Pre-Operative Testing AHS – G2023

Description of Procedure or Service

I. Policy Description
Pre-operative testing refers to the evaluation of the healthy patient to detect unrecognized disease and risk factors that may increase the risk of surgery above baseline and to propose strategies to reduce this risk. Specific laboratory studies commonly ordered for preoperative evaluation include a complete blood count, electrolytes, renal function, blood glucose, liver function studies, hemostasis evaluation, and urinalysis (Smetana, 2017).

II. Scientific Background
In general, the overall risk of surgery is extremely low and the prevalence of unrecognized disease that influences surgical risk is low in healthy individuals. Clinicians often perform laboratory tests out of habit and medicolegal concern (Kachalia et al., 2015; Sigmund, Stevens, Blitz, & Ladapo, 2015). However, there is little benefit and a high incidence of false-positive results (Smetana, 2017).

Normal test values are defined as those occurring within two standard deviations from the mean, thus, 5 percent of healthy individuals who have a single screening test will have an abnormal result. A screening panel containing 20 independent tests in a patient with no disease will yield at least one abnormal result 64 percent of the time. Thus, the predictive value of abnormal test results is low in healthy patients with a low prevalence of disease (Smetana, 2017).

Multiple reviews of perioperative consultation support a selective approach to preoperative testing (Apfelbaum et al., 2012; Fleisher et al., 2009; Garcia-Miguel, Serrano-Aguilar, & Lopez-Bastida, 2003; Kaplan et al., 1985; Macpherson, 1993; Macpherson, Snow, & Lofgren, 1990; Rusk, 2016; Smetana & Macpherson, 2003). One study found that sixty percent of routinely ordered tests would not have been performed if testing had only been done for recognizable indications and of these only 0.22 percent revealed abnormalities that might influence perioperative management (Kaplan et al., 1985). Another report found that only 10 routine laboratory test results in 3782 patients required treatment; just one of these required pharmacologic treatment (Narr, Hansen, & Warner, 1991). A prospective study found only an abnormal ECG predicted postoperative complications. Abnormalities in commonly performed blood test and chest radiography had no predictive value (Fritsch et al., 2012). In a trial of ambulatory surgical patients randomly assigned to preoperative testing (complete blood count, electrolytes, blood glucose, creatinine, electrocardiogram (ECG), and/or chest radiograph) or no testing, there was no difference in perioperative adverse events or events within 30 days of ambulatory surgery (Chung, Yuan, Yin, Vairavanathan, & Wong, 2009). Lastly, A retrospective review of 73,596 patients using the National Surgical Quality Improvement Program (NSQIP) database (Benarroch-Gampel et al., 2012) found that preoperative tests were performed in 63.8 percent of patients; 61.6 percent of these patients had at least one abnormal test result. After adjustment for demographics, comorbidities, and procedure characteristics, neither preoperative
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testing nor the finding of an abnormal test result were associated with adverse postoperative outcomes (Kachalia et al., 2015; Sigmund et al., 2015; Smetana, 2017).

A review of studies of routine preoperative testing found that for nearly all potential laboratory studies, a normal test did not substantially reduce the likelihood of a postoperative complication except for three tests (hemoglobin, renal function, and electrolytes)(Smetana & Macpherson, 2003). However, clinical evaluation can predict most patients with an abnormal result (Smetana, 2017).

A practice advisory from the American Society of Anesthesiologists (ASA) recommend against routine preoperative laboratory testing in the absence of clinical indications (Apfelbaum et al., 2012). Selective testing is appropriate in patients with known underlying diseases or risk factors that would affect operative management or increase risk, and specific high-risk surgical procedures (Smetana, 2017; Smetana & Macpherson, 2003).

A baseline hemoglobin measurement is suggested for all patients 65 years of age or older who are undergoing major surgery and for younger patients undergoing major surgery that is expected to result in significant blood loss or if the history suggests anemia. The frequency of significant unsuspected white blood cell or platelet abnormalities is low (Kaplan et al., 1985) and there is little rationale to support baseline testing of either. Nevertheless, obtaining a complete blood count, including white count and platelet measurement, can be recommended if the cost is not substantially greater than the cost of a hemoglobin concentration alone (Carson et al., 2011; Smetana, 2017; Wu et al., 2007).

