# Section D — Inpatient Surgical Procedures

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

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

**Conditions / procedures in this section:** 15

**Scope:** Cardiac, thoracic and related inpatient surgical procedures.

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

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## CABG (CORONARY ARTERY BYPASS GRAFT)

ICD-10-CM: ICD-10-CM: I25.10 (atherosclerotic heart disease of native coronary artery), I25.110 (atherosclerotic heart disease of native coronary artery with unstable angina), I25.111 (with angina with documented spasm), I25.118 (with other forms of angina pectoris), I25.119 (with unspecified angina pectoris) (native vessel with angina pectoris), I25.700-I25.799 (atherosclerosis of CABG), I25.810-I25.812 (atherosclerosis of other coronary vessels), Z95.1 (presence of aortocoronary bypass graft) | ICD-10-PCS: 0210083-02100ZF (bypass coronary artery series — by number of sites, graft type, approach) | CPT: 33510 (CABG vein x1), 33511 (x2), 33512 (x3), 33513 (x4), 33514 (x5), 33516 (x6+), 33533 (CABG arterial x1), 33534 (x2), 33535 (x3), 33536 (x4+), 33517-33523 (combined arterial-venous)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 231 (CABG w PTCA w MCC RW ~8.63), DRG 232 (w PTCA w/o MCC RW ~5.85), DRG 233 (w Cath w MCC RW ~7.73), DRG 234 (w Cath w/o MCC RW ~5.14), DRG 235 (w/o Cath w MCC RW ~6.41), DRG 236 (w/o Cath w/o MCC RW ~4.08)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: STS Adult Cardiac Surgery Database; CMS MS-DRG 231-236 GMLOS 6.0d

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

- ICU: Immediate post-op (≥12–24h standard), open chest, mediastinal bleeding >100 mL/h, mechanical support (IABP/Impella/ECMO), inotrope/vasopressor requirement, ventilator-dependent, post-op arrhythmia requiring titration.
- Stepdown (Telemetry/PCU): Extubated, off significant vasoactives, chest tubes in place, continuous telemetry, pacing wires, transitioning to PO meds, ambulating with assist.
- Med-Surg: Chest tubes ≤2 with minimal output, off pacing wires, ambulating independently, completing diuresis, transitioning to home medications, cardiac rehab pre-discharge teaching.
- Observation: Not typically applicable for open cardiac surgery; TAVR/MitraClip with uncomplicated course may discharge within 1–2 midnights per CMS/ACC/AHA/STS 2023 expert consensus.
- Post-Acute (SNF/IRF/LTAC): Cardiac rehab eligible but home unsafe (multi-comorbid, deconditioned), tracheostomy/ventilator weaning (LTAC), wound complications requiring skilled care.
- Home (with/without HHA): Ambulating, tolerating diet, pain controlled on oral, INR therapeutic if mechanical valve, sternal precautions understood, follow-up CT surgery within 1–2 weeks; cardiac rehab referral.

LOC Grid Sources: STS Adult Cardiac Surgery Database benchmarks; 2020 ACC/AHA Valvular Heart Disease Guideline; ACC/AHA/STS 2023 TAVR Expert Consensus; CMS IPPS MS-DRG 216–236.

### 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.

- Mediastinal bleeding, pericardial effusion, or tamponade requiring intervention
- Post-op atrial fibrillation requiring IV rate/rhythm control or initiation of anticoagulation with bridging concerns
- Sternal wound infection or dehiscence requiring debridement and IV antibiotics
- Respiratory failure requiring re-intubation or prolonged ventilator support (>48 h)
- Acute kidney injury post-CPB requiring dialysis access placement and initiation
- Stroke or TIA in immediate post-op period requiring neuro work-up
- Failure to wean from inotropes/vasopressors beyond 72 h

Extended Stay Sources: Sources: STS Adult Cardiac Surgery Database benchmarks; 2020 ACC/AHA Valvular Heart Disease Guideline.

