

EVH Clinical Guideline 2735.CC for Site of Service

Guideline Number: EVH_CG_2735.CC	<u>Applicable Codes</u>	
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STATEMENT

General Information

- *It is an expectation that all members receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*
- *Site of service refers to procedures that can be safely performed in an outpatient setting.*
 - *Many procedures can be performed in an outpatient setting unless otherwise specified and based on medical necessity.*
 - *Outpatient procedures do not require prior authorization unless specifically listed on the CountyCare PA Look-Up Tool.*
 - *Prior authorization is required for all elective procedures performed at an observation or inpatient level of care setting.*

Special Note

Healthcare and Family Services (HFS) Inpatient Procedure Only (IPO) List

- *If a procedure code is on the IPO list and if the procedure is medically necessary and the provider requests to perform the procedure in the inpatient setting, the procedure will be considered medically necessary for the inpatient setting. (The IPO List can be located in the CountyCare Prior Authorization Look-Up Tool and under Clinical Criteria on the CountyCare website.)*

INDICATIONS

Services Performed in an Outpatient Level of Care Setting

A surgery or procedure that is being requested in an outpatient setting may not be subject to prior authorization or medical necessity review if listed in this policy as a “Site of Service” Procedure as noted on the “Site of Service” list found here [Site of Service Procedure Code with IPO list](#).

Services Medically Necessary at Inpatient Level of Care

A surgery or procedure being requested for an inpatient level of care setting is deemed medically necessary when ANY ONE the following criteria are met:

- If medically necessary and identified in the HFS IPO list noted in the **Site of Service Procedure Code with IPO list**.
- The potential changes in the individual's medical status could require emergency resuscitation care, and inpatient admission or intensive care.
- Medical conditions that increase the risk of major post-operative complications as indicated by **one or more** of the following ^(1,2):
 - Frailty with Clinical Frailty Score > 5 ^(3,4)
 - Preoperative Myelopathy with functional impairment impacting safe ambulation ⁽⁴⁾
 - Morbid obesity (Body Mass Index (BMI) $\geq 40 \text{ kg/m}^2$) with hemodynamic or respiratory problems
 - Heart failure with Left Ventricular Ejection Fraction (EF) < 40%, symptomatic coronary artery disease, severe valvular disease (e.g., severe aortic stenosis), or dangerous arrhythmia
 - Symptomatic Chronic Obstructive Pulmonary Disease (COPD) or asthma, requiring home oxygen
 - Severe kidney disease (glomerular filtration rate (GFR) $\leq 30 \text{ mL/min}$ or on dialysis)
 - End-stage liver disease (Model for End-Stage Liver Disease 9MELD) score ≥ 10
 - Bleeding disorder requiring replacement factors or blood products
 - Severe obstructive sleep apnea (Apnea-Hypopnea Index (AHI) ≥ 30)
 - Stroke, Transient Ischemic Attack (TIA), myocardial infarction, or thromboembolism with the last 3 months
 - Cognitive impairment or dementia ⁽⁴⁾
 - Other unstable medical condition (e.g., uncontrolled hypertension, persistent electrolyte abnormalities, poorly controlled diabetes (Hemoglobin A1c ≥ 8) ⁽⁵⁻⁷⁾
 - Inadequate home care situation identified preoperatively as indicated by **one or more** of the following:
 - will have post-operative incapacitation and has no available assistance at home to provide necessary care, and arranging an alternative level of care is not possible
 - Travel time to facility is over 2 hours and procedure has urgent complication potential which limit safe transfer of care to home within 48 hours following surgery ⁽⁸⁾
 - Prolonged surgery and unanticipated changes to surgery that require inpatient stay.

NOTE: ALL criteria require additional documentation from the treating physician and/or subspecialist consultant.

Services Not Medically Necessary at Inpatient Level of Care

Requests for procedures that do not meet the criteria above will be considered not medically necessary at an inpatient level of care and require redirection to an outpatient setting.