A serum creatinine concentration is appropriate in patients over the age of 50 undergoing intermediate- or high-risk surgery, although there is no clear consensus on this point (Kaplan et al., 1985; Turnbull & Buck, 1987). It should also be ordered when hypotension is likely, or when nephrotoxic medications will be used (Velanovich, 1991). Renal insufficiency is an independent risk factor for postoperative pulmonary complications (Smetana, Lawrence, & Cornell, 2006) and a major predictor of postoperative mortality (Mathew et al., 2008). Renal insufficiency necessitates dosage adjustment of some medications that may be used perioperatively (Smetana, 2017).

Pregnancy testing is appropriate for women of childbearing age (Apfelbaum et al., 2012; Lamont, Coates, Mathew, Scarpello, & Slater, 2010; O'Neill, Carter, Pink, & Smith, 2016; Ramoska, Sacchetti, & Nepp, 1989).

Routine electrolyte determinations (Leung, McAlister, Finlayson, & Bates, 2013), blood glucose measurements (Bock et al., 2015; Grek, Gravenstein, Morey, & Rice, 2009), liver enzyme testing (Benarroch-Gampel et al., 2012; Narr et al., 1991; Powell-Jackson, Greenway, & Williams, 1982), urinalysis (David & Vrahas, 2000; Lawrence, Gafni, & Gross, 1989; Lawrence & Kroenke, 1988) and hemostasis testing (Chee, Crawford, Watson, & Greaves, 2008; Peterson et al., 1998; Rodgers & Levin, 1990; Seicane et al., 2012) are not recommended unless the patient has a history that increases the likelihood of an abnormality (Kaplan et al., 1985; Smetana, 2017; Smetana & Macpherson, 2003; Velanovich, 1991).

Nieto et al (2017) evaluated routine preoperative laboratory testing in elective pediatric cardiothoracic surgery in 1106 cases. They found that testing does not significantly impact decision-making in elective pediatric cardiothoracic surgery. The decision to order a specific screening test should be clinically driven. Selective preoperative laboratory testing may have a positive impact on healthcare costs without affecting outcomes.

Husk et al (2018) compared the prevalence of abnormal preoperative laboratory result with age in a retrospective cohort study of women undergoing urogynecologic surgery, we compared older (age, ≥65 years) with younger (age, 50-64 years) women. Our primary outcome was the prevalence of an abnormal preoperative laboratory result. They found that overall, 18.3% of
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participants had at least one abnormal preoperative laboratory, with older women more likely to have an abnormal result (28.7% vs 10.7%, P < 0.001). Compared with the younger cohort, older women had higher rates of abnormal hemoglobin (13.8% vs 6.0%, P = 0.02) and creatinine values (10.8% vs 2.7%, P = 0.005), with no significant differences for platelets (3.0% vs 1.3%, P = 0.53), sodium (3.0% vs 0.7%, P = 0.22), or potassium (6.0% vs 3.3%, P = 0.27). After adjusting for potential confounders, older age remained associated with an abnormal preoperative result (odds ratio, 3.6; 95% confidence interval, 1.9-7.1). They concluded that women 65 years or older had a greater than 25% chance of having an abnormal preoperative laboratory result and were at higher risk compared with younger women. Age 65 years or greater should be considered as a criterion for preoperative laboratory testing in urogynecologic patients.

Lakomkin et al (2018) explore the relationship between commonly obtained preoperative laboratory results and postoperative complications following one- to two-level PLF. They found that After controlling for age, ASA score, length of surgery, and all significant comorbidities, abnormal sodium (odds ratio [OR]=2.47, 95% confidence interval [CI]: 1.45-4.19, p=.001) and abnormal INR (OR=2.33, 95% CI: 1.09-4.98, p=.029) were significantly associated with the development of any complication. Sodium (OR=1.61, 95% CI: 1.01-2.54, p=.04) and platelets (OR=1.58, 95% CI: 1.02-2.44, p=.04) were associated with minor complications. Meanwhile, creatinine (OR=1.74, 95% CI: 1.02-2.99, p=.04) and platelets (OR=1.71, 95% CI: 1.02-2.89, p=.04) were significant predictors of major adverse events. They concluded that although the majority of laboratories were not significantly associated with adverse events, abnormal sodium values, INR, creatinine, and platelets were shown to be predictive of various complications.

