. Valkering, KP, van Bergen, CJ, Buijze, GA, et al. Pain experience and functional outcome of inpatient versus outpatient anterior cruciate ligament reconstruction, an equivalence randomized controlled trial with 12 months follow-up. Knee. 2015;22(2):111-6.

Spine Surgery

1. Abdallah, DY, Jadaan, MM, McCabe, JP. Body mass index and risk of surgical site infection following spine surgery: a meta-analysis. Eur Spine J. 2013;22(12):2800-9.
2. Adamson, T, Godil, SS, Mehrlich, M, et al. Anterior cervical discectomy and fusion in the outpatient ambulatory surgery setting compared with the inpatient hospital setting: analysis of 1000 consecutive cases. J Neurosurg Spine. 2016;24(6):878-84.
3. Ban, D, Liu, Y, Cao, T, et al. Safety of outpatient anterior cervical discectomy and fusion: a systematic review and meta-analysis. Eur J Med Res. 2016;21(1):34.

4. Bernatz, JT, Anderson, PA. Thirty-day readmission rates in spine surgery: systematic review and meta-analysis. Neurosurg. 2015;39(4):E7.
5. Best, NM, Sasso, RC. Outpatient lumbar spine decompression in 233 patients 65 years of age or older. Spine. 2007;32(10):1135-9; discussion 40.
6. Centers for Medicare and Medicaid Services Hospital Outpatient Prospective Payment CMS-1678-FC Addendum E: HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2018 (2017). Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending Accessed January 11, 2018.
7. Chin, KR, Pencle, FJ, Coombs, AV, et al. Lateral Lumbar Interbody Fusion in Ambulatory Surgery Centers: Patient Selection and Outcome Measures Compared With an Inhospital Cohort. Spine. 2016;41(8):686-92.
8. Di Capua, J, Somani, S, Kim, JS, et al. Analysis of Risk Factors for Major Complications Following Elective Posterior Lumbar Fusion. Spine (Phila Pa 1976). 2017;42(17):1347-54.
9. Emami, A, Faloon, M, Issa, K, et al. Minimally Invasive Transforaminal Lumbar Interbody Fusion in the Outpatient Setting. Orthopedics. 2016;39(6):e1218-e22.
10. Fei, Q, Li, J, Lin, J, et al. Risk Factors for Surgical Site Infection After Spinal Surgery: A Meta-Analysis. World Neurosurg. 2016;95:507-15.
11. Helseth, O, Lied, B, Halvorsen, CM, et al. Outpatient Cervical and Lumbar Spine Surgery is Feasible and Safe: A Consecutive Single Center Series of 1449 Patients. Neurosurgery. 2015;76(6):728-37; discussion 37-8.
12. Jiang, J, Teng, Y, Fan, Z, et al. Does obesity affect the surgical outcome and complication rates of spinal surgery? A meta-analysis. Clin Orthop. 2014;472(3):968-75.
13. Kurtz, SM, Lau, E, Ong, KL, et al. Infection risk for primary and revision instrumented lumbar spine fusion in the Medicare population. J Neurosurg Spine. 2012;17(4):342-7.
14. Lang, SS, Chen, HI, Koch, MJ, et al. Development of an outpatient protocol for lumbar discectomy: our institutional experience. World Neurosurg. 2014;82(5):897-901.
15. Lied, B, Sundseth, J, Helseth, E. Immediate (0-6 h), early (6-72 h) and late (>72 h) complications after anterior cervical discectomy with fusion for cervical disc degeneration; discharge six hours after operation is feasible. Acta Neurochir (Wien). 2008;150(2):111-8; discussion 8.
16. Lim, S, Carabini, LM, Kim, RB, et al. Evaluation of American Society of Anesthesiologists classification as 30-day morbidity predictor after single-level elective anterior cervical discectomy and fusion. Spine J. 2017;17(3):313-20.
17. Liu, FY, Yang, DL, Huang, WZ, et al. Risk factors for dysphagia after anterior cervical spine surgery: A meta-analysis. Medicine (Baltimore). 2017;96(10):e6267.
18. Liu, JT, Briner, RP, Friedman, JA. Comparison of inpatient vs. outpatient anterior cervical discectomy and fusion: a retrospective case series. BMC surg. 2009;9:3.
19. Martin, CT, Pugely, AJ, Gao, Y, et al. Incidence and risk factors for early wound complications after spinal arthrodesis in children: analysis of 30-day follow-up data from the ACS-NSQIP. Spine. 2014;39(18):1463-70.
20. Martin, CT, Pugely, AJ, Gao, Y, et al. Thirty-Day Morbidity After Single-Level Anterior Cervical Discectomy and Fusion: Identification of Risk Factors and Emphasis on the Safety of Outpatient Procedures. J Bone Joint Surg Am. 2014;96(15):1288-94.
21. McGirt, MJ, Godil, SS, Asher, AL, et al. Quality analysis of anterior cervical discectomy and fusion in the outpatient versus inpatient setting: analysis of 7288 patients from the NSQIP database. Neurosurg. 2015;39(6):E9.
22. Observation or inpatient? get it right up front. Hospital case management : the monthly update on hospital-based care planning and critical paths. 2012;20(1):1-3.
23. Ortega, A, Sarmiento, JM, Patil, C, et al. Comparative Analysis of Inpatient and Outpatient Interspinous Process Device Placement for Lumbar Spinal Stenosis. J Neurol Surg A Cent Eur Neurosurg. 2015;76(6):443-50.
24. Overman, RA, Freburger, JK, Assimon, MM, et al. Observation stays in administrative claims databases: underestimation of hospitalized cases. Pharmacoepidemiology and drug safety. 2014;23(9):902-10.
25. Puvanesarajah, V, Nourbakhsh, A, Hassanzadeh, H, et al. Readmission Rates, Reasons, and Risk Factors in Elderly Patients Treated With Lumbar Fusion for Degenerative Pathology. Spine (Phila Pa 1976). 2016;41(24):1933-8.
26. Sansone, JM, del Rio, AM, Anderson, PA. The prevalence of and specific risk factors for venous thromboembolic disease following elective spine surgery. J Bone Joint Surg Am. 2010;92(2):304-13.
27. Schoenfeld, AJ, Reamer, EN, Wynkoop, EI, et al. Does Patient Sex Affect the Rate of Mortality and Complications After Spine Surgery? A Systematic Review. Clin Orthop. 2015;473(8):2479-86.
28. Sheehy, AM, Graf, B, Gangireddy, S, et al. Hospitalized but not Admitted: Characteristics of Patients with "Observation Status" at an Academic Medical Center. JAMA internal medicine. 2013;173(21):1991-8.
29. Smith, WD, Wohns, RN, Christian, G, et al. Outpatient Minimally Invasive Lumbar Interbody: Fusion Predictive Factors and Clinical Results. Spine. 2016;41 Suppl 8:S106-22.