CONVERSION FROM OUTPATIENT TO INPATIENT STATUS

Conversion from outpatient to inpatient status may be considered for the following:

- Delayed recovery such as persistent cardiovascular instability or hypoxia
- Ambulatory status has not been achieved in a reasonable amount of time
- A surgical complication or circumstance now requires inpatient level of care, such as neurovascular injury, extensive or prolonged surgery, conversion to a more complex procedure, or requirement for excessive transfusion
- Prolonged nausea or vomiting, delirium, altered mental status, inability to void, or inadequate pain control

LIMITATIONS

This policy is intended to provide guidance for in-network care facilities. All requests for procedures done in any facility outside of CountyCare's contracted network (Out of Network) are subject to prior authorization reviews. Requests for Out of network services may be redirected to a facility within CountyCare's contracted network.

CODING AND STANDARDS

Codes

N/A

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

CountyCare's prior authorization requirements ensure that all requested services are both medically necessary and are conducted in an optimal clinical setting. This policy defines the criteria that CountyCare uses to evaluate requests for outpatient procedures to be performed in an inpatient level of care setting. The medical necessity of the procedure itself in the appropriate place where it will be provided will be reviewed against applicable policy.

CountyCare encourages the use of the safest and most appropriate places of service for certain medically necessary outpatient surgical procedures.

Authorization is required when the requested place of service is an inpatient level of care setting rather than an outpatient setting, for the surgical procedures listed in Appendix A.

Procedures reviewed by Evolent Specialty Services (ESS) will require prior authorization, regardless of site of service

Clinician will refer member to case management support to assist with barriers and connect with discharge planner to collaborate on member needs.

POLICY HISTORY

Date	Summary
August 7, 2026	Annual Review – Updated General Information to include Site of Service bullets; updated Special Note; added Outpatient Level of Care information to Indications; updated Inpatient Level of Care Indications; updated Limitations; removed the Related Documentation, Appendix A and Appendix B sections; updated Background section; updated References
November 20, 2025	This guideline replaces PA.248.CC Site of Service Policy

Date	Summary
	Annual Review - Editorial changes to match the formatting and layout of the new template; added in-text citations; added Special Note; updated Indications; added Conversion from Outpatient to Inpatient Status Section; minor update to Limitations and Appendix A; updated Appendix B; updated ASA Classification section; updated Background section; replaced outdated References with updated References

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

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REFERENCES

1. Mantel J, Ruppenkamp JW, Cantu M, Holy CE. Total knee arthroplasty in the outpatient vs inpatient settings: impact of site of care on early postoperative economic and clinical outcomes. *J Orthop Surg Res*. 2023;18(1). doi:10.1186/s13018-023-03750-4
2. Lee JH. Anesthesia for ambulatory surgery. *Korean J Anesthesiol*. 2017;70(4):398-406. doi:10.4097/kjae.2017.70.4.398
3. Rothenberg KA, Stern JR, George EL, et al. Association of frailty and postoperative complications with unplanned readmissions after elective outpatient surgery. *JAMA Netw Open*. 2019;2(5). doi:10.1001/jamanetworkopen.2019.4330
4. Charipova K, Urits I, Viswanath O, Urman RD. Preoperative assessment and optimization of cognitive dysfunction and frailty in the ambulatory surgical patient. *Curr Opin Anaesthesiol*. 2020;33(6):732-739. doi:10.1097/ACO.0000000000000901
5. Committee on Ambulatory Surgical Care. *Statement on Ambulatory Anesthesia and Surgery*.; 2023.
6. Committee on Ambulatory Surgical Care. Standards and Practice Parameters: Statement on Ambulatory Anesthesia and Surgery. American Society of Anesthesiologists. October 18, 2023. Accessed September 25, 2024. <https://www.asahq.org/standards-and-practice-parameters/statement-on-ambulatory-anesthesia-and-surgery>
7. Filipovic MG, Schwenter A, Luedi MM, Urman RD. Modern preoperative evaluation in ambulatory surgery-who, where and how? Published online 2022. doi:10.48350/173496
8. Durand WM, Badin D, Ortiz-Babilonia C, Musharbash FN, Raad M, Jain A. Emergency Department Visits After Outpatient Spine Surgery. *Spine (Phila Pa 1976)*. 2022;47(14):1011-1017. doi:10.1097/BRS.0000000000004368