Ruetzler et al (2018) investigated whether that longer periods between preoperative laboratory testing and surgery are associated with increased odds of a composite of 30-day morbidity and mortality in 2,320,920 patients in the American College of Surgeons National Surgical Quality Improvement Program. They found that the observed incidence (unadjusted) was 1.7% when the most recent laboratory blood tests measured within 1 week of surgery, 1.7% when it was within 1-2 weeks, 1.8% when it was within 2-4 weeks, 1.7% when it was between 1 and 2 months, and 2.0% for patients with most recent laboratory blood tests measured 2-3 months before surgery. None of the values within 2 months differed significantly: estimated odds ratios for patients within blood tested within 1 week were 1.00 (99.5% confidence interval, 0.89-1.12) as compared to 1-2 weeks, 0.88 (0.77-1.00) for 2-4 weeks, and 0.95 (0.79-1.14) for 1-2 months, respectively. The estimated odds ratio comparing 1-2 weeks to each of 2-4 weeks and 1-2 months were 0.88 (0.76-1.03) and 0.95 (0.78-1.16), respectively. Blood testing 2-3 months before surgery was associated with increased odds of outcome compared to patients whose most recent test was within 1 week (P = .002) and 1-2 weeks of the date of surgery. They concluded that In American Society of Anesthesiologists physical status I and II patients, risk of 30-day morbidity and mortality was not different with blood testing up to 2 months before surgery, suggesting that it is unnecessary to retest patients shortly before surgery.

Riggs, Bass and Segal (2018) conducted an assessment of the independent association of patient- and surgery-specific risk with receipt of outpatient preoperative testing on a retrospective cohort of 678,368 privately-insured, non-elderly US adults who underwent one of ten operations, including one lower-risk and one higher-risk operation from five surgical specialties. Outcomes were receipt of nine outpatient tests in the 30 days before surgery and cost of those tests. They found that receipt of tests ranged from 0.9% (pulmonary function tests) to 46.8% (blood counts), and 65.2% of patients received at least one test. Mean cost per patient for all tests was $124.38. Higher RCRI was strongly associated (Odds Ratio (OR) > 2) with receipt of stress tests and echocardiograms, and more modestly associated [OR < 2] with receipt of most other tests. Undergoing higher-risk operations was strongly associated with receipt of most tests. Results were similar using the CCI for patient-specific risk. They concluded that surgery-specific risk is strongly associated with receipt of most preoperative tests, which is consistent with preoperative testing protocols based as much or more on the planned operation as on patient-specific risk factors. Whether this pattern of preoperative testing represents optimal care is uncertain.
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III. Applicable Federal Regulations

Most routine pre-operative tests are FDA approved as routine laboratory procedures.

***Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy

BCBSNC will provide coverage for pre-operative testing when it is determined the medical criteria or reimbursement guidelines below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When pre-operative testing is covered

Reimbursement for the following pre-operative tests are allowed for the indications as noted.