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## VALVE REPLACEMENT/REPAIR (OPEN AND TAVR)

ICD-10-CM: ICD-10-CM: I35.0 (aortic stenosis nonrheumatic), I35.1 (aortic insufficiency), I35.2 (aortic stenosis w insufficiency), I34.0 (mitral insufficiency nonrheumatic), I34.1 (mitral valve prolapse), I34.2 (mitral stenosis nonrheumatic), I08.0-I08.9 (multiple valve diseases), I06.0-I06.9 (rheumatic aortic), I05.0-I05.9 (rheumatic mitral), Z95.2 (presence of prosthetic heart valve), T82.01-T82.09 (mechanical complication of heart valve prosthesis) | ICD-10-PCS: 02RF0xx (replacement aortic valve), 02RG0xx (mitral), 02QF0ZZ (repair aortic), 02QG0ZZ (repair mitral), X2RF032 (TAVR, percutaneous) | CPT: 33361-33369 (TAVR), 33405-33413 (AVR open), 33420-33427 (mitral repair), 33430 (mitral replacement)

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

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- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 216-219 (Cardiac Valve, RW 5.01-10.78), DRG 266-267 (Endovascular/TAVR, RW 4.24-5.82)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days open; 1-3 days TAVR Source: STS Adult Cardiac Surgery Database; CMS MS-DRG 216-221, 266-267

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

- ICU: Immediate post-op (≥12–24h standard), open chest, mediastinal bleeding >100 mL/h, mechanical support (IABP/Impella/ECMO), inotrope/vasopressor requirement, ventilator-dependent, post-op arrhythmia requiring titration.
- Stepdown (Telemetry/PCU): Extubated, off significant vasoactives, chest tubes in place, continuous telemetry, pacing wires,

transitioning to PO meds, ambulating with assist.

- Med-Surg: Chest tubes ≤2 with minimal output, off pacing wires, ambulating independently, completing diuresis, transitioning to home medications, cardiac rehab pre-discharge teaching.
- Observation: Not typically applicable for open cardiac surgery; TAVR/MitraClip with uncomplicated course may discharge within 1–2 midnights per CMS/ACC/AHA/STS 2023 expert consensus.
- Post-Acute (SNF/IRF/LTAC): Cardiac rehab eligible but home unsafe (multi-comorbid, deconditioned), tracheostomy/ventilator weaning (LTAC), wound complications requiring skilled care.
- Home (with/without HHA): Ambulating, tolerating diet, pain controlled on oral, INR therapeutic if mechanical valve, sternal precautions understood, follow-up CT surgery within 1–2 weeks; cardiac rehab referral.

LOC Grid Sources: STS Adult Cardiac Surgery Database benchmarks; 2020 ACC/AHA Valvular Heart Disease Guideline; ACC/AHA/STS 2023 TAVR Expert Consensus; CMS IPPS MS-DRG 216–236.

### 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.

- Mediastinal bleeding, pericardial effusion, or tamponade requiring intervention
- Post-op atrial fibrillation requiring IV rate/rhythm control or initiation of anticoagulation with bridging concerns
- Sternal wound infection or dehiscence requiring debridement and IV antibiotics
- Respiratory failure requiring re-intubation or prolonged ventilator support (>48 h)
- Acute kidney injury post-CPB requiring dialysis access placement and initiation
- Stroke or TIA in immediate post-op period requiring neuro work-up
- Failure to wean from inotropes/vasopressors beyond 72 h

Extended Stay Sources: Sources: STS Adult Cardiac Surgery Database benchmarks; 2020 ACC/AHA Valvular Heart Disease Guideline.

## CRANIOTOMY / CRANIECTOMY

ICD-10-CM: ICD-10-CM: C71.0-C71.9 (malignant neoplasm of brain), D33.0-D33.2 (benign neoplasm of brain/meninges), I61.0-I61.9 (intracerebral hemorrhage), I60.0-I60.9 (SAH), S06.xxx (TBI), G93.5 (compression of brain), G91.x (hydrocephalus) | ICD-10-PCS: 00B00ZZ-00BVXZZ (excision of brain tissue), 00N00ZZ-00NVXZZ (release of brain), 009x0ZZ (drainage of brain) | CPT: 61304-61315 (craniectomy/craniotomy for tumor/abscess), 61510-61519 (craniotomy for tumor), 61624 (craniotomy for aneurysm), 62000-62010 (craniotomy for subdural/epidural hematoma)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society).

Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 023-025 (Craniotomy w MCC/CC/w/o, RW 5.75/3.61/2.59), DRG 026-027 (Craniotomy for Trauma, RW 4.30/2.53)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-7 days Source: AANS/CNS Neurosurgery Outcomes; CMS MS-DRG 023-027

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

- ICU: Immediate post-op (≥24h standard for craniotomy/aneurysm/AVM), EVD/ICP monitor, ventilator support, vasospasm monitoring, hemodynamic lability, new neurologic deficit.
- Stepdown (Telemetry/PCU): Post-op neuro checks q2–4h, EVD weaning, transitioning antiepileptics IV → PO, BP control off drip.
- Med-Surg: Neuro exam stable, ambulating with assist, tolerating diet, transitioning to oral analgesia, dressing intact.
- Observation: Uncomplicated DBS lead placement, simple VP shunt revision, microvascular decompression may discharge within 2 midnights when stable.
- Post-Acute (SNF/IRF/LTAC): IRF for stroke-equivalent post-op deficits; SNF for skilled care; LTAC for prolonged vent.
- Home (with/without HHA): Ambulating, oriented, tolerating diet, follow-up neurosurgery in 1–2 weeks; HHA for incision care and PT/OT.

LOC Grid Sources: AANS/CNS Guidelines; NASS Spinal Surgery Guidelines 2020; CMS MS-DRG 023–027, 459–460.

### 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.

- EVD not yet weaned or shunt-dependence not established
- Persistent cerebral edema requiring continued hyperosmolar therapy
- CSF leak requiring lumbar drain or repair
- Surgical site infection or wound dehiscence
- New seizure with antiepileptic load adjustment
- Inability to safely discharge due to neurologic deficit

Extended Stay Sources: Sources: AANS/CNS Guidelines; NASS Spinal Surgery Guidelines 2020.

## SPINAL FUSION (CERVICAL, THORACOLUMBAR)

ICD-10-CM: ICD-10-CM: M43.x (spondylolisthesis), M47.x (spondylosis), M48.x (spinal stenosis), M50.x (cervical disc disorders), M51.x (thoracic/lumbar disc disorders), M54.x (dorsalgia), S12.x (cervical fracture), S22.x (thoracic fracture), S32.x (lumbar fracture), M45.x (ankylosing spondylitis), C41.2 (malignant neoplasm of vertebral column) | ICD-10-PCS: 0SG0xxx-0SG4xxx (fusion of cervical/thoracic/lumbar/sacral vertebral joints), 0RG1xxx (fusion of cervical vertebral joint) | CPT: 22551-22554 (ACDF), 22600-

22614 (posterior/posterolateral fusion), 22630-22634 (posterior interbody fusion — PLIF/TLIF), 22800-22812 (arthrodesis for scoliosis), 22840-22848 (instrumentation)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 453-455 (Combined Anterior/Posterior Spinal Fusion, RW 7.05/4.16/3.09), DRG 456-458 (Spinal Fusion Except Cervical w/wo MCC, RW 5.21/3.04/2.27), DRG 471-473 (Cervical Spinal Fusion, RW 3.67/2.14/1.59), DRG 459-461 (Spinal Fusion Except Cervical w Spinal Curvature/Malignancy, RW 8.43/5.25/4.03)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-4 days cervical; 3-5 days T/L; complex up to 7d Source: NASS 2020 Guidelines; CMS MS-DRG 459-460

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

- ICU: Immediate post-op (≥24h standard for craniotomy/aneurysm/AVM), EVD/ICP monitor, ventilator support, vasospasm monitoring, hemodynamic lability, new neurologic deficit.
- Stepdown (Telemetry/PCU): Post-op neuro checks q2–4h, EVD weaning, transitioning antiepileptics IV → PO, BP control off drip.
- Med-Surg: Neuro exam stable, ambulating with assist, tolerating diet, transitioning to oral analgesia, dressing intact.
- Observation: Uncomplicated DBS lead placement, simple VP shunt revision, microvascular decompression may discharge within 2 midnights when stable.
- Post-Acute (SNF/IRF/LTAC): IRF for stroke-equivalent post-op deficits; SNF for skilled care; LTAC for prolonged vent.
- Home (with/without HHA): Ambulating, oriented, tolerating diet, follow-up neurosurgery in 1–2 weeks; HHA for incision care and PT/OT.

LOC Grid Sources: AANS/CNS Guidelines; NASS Spinal Surgery Guidelines 2020; CMS MS-DRG 023–027, 459–460.

