Section C — Oncology: Inpatient Cancer Treatment

Source document: Curative Health Plan — Master Clinical Decision Criteria / Unified Reviewer Tool, Version 2.0 (Effective March 4, 2026)

Section: C of G (part of a 7-document set, A–G)

Conditions / procedures in this section: 10

Scope: 10 inpatient oncology / cancer-treatment conditions.

Use: Internal utilization-management criteria. Automated systems may approve but must not issue adverse determinations; all denials require licensed clinician review.

INPATIENT CHEMOTHERAPY — INDUCTION (AML, ALL, AGGRESSIVE LYMPHOMA)

ICD-10-CM: C91.00 (ALL not achieved remission), C91.01 (ALL in remission), C91.02 (ALL in relapse), C92.00 (AML not achieved remission), C92.01 (AML in remission), C92.02 (AML in relapse), C92.40 (acute promyelocytic leukemia not achieved remission), C92.41 (APL in remission), C92.42 (APL in relapse) (APL), C92.50 (AML with multilineage dysplasia not achieved remission), C92.51 (in remission), C92.52 (in relapse) (AML with MDS), C92.60 (AML with 11q23 abnormality not achieved remission), C92.61 (in remission), C92.62 (in relapse) (AML with 11q23), C92.A0 (AML with multilineage dysplasia not achieved remission), C92.A1 (in remission), C92.A2 (in relapse) (AML with multilineage dysplasia), C92.Z0 (other myeloid leukemia not achieved remission), C92.Z1 (in remission), C92.Z2 (in relapse) (other myeloid leukemia), C93.00 (acute monocytic leukemia not achieved remission), C93.01 (in remission), C93.02 (in relapse) (acute monocytic leukemia), C94.00 (acute erythroid leukemia not achieved remission), C94.01 (in remission), C94.02 (in relapse) (acute erythroid leukemia), C94.20 (acute megakaryoblastic leukemia not achieved remission), C94.21 (in remission), C94.22 (in relapse) (acute megakaryoblastic leukemia), C83.30 (DLBCL unspecified site), C83.31 (lymph nodes head/neck), C83.32 (intrathoracic), C83.33 (intra-abdominal), C83.34 (lymph nodes axilla/upper limb), C83.35 (lymph nodes inguinal/lower limb), C83.36 (intrapelvic), C83.37 (spleen), C83.38 (lymph nodes multiple sites), C83.39 (extranodal/solid organ sites) (DLBCL), C83.70 (Burkitt lymphoma unspecified site), C83.71 (head/neck), C83.72 (intrathoracic), C83.73 (intra-abdominal), C83.74 (axilla/upper limb), C83.75 (inguinal/lower limb), C83.76 (intrapelvic), C83.77 (spleen), C83.78 (multiple sites), C83.79 (extranodal/solid organ) (Burkitt lymphoma), C84.40-C84.49 (PTCL), C81.00-C81.09 (nodular lymphocyte predominant Hodgkin), C81.10-C81.19 (nodular sclerosis classical Hodgkin), C81.20-C81.29 (mixed cellularity Hodgkin), C81.70-C81.79 (other classical Hodgkin), C85.10-C85.19 (unspecified B-cell NHL), C85.80-C85.89 (other types of NHL), Z51.11 (encounter for antineoplastic chemotherapy), Z51.12 (encounter for antineoplastic immunotherapy)

A. ADMISSION CRITERIA — Severity of Illness (SI) / Intensity of Service (IS)

SEVERITY OF ILLNESS (SI) — ALL of the following (diagnosis + treatment plan):

- Active oncologic condition requiring inpatient-level monitoring, treatment, or intervention
- Complication of cancer or cancer treatment that cannot be safely managed outpatient
- Clinical severity (vital sign instability, lab abnormalities, organ dysfunction) requiring continuous monitoring
- Expected treatment duration or monitoring needs requiring ≥2 midnight hospital stay

INTENSITY OF SERVICE (IS) — Must meet ≥1:

- Multi-day continuous IV chemotherapy infusion not available outpatient
- Daily laboratory monitoring required for treatment safety (e.g., TLS prevention, DIC management)
- Blood product transfusion support (≥2 units or daily platelet requirement)
- IV medications requiring inpatient monitoring (chemotherapy, immunotherapy, biologics, antifungals)
- Strict neutropenic precautions with HEPA-filtered room (allogeneic transplant)
- ICU-level monitoring for treatment complications (CRS, ICANS, engraftment syndrome)