<table>
<thead>
<tr>
<th>TEST</th>
<th>INDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT/INR and PTT</td>
<td>o Clinical evidence or history of bleeding disorder (easy bruising, nose bleeds, bleeding gums from dental procedures), or</td>
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<td>o Family history of bleeding disorder, or</td>
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<td></td>
<td>o History or presence of liver disease, or</td>
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<td></td>
<td>o Anticoagulant use or drugs affecting coagulation, or</td>
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<td></td>
<td>o Craniotomy or spine surgery</td>
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<tr>
<td>PLATELET COUNT:</td>
<td>o Known platelet abnormality or abnormal bleeding history, or</td>
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<td></td>
<td>o History of hematological malignancy, or</td>
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<td></td>
<td>o Thrombosis, purpura, petechiae or clinical bleeding, or</td>
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<tr>
<td></td>
<td>o History of radiation or chemotherapy, or</td>
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<tr>
<td></td>
<td>o Systemic diseases that may affect platelet count (i.e. Lupus, liver disease, etc.), or</td>
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<tr>
<td></td>
<td>o HIV or AIDS</td>
</tr>
<tr>
<td>HEMOGLOBIN AND HEMATOCRIT</td>
<td>o Any procedure in which significant blood loss (greater than 500ml) is anticipated, or</td>
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<tr>
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<td>o If the patient has donated blood within the last 2 months, or</td>
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<td></td>
<td>o Patient history suggestive of anemia, leukemia or cancer, or</td>
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<tr>
<td></td>
<td>o Abnormal bleeding history, or</td>
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<tr>
<td></td>
<td>o History of renal or liver disease, or</td>
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<tr>
<td></td>
<td>o Anticoagulant use, or</td>
</tr>
<tr>
<td></td>
<td>o Bariatric surgery</td>
</tr>
<tr>
<td>SERUM CHEMISTRY-</td>
<td>o History of diabetes, or</td>
</tr>
<tr>
<td>Basic Metabolic Panel (BMP):</td>
<td>o History of hypertension or CAD, or</td>
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<tr>
<td></td>
<td>o History of renal disease or renal toxic medications, or</td>
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</tbody>
</table>
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- Medications that may cause electrolyte or other BMP abnormalities (i.e. diuretics, NSAID, steroids, Digoxin, etc.), or
- History of liver disease, or
- Central nervous system disease, or
- Morbid obesity, or
- Any systemic disease that may significantly affect electrolytes or other BMP components (i.e. adrenal disease, AIDS, etc.)

**LIVER FUNCTION TESTS:**
- Any patient with known or suspected liver disease, or
- Patients with bleeding abnormalities

**TSH**
- History of hyperthyroidism or hypo-thyroidism, or
- Patients taking medications that can alter thyroid function (i.e. Amiodarone, Lithium), or
- History of palpitations, sweating, or weight loss of unknown etiology, or
- History of lethargy, cold intolerance, weight gain, constipation or hair loss of unknown etiology

**URINALYSIS**
- Patients with or getting prosthetic implants, or
- Patients undergoing prostatectomy, or
- Patients who are symptomatic for a urinary tract infection, or
- Patients with a specific indication for urinalysis (i.e. a kidney stone or planned genitourinary procedure), or
- A reflex urinalysis (culture will only be done if UA is abnormal) should be requested rather than a UA and C/S unless a symptomatic UTI is suspected

**URINE CULTURE**
- Patients with renal stones in the genitourinary tract, or
- Patients who will have urethral manipulation as part of the surgical procedure, or
- Patients with suspected urinary tract infections

**PREGNANCY TEST**
- Any female of childbearing potential, regardless of birth control method, or
- Any patient undergoing a hysterectomy or gynecological procedure with childbearing potential or unclear childbearing status, or
- Pregnancy tests DO NOT need to be performed on women who cannot conceive

**TYPE AND SCREEN OR CROSSMATCH**
- A blood screen (T&S) should be done for any patient that has a reasonable probability for requiring blood intra-operatively, or
- A blood type and crossmatch (T&C) should be done for any patient that is expected to require an intra-operative transfusion

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**When pre-operative testing is not covered**

Reimbursement is not allowed for pre-operative testing in all situations not outlined above.