### 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.

- EVD not yet weaned or shunt-dependence not established
- Persistent cerebral edema requiring continued hyperosmolar therapy
- CSF leak requiring lumbar drain or repair
- Surgical site infection or wound dehiscence
- New seizure with antiepileptic load adjustment
- Inability to safely discharge due to neurologic deficit

Extended Stay Sources: Sources: AANS/CNS Guidelines; NASS Spinal Surgery Guidelines 2020.

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## TOTAL JOINT REPLACEMENT — COMPLEX/REVISION (HIP, KNEE)

ICD-10-CM: ICD-10-CM: M16.0-M16.9 (osteoarthritis of hip), M17.0-M17.9 (osteoarthritis of knee), T84.01-T84.09 (mechanical complication of internal joint prosthesis), T84.50-T84.59 (infection of internal joint prosthesis), Z96.641-Z96.649 (presence of joint implant), M87.x (osteonecrosis) | ICD-10-PCS: 0SR9xxx (replacement of hip joint), 0SRBxxx (replacement of hip acetabular), 0SRCxxx (replacement of knee joint), 0SW9xxx (revision of hip joint), 0SWCxxx (revision of knee joint) | CPT: 27130 (primary THA), 27134-27138 (revision THA), 27447 (primary TKA), 27486-27488 (revision TKA)

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

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

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- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
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### B. OBSERVATION vs INPATIENT DECISION MATRIX

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- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No

complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
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- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society).

Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 469 (Major Hip/Knee Joint Replacement or Reattachment of Lower Extremity w MCC, RW ~3.37), DRG 470 (w/o MCC, RW ~2.15), DRG 466 (Revision of Hip/Knee Replacement w MCC, RW ~4.47), DRG 467 (w CC, RW ~3.04), DRG 468 (w/o CC/MCC, RW ~2.50)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-4 days primary; 3-5 days revision Source: AAOS Joint Replacement Registry; CMS MS-DRG 466-470

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

- ICU: Polytrauma with hemodynamic instability, fat embolism syndrome, compartment syndrome with rhabdomyolysis and AKI, ventilator support, vasoactive requirement.
- Stepdown (Telemetry/PCU): Post-spinal cord injury with autonomic instability, post-pelvic angiography with hemodynamic concern, polytrauma stabilizing.
- Med-Surg: Pain controlled on transitioning PCA → PO, weight-bearing per protocol, VTE prophylaxis active, drains low output, PT/OT engaged.
- Observation: Uncomplicated arthroplasty with rapid recovery may discharge POD 0–1 per CMS removal from inpatient-only list.
- Post-Acute (SNF/IRF/LTAC): IRF when ≥3 hours/day multidisciplinary therapy tolerated; SNF for skilled nursing with lower therapy intensity; spinal cord injury → specialized IRF.
- Home (with/without HHA): Ambulating with assistive device, weight-bearing per protocol, pain controlled on PO, follow-up ortho in 1–2 weeks; HHA for PT/OT and skilled nursing.

LOC Grid Sources: AAOS Clinical Practice Guidelines; OTA Polytrauma Consensus; AAOS Joint Replacement Registry; AAOS Hip Fracture Guideline 2021.

### 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.

- Post-op complication: DVT/PE, surgical site infection, dislocation, periprosthetic fracture
- Inadequate pain control preventing rehab participation
- Non-weight-bearing status with no safe home environment
- Polytrauma with multiple injuries requiring staged repair
- Rehab placement (IRF/SNF) not yet finalized despite medical readiness

Extended Stay Sources: Sources: AAOS Clinical Practice Guidelines; OTA Practice Parameters.

## COLECTOMY / BOWEL RESECTION

ICD-10-CM: ICD-10-CM: C18.0 (malignant neoplasm of cecum), C18.1 (appendix), C18.2 (ascending colon), C18.3 (hepatic flexure),