B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for: induction chemotherapy (AML/ALL), stem cell transplant conditioning through engraftment, CAR-T lymphodepletion through CRS monitoring period

DOES NOT MEET CRITERIA:

- Cancer diagnosis alone without acute treatment or complication requiring inpatient monitoring
- Chemotherapy regimen that can safely be administered in outpatient infusion center
- Stable chronic cancer pain manageable with outpatient pain management adjustment
- Surveillance imaging, staging workup, or elective biopsy → outpatient
- Continued stay solely awaiting outpatient scheduling when medically stable for discharge

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY oncology review. Active treatment documented with daily progress toward milestones. For chemo induction: daily CBC, track ANC nadir/recovery. For transplant: daily engraftment assessment. For CAR-T: daily CRS/ICANS grading (ASTCT criteria).

CONTINUED STAY IF: Active treatment infusing, ANC <500 during expected nadir, active infection, transfusion-dependent, GVHD requiring IV therapy, CRS/ICANS not resolved

D. DISCHARGE CRITERIA — Safe Transition to Next Level of Care

- Acute treatment completed or condition stable for outpatient management
- ANC ≥500 x 2 days (if aplastic) or clear upward trend
- Transfusion-independent ≥48h
- Tolerating oral medications and adequate nutrition
- No active untreated infection requiring IV antibiotics
- Pain controlled on oral regimen
- Oncology follow-up with labs within 48-72h post-discharge

E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG 834-836 (Acute Leukemia w/o Major OR, RW 4.56/2.72/1.68), DRG 837-839 (Chemo w Acute Leukemia as Secondary, RW 5.27/2.78/1.69), DRG 840-842 (Lymphoma/Non-Acute Leukemia, RW 2.88/1.63/1.07)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: NCCN AML Guidelines v3.2024; CMS MS-DRG 839-841

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

I. EXTENDED STAY CRITERIA & GUIDANCE

When Goal LOS is exceeded, continued inpatient stay requires documentation of ONE OR MORE of the following medical-necessity triggers. Document the specific trigger, the clinical evidence supporting it, and the targeted intervention plan.

- Persistent febrile neutropenia despite broad-spectrum antibiotics → escalation or addition of antifungal
- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

STEM CELL TRANSPLANT (AUTOLOGOUS AND ALLOGENEIC HSCT)

ICD-10-CM: Z94.84 (stem cell transplant status), T86.00 (BMT rejection unspecified), T86.01 (BMT rejection), T86.02 (BMT failure), T86.03 (BMT infection), T86.09 (other complication of BMT), T86.5 (stem cell transplant complication), D89.810 (acute GVHD), D89.811 (chronic GVHD), D89.812 (acute on chronic GVHD), D89.813 (GVHD unspecified), D61.01 (constitutional aplastic anemia), D61.09 (other constitutional aplastic anemia), D61.1 (drug-induced aplastic anemia), D61.2 (aplastic anemia due to other agents), D61.810 (antineoplastic chemotherapy-induced pancytopenia), C91-C96 (underlying malignancy codes), Z51.11 (encounter for

chemo)

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- Blood product transfusion support (≥2 units or daily platelet requirement)
- IV medications requiring inpatient monitoring (chemotherapy, immunotherapy, biologics, antifungals)
- Strict neutropenic precautions with HEPA-filtered room (allogeneic transplant)
- ICU-level monitoring for treatment complications (CRS, ICANS, engraftment syndrome)

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C. CONTINUED STAY / CONCURRENT REVIEW

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CONTINUED STAY IF: Active treatment infusing, ANC <500 during expected nadir, active infection, transfusion-dependent, GVHD requiring IV therapy, CRS/ICANS not resolved

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E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG 014 (Allogeneic BMT RW ~12.09), DRG 016 (Autologous BMT w CC/MCC RW ~6.66), DRG 017 (Autologous BMT w/o CC/MCC RW ~4.38) CPT 38240 (allo), 38241 (auto)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 21-30 days autologous; 30-60 days allogeneic Source: ASTCT/EBMT Standards 2023; CMS MS-DRG 014-017

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis

improving.

- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

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- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

CAR-T CELL THERAPY

ICD-10-CM: Z51.12 (encounter for antineoplastic immunotherapy), C83.30 (DLBCL unspecified site), C83.31 (lymph nodes head/neck), C83.32 (intrathoracic), C83.33 (intra-abdominal), C83.34 (lymph nodes axilla/upper limb), C83.35 (lymph nodes inguinal/lower limb), C83.36 (intrapelvic), C83.37 (spleen), C83.38 (lymph nodes multiple sites), C83.39 (extranodal/solid organ sites) (DLBCL), C83.70 (Burkitt lymphoma unspecified site), C83.71 (head/neck), C83.72 (intrathoracic), C83.73 (intra-abdominal), C83.74 (axilla/upper limb), C83.75 (inguinal/lower limb), C83.76 (intrapelvic), C83.77 (spleen), C83.78 (multiple sites), C83.79 (extranodal/solid organ) (Burkitt), C85.10-C85.19 (B-cell NHL), C91.00 (ALL not having achieved remission), C91.01 (ALL in remission), C91.02 (ALL in relapse) (B-cell ALL), C90.00 (multiple myeloma not achieved remission), C90.01 (in remission), C90.02 (in relapse) (multiple myeloma), C82.00-C82.99 (follicular lymphoma — selected subtypes), C84.60-C84.69 (anaplastic large cell lymphoma) | ICD-10-PCS: XW033C7 (introduction of CAR-T into peripheral vein, percutaneous), XW043C7 (central vein)

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E. EVIDENCE SOURCES

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F. MS-DRG CROSSWALK & REVENUE CODES

DRG 018 (CAR-T and Other Immunotherapies RW ~30.28) HCPCS: Q2041 (Yescarta ~$373K), Q2042 (Kymriah ~$475K), Q2053 (Tecartus ~$373K), Q2054 (Breyanzi ~$410K), Q2055 (Abecma ~$420K), Q2056 (Carvykti ~$465K)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days monitoring; up to 30 days if CRS/ICANS Source: FDA CAR-T REMS; ASTCT CAR-T Consensus 2019; FDA labels (Yescarta, Kymriah, Breyanzi)

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

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- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

CHEMOTHERAPY-INDUCED COMPLICATIONS (MUCOSITIS, TYPHLITIS, HEMORRHAGIC CYSTITIS)

ICD-10-CM: K12.31 (oral mucositis due to antineoplastic therapy), K12.33 (oral mucositis due to radiation), T45.1X5A (adverse effect of antineoplastic/immunosuppressive drugs), K52.1 (toxic gastroenteritis and colitis — typhlitis), N30.40-N30.41 (irradiation cystitis), N30.80-N30.81 (other cystitis — hemorrhagic cystitis from cyclophosphamide/ifosfamide), D61.810 (antineoplastic chemotherapy induced pancytopenia), D70.1 (agranulocytosis secondary to cancer chemotherapy), D69.59 (other secondary thrombocytopenia),

D64.81 (anemia due to antineoplastic chemotherapy)

A. ADMISSION CRITERIA — Severity of Illness (SI) / Intensity of Service (IS)

SEVERITY OF ILLNESS (SI) — Must meet ≥1:

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D. DISCHARGE CRITERIA — Safe Transition to Next Level of Care

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E. EVIDENCE SOURCES

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F. MS-DRG CROSSWALK & REVENUE CODES

DRG 840-842 (Lymphoma/Leukemia complications), DRG 917-918 (Poisoning/Toxic Effects), DRG 640-642 (Metabolic) Rev 0335, 0250, 0390

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-10 days Source: NCCN Supportive Care; IDSA Febrile Neutropenia

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

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GRAFT-VERSUS-HOST DISEASE (GVHD) — ACUTE

ICD-10-CM: D89.810 (acute graft-versus-host disease), D89.811 (chronic graft-versus-host disease), D89.812 (acute on chronic graft-versus-host disease), D89.813 (graft-versus-host disease unspecified), T86.00 (unspecified complication of bone marrow transplant), T86.01 (bone marrow transplant rejection), T86.02 (bone marrow transplant failure), T86.03 (bone marrow transplant infection), T86.09 (other complications of bone marrow transplant) (complications of bone marrow transplant), K52.21 (food protein-induced enterocolitis — if GI GVHD), L24.x (irritant contact dermatitis — if skin GVHD coding), K71.x (toxic liver disease — if hepatic GVHD)

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- Oncology follow-up with labs within 48-72h post-discharge

E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG 814-816 (Reticuloendothelial/Immunity Disorders, RW 1.88/1.04/0.74), DRG 840-842 if underlying malignancy Rev 0250 (steroids, ruxolitinib, immunosuppressants), 0636

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 10-21 days acute flare Source: ASTCT/NIH GVHD Consensus 2020

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

I. EXTENDED STAY CRITERIA & GUIDANCE

When Goal LOS is exceeded, continued inpatient stay requires documentation of ONE OR MORE of the following medical-necessity triggers. Document the specific trigger, the clinical evidence supporting it, and the targeted intervention plan.

