**DISCLAIMER**

West Virginia Family Health medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

**POLICY STATEMENT**

West Virginia Family Health provides coverage under the medical-surgical benefits of the Company’s Medicaid products for medically necessary services performed as an outpatient.

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

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and all applicable state and federal regulations.

**DEFINITIONS**

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

1. This policy addresses the place of service only and does not address medical necessity of specific procedures. Please refer to the Provider Manual for assistance with the process of determining medical necessity of the procedure.

2. When the services are not covered
   Services identified as appropriate in the outpatient setting will not be reimbursed in the inpatient setting without a West Virginia Family Health Medical Director approval.

3. A procedure is considered appropriate in the outpatient setting when:
   A. The procedure requires the services of the recovery room
   B. Post-operative care can be managed at home

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

4. Post-payment Audit Statement
   The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by West Virginia Family Health at any time pursuant to the terms of your provider agreement.

5. Place of Service
   Place of Service for procedure codes identified below is appropriate for outpatient.

CODING REQUIREMENTS

Covered Procedure Codes
Hysterectomy

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal tube(s), and or ovary(s)</td>
</tr>
<tr>
<td>58263</td>
<td>Vaginal hysterectomy, for uterus 250 g or less with removal of tubes and/or ovary(s) with repair of enterocele</td>
</tr>
<tr>
<td>58270</td>
<td>Vaginal hysterectomy w/colp-urethocystopexy (Marshall-Marchetti-Krantz type, Pereya type) with or without endoscopic control w/repair of enterocele</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy with uterus greater than 250 g</td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy with uterus greater than 250 g; with removal of tube(s) or ovary(s)</td>
</tr>
<tr>
<td>58292</td>
<td>Vaginal hysterectomy with uterus greater than 250 g; with removal of tube(s) or ovary(s), with repair of enterocele</td>
</tr>
<tr>
<td>58294</td>
<td>Vaginal hysterectomy for uterus greater than 250 g with repair of enterocele</td>
</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less, with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
</tbody>
</table>
Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less

Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)

Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g

Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g or less

Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g or less; with removal of tube(s) and/or ovary(s)

Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g

Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Cholecystectomy

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47562</td>
<td>Laparoscopy, surgical; cholecystectomy</td>
</tr>
<tr>
<td>47563</td>
<td>Laparoscopy, cholecystectomy with cholangiography</td>
</tr>
<tr>
<td>47564</td>
<td>Laparoscopy, cholecystectomy with exploration of common duct</td>
</tr>
</tbody>
</table>

REIMBURSEMENT

Participating facilities will be reimbursed per their West Virginia Family Health contract.

SUMMARY OF LITERATURE

Hysterectomy

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

Place of Service

Outpatient Setting

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

Minimally Invasive Techniques

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

Up To Date

Patients who have laparoscopic hysterectomy without perioperative complication or comorbidities can be discharged home on the same day, or stay in the hospital overnight, typically one night. Observational studies have consistently found the same day discharge is safe and less costly and experience fewer postoperative complications.
As reported by Guta (2011), nineteen laparoscopically assisted vaginal hysterectomies and 17 total laparoscopic hysterectomies were performed. The 2 groups were similar in age, BMI, uterine weight, and surgical time. Comparing the 2 groups, there were no statistically significant differences in pain throughout any time points of the study. The authors concluded that outpatient hysterectomy is a safe procedure that may improve patient satisfaction surgically and financially, and either approach is well tolerated by patients.

Whiteman (2010) reported that gynecologic disorders accounted for 7% of all inpatient hospitalizations among reproductive age women that uterine leiomyoma was the most common diagnosis, and that 80% of women who were hospitalized for uterine leiomyoma, menstrual disorders, or endometriosis underwent hysterectomy. Overall costs and Medicare coinsurance rates are lower in ASCs.

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

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

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

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

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

- Patients undergoing uncomplicated laparoscopic cholecystectomy for symptomatic cholelithiasis may be discharged home on the day of surgery; control of postoperative pain, nausea, and vomiting are important to successful same day discharge. (Level II, Grade B)
- Patients older than age 50 may be at increased risk for admission. (Level II, Grade B).
- Time to discharge after surgery for patients with acute cholecystitis, bile duct stones, or in patients converted to an open procedure should be determined on an individual basis. (Level III, Grade A).
In 2013, Vaughan et al. performed a review of randomized clinical trials comparing day-surgery versus overnight stay surgery for laparoscopic cholecystectomy. It was reported that day-surgery seems to be as safe as overnight stay surgery. There was no improvement in any patient-oriented outcomes such as a return to normal activity or earlier return to work. The authors stated that more randomised clinical trials are needed to assess the impact of day-surgery laparoscopic cholecystectomy on the quality of life and other patient outcomes.

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

**POLICY SOURCE(S)**


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

Additions to List of ASC Covered Surgical Procedures for CY 2016. Table 68. Federal Register 80(219), November 13, 2015: p 70490.


Medicare co-insurance rates are lower in ASCs than in hospitals. MedPAC, Report to the Congress: Medicare Payment Policy, March 2004


Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>09/06/2016</td>
<td>Policy approved at QI/UM Meeting</td>
</tr>
<tr>
<td>11/03/2016</td>
<td>Provider effective date</td>
</tr>
<tr>
<td>02/01/2017</td>
<td>Annual review; Revised Operational Guidelines, additional formatting changes; Added Policy History box page 7; Revised section #2 'When services are not covered' to read 'will not be reimbursed in the inpatient setting without WVFH Medical Director approval'; WVFH disclaimer update</td>
</tr>
<tr>
<td>03/01/2017</td>
<td>QI/UM Review and approval</td>
</tr>
<tr>
<td>08/02/2017</td>
<td>Revision of language in #2 criteria of Procedures stating inpatient requests must be approved by medical director.</td>
</tr>
<tr>
<td>08/08/2017</td>
<td>Revisions: Under Procedures, #2, language revised to allow medical director approval for inpatient requests.</td>
</tr>
<tr>
<td>09/06/2017</td>
<td>QI/UM Committee approval</td>
</tr>
<tr>
<td>11/01/2017</td>
<td>Provider effective date</td>
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</table>