30. Somani, S, Di Capua, J, Kim, JS, et al. Comparing National Inpatient Sample and National Surgical Quality Improvement Program: An Independent Risk Factor Analysis for Risk Stratification in Anterior Cervical Discectomy and Fusion. Spine (Phila Pa 1976). 2017;42(8):565-72.
31. Stieber, JR, Brown, K, Donald, GD, et al. Anterior cervical decompression and fusion with plate fixation as an outpatient procedure. Spine J. 2005;5(5):503-7.
32. Sturiale, CL, Rossetto, M, Ermani, M, et al. Remote cerebellar hemorrhage after spinal procedures (part 2): a systematic review. Neurosurg Rev. 2016;39(3):369-76.
33. Tan, TP, Govindarajulu, AP, Massicotte, EM, et al. Vocal cord palsy after anterior cervical spine surgery: a qualitative systematic review. Spine J. 2014;14(7):1332-42.
34. Tetreault, L, Ibrahim, A, Cote, P, et al. A systematic review of clinical and surgical predictors of complications following surgery for degenerative cervical myelopathy. J Neurosurg Spine. 2016;24(1):77-99.
35. Wang, T, Yang, SD, Huang, WZ, et al. Factors predicting venous thromboembolism after spine surgery. Medicine (Baltimore). 2016;95(52):e5776.
36. Wright, B, Jung, HY, Feng, Z, et al. Trends in observation care among Medicare fee-for-service beneficiaries at critical access hospitals, 2007-2009. The Journal of rural health : official journal of the American Rural Health Association and the National Rural Health Care Association. 2013;29 Suppl 1:s1-6.
37. Xing, D, Ma, JX, Ma, XL, et al. A methodological, systematic review of evidence-based independent risk factors for surgical site infections after spinal surgery. Eur Spine J. 2013;22(3):605-15.
38. Yen, D, Albargi, A. Results and limitations of outpatient and overnight stay laminectomies for lumbar spinal stenosis. Can J Surg. 2017;60(5):329-34.

Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Specific CPT codes for services should be used when available. Nonspecific or not otherwise classified codes may be subject to additional documentation requirements and review.

CPT/HCPCS codes for Joint Surgery

Note: Codes listed are in scope for joint surgery.

Shoulder Arthroscopy and Open Procedures

23105 .....Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy
23107 .....Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
23120 .....Claviculectomy; partial
23130 .....Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
23410 .....Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute
23412 .....Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic
23415 .....Coracoacromial ligament release, with or without acromioplasty
23420 .....Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
23430 .....Tenodesis of long tendon of biceps
23440 .....Resection or transplantation of long tendon of biceps
23450 .....Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455 .....Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)
23460 .....Capsulorrhaphy, anterior, any type; with bone block
23462 .....Capsulorrhaphy, anterior, any type; with coracoid process transfer
23465 .....Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466 .....Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
29805 .....Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806 .....Arthroscopy, shoulder, surgical; capsulorrhaphy

29807 .....Arthroscopy, shoulder, surgical; repair of SLAP lesion

29819 .....Arthroscopy, shoulder, surgical; with removal of loose body or foreign body

29820 .....Arthroscopy, shoulder, surgical; synovectomy, partial

29821 .....Arthroscopy, shoulder, surgical; synovectomy, complete

29822 .....Arthroscopy, shoulder, surgical; debridement, limited

29823 .....Arthroscopy, shoulder, surgical; debridement, extensive

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

29826 .....Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)

29827 .....Arthroscopy, shoulder, surgical; with rotator cuff repair

29828 .....Arthroscopy, shoulder, surgical; biceps tenodesis

Hip Arthroplasty (Total/Partial/Revision Hip Replacement)

27125 .....Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)

27130 .....Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

Hip Arthroscopy

29860 .....Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)

29861 .....Arthroscopy, hip, surgical; with removal of loose body or foreign body

29862 .....Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum

29863 .....Arthroscopy, hip, surgical; with synovectomy

29914 .....Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)

29915 .....Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)

29916 .....Arthroscopy, hip, surgical; with labral repair

Knee Arthroplasty (Total/Partial/Revision Knee Replacement)

27437 .....Arthroplasty, patella; without prosthesis

27438 .....Arthroplasty, patella; with prosthesis

27440 .....Arthroplasty, knee, tibial plateau

27441 .....Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy

27442 .....Arthroplasty, femoral condyles or tibial plateau(s), knee

27443 .....Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy

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)

Knee Arthroscopy and Open Procedures

27331 .....Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies

27332 .....Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral

27333 .....Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral

27334 .....Arthrotomy, with synovectomy, knee; anterior OR posterior

27335 .....Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area

27403 .....Arthrotomy with meniscus repair, knee

27405 .....Repair, primary, torn ligament and/or capsule, knee; collateral

27407 .....Repair, primary, torn ligament and/or capsule, knee; cruciate

27409 .....Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments

27427 .....Ligamentous reconstruction (augmentation), knee; extra-articular

27428 .....Ligamentous reconstruction (augmentation), knee; intra-articular (open)