- Persistent febrile neutropenia despite broad-spectrum antibiotics → escalation or addition of antifungal
- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

ONCOLOGIC PAIN CRISIS / PALLIATIVE ADMISSION

ICD-10-CM: G89.3 (neoplasm related pain), R52 (pain unspecified), C00-C96 (underlying malignancy), Z51.5 (encounter for palliative care), G89.0 (central pain syndrome), G89.4 (chronic pain syndrome)

A. ADMISSION CRITERIA — Severity of Illness (SI) / Intensity of Service (IS)

SEVERITY OF ILLNESS (SI) — Must meet ≥2:

- Active oncologic condition requiring inpatient-level monitoring, treatment, or intervention
- Complication of cancer or cancer treatment that cannot be safely managed outpatient
- Clinical severity (vital sign instability, lab abnormalities, organ dysfunction) requiring continuous monitoring
- Expected treatment duration or monitoring needs requiring ≥2 midnight hospital stay

INTENSITY OF SERVICE (IS) — Must meet ≥1:

- Multi-day continuous IV chemotherapy infusion not available outpatient
- Daily laboratory monitoring required for treatment safety (e.g., TLS prevention, DIC management)
- Blood product transfusion support (≥2 units or daily platelet requirement)
- IV medications requiring inpatient monitoring (chemotherapy, immunotherapy, biologics, antifungals)
- Strict neutropenic precautions with HEPA-filtered room (allogeneic transplant)
- ICU-level monitoring for treatment complications (CRS, ICANS, engraftment syndrome)

B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for: induction chemotherapy (AML/ALL), stem cell transplant conditioning through engraftment, CAR-T lymphodepletion through CRS monitoring period

DOES NOT MEET CRITERIA:

- Cancer diagnosis alone without acute treatment or complication requiring inpatient monitoring
- Chemotherapy regimen that can safely be administered in outpatient infusion center
- Stable chronic cancer pain manageable with outpatient pain management adjustment
- Surveillance imaging, staging workup, or elective biopsy → outpatient
- Continued stay solely awaiting outpatient scheduling when medically stable for discharge

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY oncology review. Active treatment documented with daily progress toward milestones. For chemo induction: daily CBC, track ANC nadir/recovery. For transplant: daily engraftment assessment. For CAR-T: daily CRS/ICANS grading (ASTCT criteria).

CONTINUED STAY IF: Active treatment infusing, ANC <500 during expected nadir, active infection, transfusion-dependent, GVHD requiring IV therapy, CRS/ICANS not resolved

D. DISCHARGE CRITERIA — Safe Transition to Next Level of Care

- Acute treatment completed or condition stable for outpatient management
- ANC ≥500 x 2 days (if aplastic) or clear upward trend
- Transfusion-independent ≥48h
- Tolerating oral medications and adequate nutrition
- No active untreated infection requiring IV antibiotics
- Pain controlled on oral regimen
- Oncology follow-up with labs within 48-72h post-discharge

E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG determined by underlying malignancy or G89.3 as PDx → DRG 091-093 (Other Disorders of Nervous System) Rev 0250 (PCA opioids, ketamine, nerve blocks), 0420 (PT), 0940 (palliative consult)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: NCCN Palliative Care v1.2024; AAHPM

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

I. EXTENDED STAY CRITERIA & GUIDANCE

When Goal LOS is exceeded, continued inpatient stay requires documentation of ONE OR MORE of the following medical-necessity triggers. Document the specific trigger, the clinical evidence supporting it, and the targeted intervention plan.

