Evolent Place of Service Policy 1773 for Musculoskeletal Surgery

Policy Number: Evolent_POS_1773	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc.		
Original Date: March 2025	**Last Revised Date:** December 2025	**Implementation Date:** July 2026

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STATEMENT

General Information

- *It is an expectation that all patients 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.*
- *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.*

Purpose

The following Place of Service policy is intended to provide guidance for the appropriateness of inpatient vs. outpatient surgery. The criteria for inpatient level of care are listed in the Criteria for Selection of Inpatient Setting section.

LEVEL OF CARE

- **LEVEL OF CARE** refers to the intensity of the services required for the patient while they are receiving care.
    - **INPATIENT SURGERY** is surgical treatment administered to a patient whose condition requires treatment in a hospital or other health care facility, and the patient is formally admitted to the facility by a doctor. Inpatient surgery can only take place in an inpatient hospital facility.
    - **OUTPATIENT SURGERY** is defined as occurring when a patient has surgery and is expected to be discharged without requiring a hospital admission. Outpatient surgery can include both same day surgery (patient returns home on the same day) or surgery that includes an observation period that may extend to include overnight.

PLACE OF SERVICE

- **PLACE OF SERVICE (POS)** is the facility code that is applied to claims to describe where a medical procedure was performed. It impacts reimbursement to the facility, determines whether a procedure qualifies for specific programs, for example Bundled Payments for Care Improvement (BPCI) or Comprehensive Care for Joint Replacement (CJR), and determines which claims-based outcomes reporting system is utilized. [1]

- **OUTPATIENT HOSPITAL OFF CAMPUS - POS CODE 19**

  A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

- **HOSPITAL - POS CODE 21**

  A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

- **OUTPATIENT HOSPITAL ON CAMPUS - POS CODE 22**

  A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

- **AMBULATORY SURGERY CENTER - POS CODE 24**

  A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

POLICY AND PROCEDURE

Identifying the optimal level and place of care for surgical procedures has been increasingly recognized as a critical component to improving outcomes and reducing costs. Advances in surgical technique and care delivery, including pain and anesthesia management, perioperative medical optimization, early mobilization, and care coordination, have enabled specific surgical procedures to move out of the inpatient environment and into the outpatient area of either a hospital or to an ambulatory surgical center (ASC). [(2)] This transition is predicted to accelerate, and it is estimated that greater than one half of primary joint replacement surgeries, as well as many spine surgeries, will take place in an outpatient setting by 2026.

Providers and patients have recognized the benefits associated with surgical procedures performed in the outpatient setting, with either a same day discharge to home or a brief period of post-operative observation. Some of the advantages include less chance of infection, less financial burden, and increased patient satisfaction with the ability to recover in the more comfortable environment of one's own home. [(3,4)] While total hip, knee, and shoulder arthroplasty were previously designated by The Centers for Medicare & Medicaid Services (CMS) as procedures belonging on the inpatient-only (IPO) list, CMS now allows for these procedures, as well as many spine procedures, to be performed in an outpatient setting. [(4,5)]

In 2020, the COVID-19 pandemic required a cancellation of many inpatient surgical procedures to conserve resources for an already over-burdened health care system. This caused a shift of arthroplasty procedures to the outpatient environment that has not demonstrated an increase in complications or hospital readmissions. [(6)] Some outcome studies indicate that in appropriately selected patients, there may be an actual decrease in surgical complications performed in the outpatient versus the inpatient environment. Despite the increasing prevalence and appropriateness of certain procedures shifting to an outpatient, there remains a sub-group of patients for whom elective musculoskeletal surgery may be more appropriately performed in the inpatient setting. [(7)] Institutional protocols and risk assessment prediction tools such as the

American Society of Anesthesiologists (ASA) classification, Charleston Comorbidity index (CCI) and Outpatient Arthroplasty Risk Assessment (OARA) have been utilized to help predict suitability for outpatient procedures and position statements have been developed by orthopedic specialty societies that provide some guidance for outpatient surgery criteria. [8,9] However, while there is still no definitive agreement as to which patients can safely have surgery in the outpatient environment, recent experience helps to inform this decision. Determining inpatient versus outpatient status is a complex decision involving clinical and social factors, the patient's general health and suitability, as well as surgical complexity, all playing a significant role in the decision-making process. [10]

Other factors may be equally as important in the safe move of surgery to lower intensive environments. For example, managing preoperative patient and family education and expectations, as well as preoperative physical therapy assessment can prepare a patient for a safe discharge to home. Additionally, the entire care team must understand those factors that require optimization including anesthesia familiarity with outpatient pain management techniques that require the minimal use of opioids, nursing management of fluids in the post-acute unit, early ambulation within hours of surgery, and the ability to identify and manage short-term physiologic impacts of surgery. [11] Of particular importance are those potential complications that can occur within the first 24 hours of surgery, such as urinary retention, hypotension or dehydration requiring the prolonged use of IV fluids, and prolonged nausea and vomiting. Although the literature and science are evolving rapidly, there is a growing consensus regarding the factors that impact the most appropriate setting for a given procedure on a given patient and each facility must adapt to the care of these patients as they gain and solidify their experience with major surgery in the outpatient arena. [12] As musculoskeletal surgery transitions to this outpatient setting, an understanding of the differences between the outpatient setting of a hospital and an ASC are of paramount importance for patient safety in a free-standing facility. Factors such as immediate postoperative treatment, disposition, physical space of the facility, and sterile processing procedures are usually different from the traditional hospital environment.