27429 .....Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular

29870 .....Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)

29871 .....Arthroscopy, knee, surgical; for infection, lavage and drainage

29873 .....Arthroscopy, knee, surgical; with lateral release

29874 .....Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)

29875 .....Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)

29876 .....Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)

29877 .....Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

29879 .....Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture

29880 .....Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

29881 .....Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

29882 .....Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)

29883 .....Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)

29884 .....Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)

29885 .....Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)

29886 .....Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion

29887 .....Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation

29888 .....Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

29889 .....Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

Meniscal Allograft Transplantation of the Knee

29868 .....Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral

Treatment of Osteochondral Defects

27412 .....Autologous chondrocyte implantation, knee

27415 .....Osteochondral allograft, knee, open

27416 .....Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])

29866 .....Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])

29867 .....Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)

29892 .....Arthroscopically aided repair of large osteochondritis disssecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthoscopy)

Small Joint Surgery

27702 .....Arthroplasty, ankle; with implant (total ankle)

27703 .....Arthroplasty, ankle; revision, total ankle

27704 .....Removal of ankle implant

27870 .....Arthrodesis, ankle, open

28110 .....Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)

28285 .....Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)

28286 .....Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)

28289 .....Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant

28291 .....Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant

28292 .....Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method

28295 .....Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method

28296 .....Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method

28297 .....Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method

28298 .....Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method

28299 .....Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method

28306 .....Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal

28307 .....Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)

28308 .....Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each

28310 .....Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

28312 .....Osteotomy, shortening, angular or rotational correction; other phalanges, any toe

28315 .....Sesamoidectomy, first toe (separate procedure)

28750 .....Arthrodesis, great toe; metatarsophalangeal joint

CPT/HCPCS codes for Spine Surgery

Note: Codes listed are in scope for spine surgery.

Anterior Cervical Discectomy Fusion (ACDF) or Artificial Cervical Disc Arthroplasty

22551 .....Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2

22552 .....Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)

22554 .....Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

22585 .....Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)

22634 .....Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace, single interspace and segment; lumbar; each additional interspace and segment

22845 .....Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)

22853 .....Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)

22856 .....Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical

22858 .....Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)

Cervical Laminotomy/Laminectomy

63020 .....Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

63035 .....Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

63040 .....Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical

63043 .....Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)

63048 .....Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar

63075 .....Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

63076 .....Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)

63265 .....Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical

Lumbar Discectomy/Laminectomy

63005 .....Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis

63012 .....Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)

63017 .....Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar

63030 .....Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

63042 .....Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar

63044 .....Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)

63047 .....Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar

63048 .....Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar

63056 .....Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)

63057 .....Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)

63267 .....Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar

Lumbar Fusion and Treatment of Spinal Deformity (including Scoliosis and Kyphosis)

22633 .....Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace, single interspace and segment; lumbar

Vertebroplasty/Kyphoplasty

22510 .....Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 .....Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

22512 .....Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

22513 .....Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

22514 .....Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

22515 .....Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

Appendix

ASA Physical Status Classification System

Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A 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 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A 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 (BMI ≥ 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 CAD/stents.
ASA IV	A 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, DIC, 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 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)

Source: 2014 ASA Physical Status Classification System available at the American Society of Anesthesiologists website; Accessed June 26, 2018.

History

Status	Review Date	Effective Date	Action
Archived	–	01/01/2021	Archived.
Revised	02/03/2020	11/01/2020	IMPP review. Added clarifications for thoracic and sacral spine. Added CPT codes for joint surgery: 27702, 27703, 27704, 27870, 28110, 28285, 28286, 28289, 28291, 28292, 28295, 28296, 28297, 28298, 28299, 28306, 28307, 28308, 28310, 28312, 28315, 28750, 29871, 29892. Added CPT codes for spine surgery: 22633, 22634, 63265, 63267.
Revised	07/11/2018	03/09/2019	IMPP review. Added the General Clinical Guideline.
Revised	07/11/2018	01/28/2019	IMPP review. Added observation surgical setting.
Created	12/12/2017	03/01/2018	IMPP review. Original effective date.