- Persistent febrile neutropenia despite broad-spectrum antibiotics → escalation or addition of antifungal
- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

BRAIN METASTASES WITH CEREBRAL EDEMA

ICD-10-CM: C79.31 (secondary malignant neoplasm of brain), C79.32 (secondary malignant neoplasm of cerebral meninges), C79.40 (secondary malignant neoplasm of unspecified part of nervous system), G93.6 (cerebral edema), G91.0-G91.9 (hydrocephalus)

A. ADMISSION CRITERIA — Severity of Illness (SI) / Intensity of Service (IS)

SEVERITY OF ILLNESS (SI) — Must meet ≥1:

- Active oncologic condition requiring inpatient-level monitoring, treatment, or intervention
- Complication of cancer or cancer treatment that cannot be safely managed outpatient
- Clinical severity (vital sign instability, lab abnormalities, organ dysfunction) requiring continuous monitoring
- Expected treatment duration or monitoring needs requiring ≥2 midnight hospital stay

INTENSITY OF SERVICE (IS) — Must meet ≥1:

- Multi-day continuous IV chemotherapy infusion not available outpatient
- Daily laboratory monitoring required for treatment safety (e.g., TLS prevention, DIC management)
- Blood product transfusion support (≥2 units or daily platelet requirement)
- IV medications requiring inpatient monitoring (chemotherapy, immunotherapy, biologics, antifungals)
- Strict neutropenic precautions with HEPA-filtered room (allogeneic transplant)
- ICU-level monitoring for treatment complications (CRS, ICANS, engraftment syndrome)

B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for: induction chemotherapy (AML/ALL), stem cell transplant conditioning through engraftment, CAR-T lymphodepletion through CRS monitoring period

DOES NOT MEET CRITERIA:

- Cancer diagnosis alone without acute treatment or complication requiring inpatient monitoring
- Chemotherapy regimen that can safely be administered in outpatient infusion center
- Stable chronic cancer pain manageable with outpatient pain management adjustment
- Surveillance imaging, staging workup, or elective biopsy → outpatient
- Continued stay solely awaiting outpatient scheduling when medically stable for discharge

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY oncology review. Active treatment documented with daily progress toward milestones. For chemo induction: daily CBC, track ANC nadir/recovery. For transplant: daily engraftment assessment. For CAR-T: daily CRS/ICANS grading (ASTCT criteria).

CONTINUED STAY IF: Active treatment infusing, ANC <500 during expected nadir, active infection, transfusion-dependent, GVHD requiring IV therapy, CRS/ICANS not resolved

D. DISCHARGE CRITERIA — Safe Transition to Next Level of Care

- Acute treatment completed or condition stable for outpatient management
- ANC ≥500 x 2 days (if aplastic) or clear upward trend
- Transfusion-independent ≥48h
- Tolerating oral medications and adequate nutrition
- No active untreated infection requiring IV antibiotics
- Pain controlled on oral regimen
- Oncology follow-up with labs within 48-72h post-discharge

E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG 054-056 (Nervous System Neoplasms, RW 1.72/1.00/0.74), DRG 023-027 if surgical (craniotomy, RW 5.75+) Rev 0250 (dexamethasone), 0330 (radiation therapy), 0610 (MRI), 0360 (OR)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-7 days Source: NCCN CNS v1.2024; ASTRO Brain Mets Guideline

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

I. EXTENDED STAY CRITERIA & GUIDANCE

When Goal LOS is exceeded, continued inpatient stay requires documentation of ONE OR MORE of the following medical-necessity triggers. Document the specific trigger, the clinical evidence supporting it, and the targeted intervention plan.

- Persistent febrile neutropenia despite broad-spectrum antibiotics → escalation or addition of antifungal
- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

MALIGNANT PLEURAL/PERITONEAL EFFUSION REQUIRING INTERVENTION

ICD-10-CM: J91.0 (malignant pleural effusion), C78.2 (secondary malignant neoplasm of pleura), C78.6 (secondary malignant neoplasm of retroperitoneum and peritoneum), R18.0 (malignant ascites), C48.1-C48.2 (malignant neoplasm of peritoneum)

A. ADMISSION CRITERIA — Severity of Illness (SI) / Intensity of Service (IS)

SEVERITY OF ILLNESS (SI) — Must meet ≥1:

- Active oncologic condition requiring inpatient-level monitoring, treatment, or intervention
- Complication of cancer or cancer treatment that cannot be safely managed outpatient
- Clinical severity (vital sign instability, lab abnormalities, organ dysfunction) requiring continuous monitoring
- Expected treatment duration or monitoring needs requiring ≥2 midnight hospital stay