Successful facilities that are most adept at performing outpatient surgery are those that commit to refining their approach through the adoption of team-based care guided by multidisciplinary, guideline-based care pathways that are continuously refined with increasing experience.

CRITERIA FOR SELECTION OF INPATIENT SETTING

Elective Spine, Hip, Knee, and Shoulder Procedures

Patients having elective spine, hip, knee, or shoulder procedures will generally be managed as outpatients, with or without an observation level of care following the procedure. [2,13–15] It is expected that most patients undergoing these procedures will not require inpatient hospital services to deliver either complex care or more than an overnight observation.

In certain circumstances, a patient will qualify for inpatient level of care. Inpatient level of care will be deemed appropriate when **ANY ONE** of the following criteria are met:

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

- Medical conditions increasing the risk of major post-operative complications as indicated by **one or more** of the following [4,7]:

- American Society of Anesthesiologists (ASA) class IV or greater [7,8,16]
- Frailty with Clinical Frailty Score >5 [17,18]
- Preoperative Myelopathy with functional impairment impacting safe ambulation [18]
- Morbid obesity (Body Mass Index (BMI) ≥ 40 kg/m²) 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) ≤ 30mL/min or on dialysis)
- End-stage liver disease (Model for End-Stage Liver Disease (MELD) 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 within the last 3 months [19]
- Cognitive impairment or dementia [18]
- Other unstable medical condition (e.g., uncontrolled hypertension, persistent electrolyte abnormalities, poorly controlled diabetes (Hemoglobin A1c ≥ 8%)) [20,21]

- Inadequate home care situation identified preoperatively as indicated by **one or more** of the following:
  - Patient 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 limits safe transfer of care to home within 48 hours following surgery [22]
- Any of the following surgical procedures:
  - Revision total joint arthroplasty (hip, knee, or shoulder) [3,5]
  - Simultaneous bilateral total joint arthroplasty [3,5]
  - Multilevel lumbar decompression and fusion [23,24]
  - Multilevel cervical posterior decompression and fusion [15]
  - Multilevel lumbar artificial disc replacement [15,22,25]
  - Revision Lumbar or Cervical artificial disc replacement [14,15,26]
  - Revision Lumbar or Cervical Spine Fusion (single or multilevel) [27]

CRITERIA FOR SELECTION OF AMBULATORY SURGICAL CENTERS VS. HOSPITAL OUTPATIENT SURGICAL DEPARTMENT (HOPD)

- Ambulatory Surgical Center is considered medically necessary if the patient does not meet the above inpatient criteria and is having one of the following procedures:
  - One or two level Anterior Cervical Discectomy and Fusion (ACDF)
  - One or two level Lumbar Spinal Fusion
  - One or two level(s) for Cervical disc replacement
  - One or two level(s) for Lumbar disc replacement
  - Primary total knee replacement
  - Primary partial knee replacement
  - Knee Arthroscopy
  - Primary hip replacement
  - Primary/partial/total shoulder arthroplasty
  - Shoulder Arthroscopy
- And meets **ALL** of the following criteria [4,7]:
  - American Society of Anesthesiologists (ASA) class I [7,8,16]
  - No functional impairment impacting safe ambulation [18]
  - Body Mass Index (BMI) ≤ 40 kg/m² with no hemodynamic or respiratory problems [28–30]
  - No evidence of unstable angina, heart failure, symptomatic coronary artery disease, severe valvular disease (e.g., severe aortic stenosis), dangerous arrhythmia [7]
  - No symptomatic Chronic Obstructive Pulmonary Disease (COPD) or asthma, and not requiring home oxygen
  - No known kidney disease or dialysis
  - No known liver disease
  - No known bleeding disorders
  - No known severe obstructive sleep apnea
  - No known stroke or Transient Ischemic Attack (TIA), myocardial infarction, or thromboembolism within the last 3 months with neurologic and hemodynamic stabilization [19]
  - No cognitive impairment or dementia [18]

- No other unstable medical condition (e.g., uncontrolled hypertension, persistent electrolyte abnormalities, poorly controlled diabetes (Hemoglobin A1c > 8%)) [20,21]
- If there are no participating ASCs within a 2 hour drive from the member or the surgeon does not have operating privileges at a participating ASC within a 2 hour drive from the members residence, the surgery may be performed at an alternative location such as an HOPD [22]

Hospital Outpatient Surgical Department (HOPD)

If the patient does not meet the above inpatient criteria **OR** ASC criteria then Hospital Outpatient Surgical Department is appropriate.