**Policy Guidelines**

A. Guidelines and Recommendations

ASA Guidelines (ASA, 2012)
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<table>
<thead>
<tr>
<th>Test</th>
<th>Indication</th>
</tr>
</thead>
</table>
| Hemoglobin/Hematocrit Measurement         | - Routine hemoglobin or hematocrit is not indicated.  
- Clinical characteristics to consider as indications for hemoglobin or hematocrit include  
  o type and invasiveness of procedure,  
  o patients with liver disease,  
  o extremes of age,  
  o history of anemia, bleeding, and  
  o other hematologic disorders.       |
| Coagulation Studies                       | Clinical characteristics to consider for ordering selected coagulation studies include:  
- Known h/o bleeding disorder or  
- previous bleeding complications  
- On current anticoagulation  
- H&P suggests bleeding or coagulation problem  
- Renal dysfunction (creatinine > 200 μmol/litre);  
- Liver dysfunction |
| Serum Chemistries (i.e., Potassium, Glucose, Sodium, Renal and Liver Function Studies) | Clinical characteristics to consider serum chemistries include:  
- likely perioperative therapies,  
- endocrine disorders,  
- risk of renal dysfunction  
- liver dysfunction,  
- use of certain medications or alternative therapies |
| Albumin                                   | Pulmonary complications increased  
- Infectious complications increased  
- Wound healing issues |
| Urinalysis                                 | Urinalysis is not indicated except for specific procedures:  
- prosthesis implantation,  
- urologic procedures or  
- when urinary tract symptoms are present.  
- Test results obtained from the medical record within 6 months of surgery generally are acceptable if the patient’s medical history has not changed substantially |
| Pregnancy Testing                         | Pregnancy testing may be offered to female patients of child bearing age and for whom the result would alter the patient’s management. |

Guidelines summary from various institutions (AAFP - Molly et al, 2013)

### Guideline Summary for Preoperative Electrolyte Measurement

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Summary of recommendations</th>
</tr>
</thead>
</table>
| Institute for Clinical Systems Improvement | Electrolyte measurement can be considered for:  
Patients taking digoxin  
Patients taking diuretics  
Patients taking angiotensin-converting enzyme inhibitors or angiotensin receptor blockers |

### Guideline Summary for Preoperative CBC

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Summary of recommendations</th>
</tr>
</thead>
</table>
| Institute for Clinical Systems Improvement | CBC is recommended for:  
Patients with a history of anemia |
## Guideline Summary for Preoperative Coagulation Testing

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Summary of recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Committee for Standards in Haematology</td>
<td>Bleeding history is recommended for all patients Coagulation testing is recommended for patients with positive bleeding history or a clear clinical indication for testing</td>
</tr>
<tr>
<td>Institute for Clinical Systems Improvement</td>
<td>Coagulation testing is recommended for: Patients with a history of coagulation abnormalities Patients taking anticoagulant medications Patients with a recent history suggesting coagulation problems Patients needing postoperative anti-coagulation (baseline testing)</td>
</tr>
</tbody>
</table>

### Routine preoperative tests for elective surgery, UK (NICE, 2016)

#### Recommendations relevant for all types of surgery

**Pregnancy tests**
- On the day of surgery, sensitively ask all women of childbearing potential whether there is any possibility they could be pregnant.
- Carry out a pregnancy test with the woman's consent if there is any doubt about whether she could be pregnant.

**Sickle cell disease or sickle cell trait tests**
- Do not routinely offer testing for sickle cell disease or sickle cell trait before surgery.

**HbA1c testing for people without diagnosed diabetes**
- Do not routinely offer HbA1c testing before surgery to people without diagnosed diabetes.

**HbA1c testing for people with diabetes**
- People with diabetes who are being referred for surgical consultation from primary care should have their most recent HbA1c test results included in their referral information.
- Offer HbA1c testing to people with diabetes having surgery if they have not been tested in the last 3 months.

**Urine tests**
- Do not routinely offer urine dipstick tests before surgery.
- Consider microscopy and culture of midstream urine sample before surgery if the presence of a urinary tract infection would influence the decision to operate.

**Recommendations for specific surgery grades (minor, intermediate, and major or complex) and ASA grades**

The following recommendations are specific to surgery grade and ASA grade.
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### Table 1 Minor surgery

<table>
<thead>
<tr>
<th>Test</th>
<th>ASA grade</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>ASA 1</td>
</tr>
<tr>
<td><strong>Full blood count</strong></td>
<td>Not routinely</td>
</tr>
<tr>
<td><strong>Haemostasis</strong></td>
<td>Not routinely</td>
</tr>
<tr>
<td><strong>Kidney function</strong></td>
<td>Not routinely</td>
</tr>
<tr>
<td>Lung function/arterial blood gas</td>
<td>Not routinely</td>
</tr>
</tbody>
</table>