INTENSITY OF SERVICE (IS) — Must meet ≥1:

- Multi-day continuous IV chemotherapy infusion not available outpatient
- Daily laboratory monitoring required for treatment safety (e.g., TLS prevention, DIC management)
- Blood product transfusion support (≥2 units or daily platelet requirement)
- IV medications requiring inpatient monitoring (chemotherapy, immunotherapy, biologics, antifungals)
- Strict neutropenic precautions with HEPA-filtered room (allogeneic transplant)
- ICU-level monitoring for treatment complications (CRS, ICANS, engraftment syndrome)

B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for: induction chemotherapy (AML/ALL), stem cell transplant conditioning through engraftment, CAR-T lymphodepletion through CRS monitoring period

DOES NOT MEET CRITERIA:

- Cancer diagnosis alone without acute treatment or complication requiring inpatient monitoring

- Chemotherapy regimen that can safely be administered in outpatient infusion center
- Stable chronic cancer pain manageable with outpatient pain management adjustment
- Surveillance imaging, staging workup, or elective biopsy → outpatient
- Continued stay solely awaiting outpatient scheduling when medically stable for discharge

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY oncology review. Active treatment documented with daily progress toward milestones. For chemo induction: daily CBC, track ANC nadir/recovery. For transplant: daily engraftment assessment. For CAR-T: daily CRS/ICANS grading (ASTCT criteria).

CONTINUED STAY IF: Active treatment infusing, ANC <500 during expected nadir, active infection, transfusion-dependent, GVHD requiring IV therapy, CRS/ICANS not resolved

D. DISCHARGE CRITERIA — Safe Transition to Next Level of Care

- Acute treatment completed or condition stable for outpatient management
- ANC ≥500 x 2 days (if aplastic) or clear upward trend
- Transfusion-independent ≥48h
- Tolerating oral medications and adequate nutrition
- No active untreated infection requiring IV antibiotics
- Pain controlled on oral regimen
- Oncology follow-up with labs within 48-72h post-discharge

E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG 186-188 (Pleural Effusion, RW 1.53/1.03/0.78), DRG 163-165 if VATS (Major Chest Procedures) CPT 32556 (thoracentesis), 32550 (PleurX catheter), 32440 (pleurodesis) Rev 0270, 0360, 0481

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-5 days Source: ATS/STS/STR Malignant Pleural Effusion Guideline 2018

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

I. EXTENDED STAY CRITERIA & GUIDANCE

When Goal LOS is exceeded, continued inpatient stay requires documentation of ONE OR MORE of the following medical-necessity triggers. Document the specific trigger, the clinical evidence supporting it, and the targeted intervention plan.

- Persistent febrile neutropenia despite broad-spectrum antibiotics → escalation or addition of antifungal
- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

PATHOLOGIC FRACTURE FROM METASTATIC DISEASE

ICD-10-CM: M84.40XA (pathological fracture unspecified site initial), M84.411A-M84.419A (shoulder), M84.421A-M84.429A (humerus), M84.431A-M84.439A (ulna/radius), M84.441A-M84.449A (hand), M84.451A-M84.459A (femur), M84.461A-M84.469A (tibia/fibula), M84.471A-M84.479A (ankle/foot), M84.48XA (other site), M84.50XA-M84.58XA (pathological fracture in neoplastic disease by site) (pathological fracture series — by site), C79.51 (secondary malignant neoplasm of bone), C79.52 (secondary malignant neoplasm of bone marrow), M80.x (osteoporosis with pathological fracture — if also present)

A. ADMISSION CRITERIA — Severity of Illness (SI) / Intensity of Service (IS)

SEVERITY OF ILLNESS (SI) — Must meet ≥1:

- Active oncologic condition requiring inpatient-level monitoring, treatment, or intervention
- Complication of cancer or cancer treatment that cannot be safely managed outpatient
- Clinical severity (vital sign instability, lab abnormalities, organ dysfunction) requiring continuous monitoring
- Expected treatment duration or monitoring needs requiring ≥2 midnight hospital stay

INTENSITY OF SERVICE (IS) — Must meet ≥1:

