NOTE: This policy is not effective until January 1, 2026.

Medical Policy Manual Utilization Management, Policy No. 20

Surgical Site of Care – Colonoscopy

Effective: January 1, 2026

Next Review: August 2026
Last Review: August 2025

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

An ambulatory surgery center (ASC) is a health care facility which offers same-day surgery care outside the hospital setting. An ASC is a surgical facility that does not have inpatient beds, and the entity may or may not be sponsored by a hospital. An individual's health status is considered when determining the appropriateness for the site of care among other factors including facility and geographic availability, specialty requirements, and physician privileges.

MEDICAL POLICY CRITERIA

Notes:

- This policy does not address procedures performed in an ambulatory surgery center (ASC), physician office, or emergency facility for urgent services.
- This policy addresses prior authorization for site of care only. The procedure may require prior authorization separately (see applicable Medical Policy).
- For coverage of a procedure in a hospital outpatient department, in addition to meeting the criteria in this medical policy, the type of service being performed must be considered medically necessary per prior authorization review requirements and the applicable medical policy OR the health plan does not require prior authorization for the service being performed.

I. The use of a hospital outpatient department instead of an ambulatory surgery center (ASC) or physician office for surgical services may be considered **medically necessary** when one or more of the following Criteria is met:

A. There is no qualifying in-network ASC within 25 miles that can provide the necessary care for the patient due to one of the following:

1. There is no geographically accessible in-network ASC that has the necessary equipment for the procedure; or
2. A diagnostic colonoscopy is necessary and there is no geographically accessible in-network ambulatory surgical center available at which the individual's physician has privileges (See Policy Guidelines); or
3. An ASC's specific guideline regarding the individual's weight or health conditions prevents the use of an ASC;

B. The procedure requires discontinuing medications (e.g. antiarrhythmics, antiseizure medication), which necessitate preoperative or postoperative inpatient monitoring or treatment;

C. The individual is using substances or medications (e.g. cocaine, amphetamines, monoamine oxidase inhibitor, alcohol) that may interact with the anticipated anesthetic regimen or lead to withdrawal syndrome;

D. History of a significant hemodynamic instability during a prior surgical procedure and is considered a risk for future procedures;

E. Age 17 years and younger;

F. The service being performed is in conjunction with an additional service that requires the use of a hospital outpatient department and they are being performed in the same operative session;

G. American Society of Anesthesiologists (ASA) Physical Status (PS) Classification III or higher (see Policy Guidelines);

H. Body mass index (BMI) is over 40;

I. Bleeding disorder requiring replacement factor or special infusion products to correct a coagulation defect;

J. Complex anticoagulation management anticipated;

K. Transfusion anticipated;

L. Sickle cell disease;

M. Clinical documentation that cardiovascular risk is increased by any of the following factors:

1. Symptomatic cardiac arrhythmia despite medication
2. Coronary artery disease (CAD)
3. Drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days
4. History of cerebrovascular accident (CVA) or transient ischemic attack (TIA) within past three months

5. History of myocardial infarction (MI) within past three months
6. Implantable cardioverter-defibrillator (ICD)
7. Implanted pacemaker
8. Mechanical cardiovascular support (e.g., left ventricular assist device [LVAD] or total artificial heart)
9. Peripheral vascular disease (PVD)
10. Ongoing evidence of myocardial ischemia
11. Hypertension, severe (>180/110) or resistant (not responsive to three antihypertensive medications)
12. Uncompensated chronic heart failure (CHF) (NYHA class III or IV)
13. Valvular heart disease and/or cardiomyopathy, moderate or severe;

N. Prolonged surgery (> 3 hours);

O. Advanced liver disease (Model for End-Stage Liver Disease [MELD] Score > 8);

P. Diabetes, when uncontrolled (HgbA1c >8%) or with recurrent diabetic ketoacidosis (DKA) or severe hypoglycemia;

Q. End stage renal disease (ESRD), Stage 4 or 5 chronic kidney disease;

R. Incompletely treated skin or wound infection;

S. Pregnancy;

T. Pulmonary risk is increased by any of the following factors:

1. Abnormal airway
2. Prior difficult intubation
3. Active respiratory infection
4. Chronic obstructive pulmonary disease (COPD) (FEV1 < 50%)
5. Medical conditions that are commonly connected with difficult airway (e.g., Pierre-Robin, Treacher-Collins, Goldenhar's Syndrome, and Epidermolysis Bullosa)
6. Poorly controlled asthma (FEV1 < 80% despite medical management)
7. Moderate to severe obstructive sleep apnea:
    a. Moderate = Apnea hypopnea index (AHI) or respiratory disturbance index (RDI) $\geq$15 and $\leq$30;
    b. Severe = AHI or RDI >30/hr;
8. Dependent on a ventilator or continuous supplemental oxygen;

U. Personal history or family history of complication of anesthesia such as malignant hyperthermia;

V. History of any of the following gastrointestinal conditions that would increase risk for aspiration:

1. Documented history of achalasia

2. Documented history of delayed gastric emptying disorder or gastroparesis;

W. History of any of the following neurological diagnoses that would increase risk:

1. Active multiple sclerosis

2. Myasthenia gravis

3. Severe motor disorder (e.g. severe Parkinson's, or other severe neurological dysfunction)

X. A condition is present that will require the use of restraints;

Y. History of total joint infection;

Z. Individual is awaiting major organ transplant;

AA. Risk of procedure-specific complication;

BB. Member has a documented disability that makes receiving care in an ASC setting inappropriate;

CC. Provider documents a requirement for overnight recovery based on a unique circumstance for the individual.

II. The use of a hospital outpatient department for surgical services instead of an ambulatory surgery center or physician office is considered **not medically necessary** when Criteria I. is not met.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

Site of care medical necessity reviews will be conducted for surgical procedures on the Codes list provided in this policy only when performed in an outpatient hospital setting.