### Table 2 Intermediate surgery

<table>
<thead>
<tr>
<th>Test</th>
<th>ASA grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASA 1</td>
</tr>
<tr>
<td><strong>Full blood count</strong></td>
<td>Not routinely</td>
</tr>
<tr>
<td><strong>Haemostasis</strong></td>
<td>Not routinely</td>
</tr>
<tr>
<td>• If people taking anticoagulants need modification of their treatment regimen, make an individualised plan in line with local guidance</td>
<td></td>
</tr>
<tr>
<td>• If clotting status needs to be tested before surgery (depending on local guidance) use point-of-care testing¹</td>
<td></td>
</tr>
<tr>
<td><strong>Kidney function</strong></td>
<td>Not routinely</td>
</tr>
<tr>
<td><strong>Lung function/arterial blood gas</strong></td>
<td>Not routinely</td>
</tr>
</tbody>
</table>
Table 3 Major or complex surgery

<table>
<thead>
<tr>
<th>Test</th>
<th>ASA grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASA 1</td>
</tr>
<tr>
<td>Full blood count</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Haemostasis                       | Not routinely   | Not routinely   | Consider in people with chronic liver disease
|                                   |       |       | • If people taking anticoagulants need modification of their treatment regimen, make an individualised plan in line with local guidance
|                                   |       |       | • If clotting status needs to be tested before surgery (depending on local guidance) use point-of-care testing |
| Kidney function                   | Consider in people at risk of AKI | Yes | Yes |
| Lung function/arterial blood gas  | Not routinely | Not routinely | Consider seeking advice from a senior anaesthetist for ASA grade 3 or 4 due to known or suspected respiratory disease |

American Society for Clinical Pathology (ASCP)

The ASCP released a recommendation (2013) as part of the Choosing Wisely campaign that states: “Avoid routine preoperative testing for low risk surgeries without a clinical indication.

Most preoperative tests (typically a complete blood count, Prothrombin Time and Partial Prothromboplastin Time, basic metabolic panel and urinalysis) performed on elective surgical patients are normal. Findings influence management in under 3% of patients tested. In almost all cases, no adverse outcomes are observed when clinically stable patients undergo elective surgery, irrespective of whether an abnormal test is identified. Preoperative testing is appropriate in symptomatic patients and those with risks factors for which diagnostic testing can provide clarification of patient surgical risk.”

Society of General Internal Medicine (SGIM)

The SGIM released a recommendation (2018) as part of the Choosing Wisely campaign which states:” Don’t perform routine pre-operative testing before low-risk surgical procedures.

The goal of the preoperative evaluation is to identify, stratify, and reduce risk for major postoperative complications. The crucial elements of this evaluation are a careful history and physical examination. Preoperative testing for low-risk surgical procedures typically does not reclassify the risk estimate established through the history and physical examination, may result
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in unnecessary delays, lead to downstream risk from additional testing, and add avoidable costs. Clinicians should not routinely order testing before low-risk surgery.”

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes:  80047, 80048, 80050, 80053, 8100, 81001, 81002, 81003, 81005, 81025, 84702, 84703, 85014, 85018, 85025, 85027, 85610, 86904, 86920, 87086, 87088

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources


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NICE. (2016). Routine preoperative tests for elective surgery | Guidance and guidelines | NICE. from NICE https://www.nice.org.uk/guidance/ng45/chapter/Recommendations


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Policy Implementation/Update Information

1/1/19  New policy developed. BCBSNC will provide coverage for pre-operative testing when it is determined to be medically necessary because the medical criteria and guidelines are met. Medical Director review 1/1/2019. Policy noticed 1/1/2019 for effective date 4/1/2019. (sk)

10/29/19  Reviewed by Avalon 3rd Quarter CAB. No change in overall intent of policy. Wording in the Policy, When Covered, and/or Not Covered section(s) changed from Medical Necessity to Reimbursement language, where needed. (gm)

12/10/19  Specialty Matched Consultant Advisory Panel review 11/20/2019. (sk)

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