- Multi-day continuous IV chemotherapy infusion not available outpatient
- Daily laboratory monitoring required for treatment safety (e.g., TLS prevention, DIC management)
- Blood product transfusion support (≥2 units or daily platelet requirement)
- IV medications requiring inpatient monitoring (chemotherapy, immunotherapy, biologics, antifungals)
- Strict neutropenic precautions with HEPA-filtered room (allogeneic transplant)
- ICU-level monitoring for treatment complications (CRS, ICANS, engraftment syndrome)

B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for: induction chemotherapy (AML/ALL), stem cell transplant conditioning through engraftment, CAR-T lymphodepletion through CRS monitoring period

DOES NOT MEET CRITERIA:

- Cancer diagnosis alone without acute treatment or complication requiring inpatient monitoring
- Chemotherapy regimen that can safely be administered in outpatient infusion center
- Stable chronic cancer pain manageable with outpatient pain management adjustment
- Surveillance imaging, staging workup, or elective biopsy → outpatient
- Continued stay solely awaiting outpatient scheduling when medically stable for discharge

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY oncology review. Active treatment documented with daily progress toward milestones. For chemo induction: daily CBC, track ANC nadir/recovery. For transplant: daily engraftment assessment. For CAR-T: daily CRS/ICANS grading (ASTCT criteria).

CONTINUED STAY IF: Active treatment infusing, ANC <500 during expected nadir, active infection, transfusion-dependent, GVHD requiring IV therapy, CRS/ICANS not resolved

D. DISCHARGE CRITERIA — Safe Transition to Next Level of Care

- Acute treatment completed or condition stable for outpatient management
- ANC ≥500 x 2 days (if aplastic) or clear upward trend
- Transfusion-independent ≥48h
- Tolerating oral medications and adequate nutrition
- No active untreated infection requiring IV antibiotics
- Pain controlled on oral regimen
- Oncology follow-up with labs within 48-72h post-discharge

E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG 542-544 (Pathological Fractures/Musculoskeletal Neoplasms, RW 1.86/1.11/0.79), DRG 480-482 (Hip/Femur Procedures if surgical stabilization) Rev 0330 (radiation), 0360 (OR), 0610 (MRI)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-7 days Source: AAOS/MSTS Mirels Criteria; NCCN Bone Metastases

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.

- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

I. EXTENDED STAY CRITERIA & GUIDANCE

When Goal LOS is exceeded, continued inpatient stay requires documentation of ONE OR MORE of the following medical-necessity triggers. Document the specific trigger, the clinical evidence supporting it, and the targeted intervention plan.

- Persistent febrile neutropenia despite broad-spectrum antibiotics → escalation or addition of antifungal
- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.

RADIATION-INDUCED COMPLICATIONS (PNEUMONITIS, ENTERITIS, MYELITIS)

ICD-10-CM: J70.0 (acute pulmonary manifestations due to radiation — radiation pneumonitis), J70.1 (chronic pulmonary manifestations due to radiation), K52.0 (radiation gastroenteritis and colitis), K62.7 (radiation proctitis), G62.82 (radiation-induced polyneuropathy), G95.0 (syringomyelia and syringobulbia), G95.89 (other specified diseases of spinal cord — radiation myelopathy), Y84.2 (radiological procedure as cause of abnormal reaction)

A. ADMISSION CRITERIA — Severity of Illness (SI) / Intensity of Service (IS)

SEVERITY OF ILLNESS (SI) — Must meet ≥1:

- Active oncologic condition requiring inpatient-level monitoring, treatment, or intervention
- Complication of cancer or cancer treatment that cannot be safely managed outpatient
- Clinical severity (vital sign instability, lab abnormalities, organ dysfunction) requiring continuous monitoring
- Expected treatment duration or monitoring needs requiring ≥2 midnight hospital stay

INTENSITY OF SERVICE (IS) — Must meet ≥1:

- Multi-day continuous IV chemotherapy infusion not available outpatient
- Daily laboratory monitoring required for treatment safety (e.g., TLS prevention, DIC management)
- Blood product transfusion support (≥2 units or daily platelet requirement)
- IV medications requiring inpatient monitoring (chemotherapy, immunotherapy, biologics, antifungals)
- Strict neutropenic precautions with HEPA-filtered room (allogeneic transplant)
- ICU-level monitoring for treatment complications (CRS, ICANS, engraftment syndrome)