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 a 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

CODING AND STANDARDS

Codes

POS	
Code	**Description**
19	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
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Applicable Lines of Business

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

SUMMARY OF EVIDENCE

Outpatient Versus Inpatient Anterior Lumbar Spine Surgery: A Multisite, Comparative Analysis of Patient Safety Measures [23]

- Study Design: This study is a retrospective comparative analysis.
- Target Population: The study included 226 consecutive patients who underwent anterior lumbar spine surgeries (ALIF, ADR, and hybrids) either in an ambulatory surgery center (ASC) or an inpatient tertiary care hospital over a three-year period.
- Key Factors: The study compared 90-day complication and readmission rates between the two settings. The results showed that while there was a trend toward fewer complications, reoperations, and readmissions for the ASC cohort, the differences were not statistically significant. The overall 90-day postoperative complication rate was 5.6% for the inpatient cohort and 0.9% for the ASC cohort.

Patient Outcomes Following Total Joint Replacement Surgery: A Comparison of Hospitals and Ambulatory Surgery Centers [3]

- Study Design: This study used a large claims database and applied propensity score methods to match inpatients with ASC patients and HOPD patients with ASC patients.

- Target Population: The study focused on non-Medicare patients aged 55-64 who underwent total knee arthroplasty (TKA) or total hip arthroplasty (THA) in an inpatient, hospital outpatient, or ASC setting during 2014-2016.
- Key Factors: The study found that readmissions, post-surgical complications, and payments were lower for outpatients than for inpatients. Within outpatient settings, readmissions and post-surgical complications were lower in ASCs than in HOPDs, but payments for ASC patients were higher than for HOPD patients.

A comparison of functional outcomes following inpatient versus outpatient hip or knee arthroplasty [13]

- Study Design: This is a systematic review adhering to PRISMA guidelines.
- Target Population: The review included seven studies with a total of 1,876 participants who underwent hip or knee arthroplasty.
- Key Factors: The review aimed to explore the effects on functional outcomes following inpatient versus outpatient hip or knee arthroplasty. The results suggested that outpatient or inpatient pathway selection should not be based solely on the superiority of functional outcomes. The review found mixed support for both pathways, with no significant difference in patient-reported satisfaction.

Spine Surgery Complications in the Ambulatory Surgical Center Setting: Systematic Review [27]

- Study Design: This is a systematic review study.
- Target Population: The review included 22 studies with a total of 11,245 patients who underwent spine surgery in an ASC setting.
- Key Factors: The study aimed to determine the rates of complications in relation to spine surgery in ASCs. The most common complications were gastrointestinal (1.12%) and the most infrequent were vascular (0.25%). The study provided complication profiles to assist surgeons in counseling patients on realistic expectations

ANALYSIS OF EVIDENCE

Shared Findings:

- Safety and Efficacy: All studies suggest that outpatient settings, including ASCs, are generally safe and effective for various surgical procedures. Cuellar et al and Carey et al both highlight that ASCs can achieve similar or better outcomes compared to inpatient settings. [3,13,23,27]
- Complication Rates: Both Cuellar et al [23] and Cha et al [27] found low complication rates in ASCs. Carey et al [3] also noted lower readmissions and complications in ASCs compared to HOPDs.
- Cost Implications: Carey et al [3] and Cuellar et al [23] discuss the cost-saving potential of ASCs. Carey et al [3] found that while ASC payments were higher than HOPDs, they were still lower than inpatient settings.

Differing Findings:

- Functional Outcomes: Sattler et al [13] found mixed results regarding functional outcomes, suggesting that the choice between inpatient and outpatient settings should not be based solely on functional outcomes. This contrasts with the other studies that focus more on safety and cost.
- Specific Complications: Cha et al [27] provided a detailed breakdown of specific complications, highlighting gastrointestinal issues as the most common, which was not a focus in the other studies.
- Payment Differences: Carey et al [3] noted that payments for ASC patients were higher than for HOPD patients, a detail not discussed in the other studies.

Conclusion:

In summary, while all studies support the safety and efficacy of ASCs, they differ in their focus on functional outcomes, specific complications, and cost implications. This comprehensive analysis helps to provide a well-rounded understanding of the benefits and considerations of outpatient surgical settings

POLICY HISTORY

Date	Summary
December 2025	• Added General Information section • Added criteria for ambulatory surgical centers • Added criteria for hospital outpatient surgical department • Added a Summary of Evidence and Analysis of Evidence • Adjusted POS code description
May 2025	• New Policy

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review 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.

Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.

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