Diagnostic colonoscopy: documentation of signs and/or symptoms is required.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PHYSICAL STATUS CLASSIFICATION SYSTEM[1]

ASA PS Classification	Definition	Adult 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. 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. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker,

ASA PS Classification	Definition	Adult Examples, including but not limited to:
		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	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	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)

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and physical/chart notes
- American Society of Anesthesiologists (ASA) score, as applicable
- Clinical documentation for specific policy criteria (refer to the Policy Criteria) that qualifies the individual for the site of care requested
- For specific services requiring prior authorization in addition to the site of care, submission of the applicable medical policy clinical documentation required for review.
- The best way to ensure criteria are met is to submit the Surgical Site of Care Additional Information form if faxing a pre-authorization request for these services.

CROSS REFERENCES

1. Surgical Site of Care – Hospital Outpatient, Utilization Management, Policy No. 19

BACKGROUND

An ambulatory surgery center (ASC) is a health care facility which offers same-day surgery services outside the hospital setting. An ASC is a surgical facility that does not have inpatient beds, and the entity may or may not be sponsored by a hospital.

An individual's health status is considered when determining the appropriateness for the site of care among other factors including facility and geographic availability, specialty requirements, and physician privileges. The American Society of Anesthesiologist (ASA) physical status classification system (see Appendix I), and/or significant comorbidities may be taken into

account.[1] The ASA risk scoring system is regarded by hospitals, legal firms, accrediting bodies, and other healthcare groups as a preoperative health grading system for individuals undergoing a surgical procedure. For example, individuals with ASA I-II status might be appropriate candidates for ASC care, though ASA III and above may not. Significant comorbidities may include but are not limited to significant cardiorespiratory condition (e.g., recent myocardial infarction, cardiac arrhythmia, and myocardial ischemia), moderate-to-severe obstructive sleep apnea, pregnancy, and poorly controlled asthma.

EVIDENCE SUMMARY

PEDIATRIC SITE OF CARE

In general, ASCs provide more services to adults than to children. According to Eklund (2024), ASCs that provide care to children need an infrastructure that ensures staff have pediatric life-support training (PALS), as well as pediatric emergency equipment and pharmacy expertise.[2] Tian (2023) published a study that compared patient and procedure characteristics from 198,362 observations of outpatient procedures in three states.[3] Compared to hospital-owned facilities, freestanding ASCs were less likely to provide services to people with Medicaid or the Children's Health Insurance Program (CHIP) ($p<0.001$). The authors note that almost 40% of American children are insured through Medicaid or CHIP. The study findings suggest ASCs are less likely to have an adequate infrastructure to provide safe pediatric care.

PRACTICE GUIDELINE SUMMARY

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

The American Society of Anesthesiologists (ASA) maintains a Physical Status Classification System with definitions and ASA-approved examples (reproduced in Appendix I).[1] This system is intended to be used in conjunction with other factors to aid in predicting perioperative risks. The system was originally proposed in 1942, and the current version was published in 2014 with the inclusion of examples, and was most recently updated in 2020.

SUMMARY

The use of a hospital outpatient department instead of an ambulatory surgical center (ASC) for surgical services may be considered medically necessary when the procedure is of a level of complexity such that it may not be performed in a less intensive setting, the service being performed is medically necessary, and the surgical site of care policy criteria are met.

The use of a hospital outpatient department instead of an ambulatory surgical center (ASC) for surgical services is not medically necessary when the policy criteria are not met including when the procedure can be safely performed in a less intensive setting, the specific service requires prior authorization and does not meet applicable policy criteria, or the surgical site of care policy criteria are not met.

REFERENCES

1. American Society of Anesthesiologists (ASA) Physical Status Classification System. Last amended: December 13, 2020. 12/13/2020 [cited 8/25/2025]. 'Available from:'

https://www.asahq.org/standards-and-practice-parameters/statement-on-asa-physical-status-classification-system.
2. Eklund JE, Chang CC, Donnelly MJ. Critical patient safeguards for ambulatory surgery centers. *Curr Opin Anaesthesiol.* 2024. PMID: 39377472
3. Tian Y, Allen LD, Ingram ME, et al. Disparities in Delivery of Ambulatory Surgical Care for Children. *JAMA Netw Open.* 2023;6(6):e2317018. PMID: 37273209

CODES

NOTE: Site of care medical necessity reviews will be conducted for surgical procedures on the Codes list below only when performed in an outpatient hospital setting.

Codes	Number	Description
CPT	44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
	44389	Colonoscopy through stoma; with biopsy, single or multiple
	44391	Colonoscopy through stoma; with control of bleeding, any method
	44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
	44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
	44408	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
	45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
	45379	Colonoscopy, flexible; with removal of foreign body(s)
	45380	Colonoscopy, flexible; with biopsy, single or multiple
	45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
	45382	Colonoscopy, flexible; with control of bleeding, any method
	45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
	45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
	45386	Colonoscopy, flexible; with transendoscopic balloon dilation
	45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
	45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)
	45390	Colonoscopy, flexible; with endoscopic mucosal resection
	45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
	45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
	45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
	45398	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
HCPCS	G0105	Colorectal cancer screening; colonoscopy on individual at high risk

Codes	Number	Description
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Date of Origin: *July 2022*