B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for: induction chemotherapy (AML/ALL), stem cell transplant conditioning through engraftment, CAR-T lymphodepletion through CRS monitoring period

DOES NOT MEET CRITERIA:

- Cancer diagnosis alone without acute treatment or complication requiring inpatient monitoring
- Chemotherapy regimen that can safely be administered in outpatient infusion center
- Stable chronic cancer pain manageable with outpatient pain management adjustment
- Surveillance imaging, staging workup, or elective biopsy → outpatient
- Continued stay solely awaiting outpatient scheduling when medically stable for discharge

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY oncology review. Active treatment documented with daily progress toward milestones. For chemo induction: daily CBC, track ANC nadir/recovery. For transplant: daily engraftment assessment. For CAR-T: daily CRS/ICANS grading (ASTCT criteria).

CONTINUED STAY IF: Active treatment infusing, ANC <500 during expected nadir, active infection, transfusion-dependent, GVHD requiring IV therapy, CRS/ICANS not resolved

D. DISCHARGE CRITERIA — Safe Transition to Next Level of Care

- Acute treatment completed or condition stable for outpatient management
- ANC ≥500 x 2 days (if aplastic) or clear upward trend
- Transfusion-independent ≥48h
- Tolerating oral medications and adequate nutrition
- No active untreated infection requiring IV antibiotics
- Pain controlled on oral regimen
- Oncology follow-up with labs within 48-72h post-discharge

E. EVIDENCE SOURCES

NCCN Clinical Practice Guidelines (condition-specific). Version 2024. ASCO/ASH Guidelines for Supportive Care. ASTCT Consensus Grading for CRS/ICANS. Lee DW, et al. BBMT. 2019;25:625-638.

F. MS-DRG CROSSWALK & REVENUE CODES

DRG varies by organ system affected: Respiratory (DRG 177-179), GI (DRG 391-393), Neurological (DRG 091-093) Rev 0250 (steroids, immunosuppressants), 0350 (CT), 0610 (MRI)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-7 days Source: ASTRO Toxicity Consensus 2020

H. LEVEL OF CARE (LOC) GRID — PUBLIC-SOURCE STANDARDIZED CRITERIA

- ICU: CRS grade ≥3 (CAR-T) requiring vasopressors, ICANS grade ≥3, septic shock from neutropenia, tumor lysis with severe AKI on CRRT, intracranial mass with herniation risk on osmotherapy, ventilator support.
- Stepdown (Telemetry/PCU): CRS grade 2 on tocilizumab, ICANS grade 1–2 with frequent neuro checks, febrile neutropenia with hemodynamic concern, tumor lysis on aggressive IV fluids/rasburicase, post-engraftment graft failure monitoring.
- Med-Surg: Afebrile, ANC recovering, tolerating diet, transitioning IV → PO antibiotics, completing chemotherapy cycle, mucositis improving.
- Observation: Generally not applicable for active induction/HSCT/CAR-T; chemo administration with rapid recovery may use observation status when CMS criteria met.
- Post-Acute (SNF/IRF/LTAC): Post-HSCT/CAR-T patients deconditioned may require SNF; LTAC for prolonged vent weaning; IRF for stroke/neurologic complication.
- Home (with/without HHA): Afebrile, ANC ≥500, tolerating PO, pain controlled, follow-up onc 1–2 times/week; HHA for IV antibiotics, line care, and home labs.

LOC Grid Sources: NCCN Hematologic Malignancies Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT/EBMT HSCT Standards 2023; ASTCT CRS/ICANS Consensus 2019 (Lee criteria).

I. EXTENDED STAY CRITERIA & GUIDANCE

When Goal LOS is exceeded, continued inpatient stay requires documentation of ONE OR MORE of the following medical-necessity triggers. Document the specific trigger, the clinical evidence supporting it, and the targeted intervention plan.

- Persistent febrile neutropenia despite broad-spectrum antibiotics → escalation or addition of antifungal
- Tumor lysis with continued laboratory abnormalities requiring rasburicase or dialysis
- Mucositis preventing oral intake with TPN dependence
- CRS or ICANS persisting beyond expected duration requiring tocilizumab/anakinra/steroids
- Graft failure or delayed engraftment (HSCT) beyond expected day +14

Extended Stay Sources: Sources: NCCN Guidelines; IDSA/NCCN Febrile Neutropenia 2018; ASTCT CRS/ICANS Consensus 2019.