C18.4 (transverse colon), C18.5 (splenic flexure), C18.6 (descending colon), C18.7 (sigmoid colon), C18.8 (overlapping sites of colon), C18.9 (colon unspecified) (malignant neoplasm of colon by site), C19 (malignant neoplasm of rectosigmoid junction), C20 (malignant neoplasm of rectum), K57.20-K57.21 (diverticulitis of large intestine with perforation/abscess), K63.1 (perforation of intestine), K55.011-K55.069 (acute vascular disorders of intestine), K56.50-K56.699 (intestinal obstruction), K50.x-K51.x (Crohn/UC requiring colectomy) | ICD-10-PCS: 0DTE0ZZ (resection of large intestine), 0DTH0ZZ (resection of cecum), 0DTN0ZZ (resection of sigmoid), 0DBE0ZZ (excision of large intestine), 0D1E0Z4 (bypass large intestine to cutaneous — colostomy) | CPT: 44140-44160 (colectomy open), 44204-44213 (laparoscopic colectomy), 44150 (total colectomy w ileostomy), 44210 (laparoscopic total colectomy)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 329-331 (Major Small & Large Bowel Procedures, RW 4.44/2.23/1.42)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-7 days open; 3-5 days laparoscopic Source: NSQIP; ASCRS 2017 ERAS Colorectal Guideline; CMS MS-DRG 329-331

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

- ICU: Post-Whipple/esophagectomy/HIPEC with hemodynamic instability, anastomotic leak with sepsis, ventilator-dependent, ongoing transfusion, planned re-look laparotomy.
- Stepdown (Telemetry/PCU): Post-op telemetry for AF, epidural in place, NG decompression, drain output significant, transitioning vasoactives off.
- Med-Surg: Bowel function returning (flatus/BM), tolerating clears → diet, drains low output, ambulating, transitioning to oral analgesia per ERAS pathway.
- Observation: Uncomplicated laparoscopic appendectomy/cholecystectomy with rapid recovery may discharge within 1–2 midnights; falls under CMS 2-Midnight Rule.
- Post-Acute (SNF/IRF/LTAC): Major resection patients commonly require SNF for nutrition (TPN/enteral) management when home unsafe; LTAC for vent weaning or chronic wound.
- Home (with/without HHA): Tolerating diet, ambulating, drains managed, pain controlled on oral, follow-up surgery in 1–2 weeks; HHA for drain, wound, or TPN/enteral support.

LOC Grid Sources: ACS NSQIP benchmarks; ASCRS 2017 ERAS Colorectal Pathway; AHPBA HPB Guidelines; SAGES.

### 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.

- Anastomotic leak requiring imaging, drainage, or revision
- Postoperative ileus >5 days requiring NG decompression and TPN
- Surgical site infection or wound dehiscence
- Pancreatic fistula (post-Whipple/distal pancreatectomy) per ISGPF grade B/C
- Bile leak requiring drainage or ERCP
- Post-op hemorrhage requiring transfusion or re-operation

Extended Stay Sources: Sources: ACS NSQIP; ASCRS Practice Parameters; AHPBA Consensus.

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## WHIPPLE PROCEDURE (PANCREATICODUODENECTOMY)

ICD-10-CM: ICD-10-CM: C25.0 (malignant neoplasm of head of pancreas), C25.1 (body), C25.2 (tail), C25.3 (pancreatic duct), C25.8-C25.9 (other/unspecified pancreas), C24.0-C24.1 (extrahepatic bile duct/ampulla of Vater), D13.6 (benign neoplasm of pancreas) | ICD-10-PCS: 0FTG0ZZ (resection of pancreas), 0FT90ZZ (resection of duodenum), 0DT90ZZ (resection of duodenum), 0FT20ZZ (resection of common bile duct) | CPT: 48150 (pancreatectomy proximal subtotal with total duodenectomy — Whipple), 48153 (with distal gastrectomy), 48154 (with total pancreatectomy)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery

- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society).

Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 405 (Pancreas/Liver/Shunt Procedures w MCC, RW ~4.87), DRG 406 (w CC, RW ~2.77), DRG 407 (w/o CC/MCC, RW ~1.79)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 8-14 days Source: AHPBA Whipple Guidelines; NSQIP HPB; CMS MS-DRG 405-407

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

- ICU: Post-Whipple/esophagectomy/HIPEC with hemodynamic instability, anastomotic leak with sepsis, ventilator-dependent, ongoing transfusion, planned re-look laparotomy.
- Stepdown (Telemetry/PCU): Post-op telemetry for AF, epidural in place, NG decompression, drain output significant, transitioning vasoactives off.
- Med-Surg: Bowel function returning (flatus/BM), tolerating clears → diet, drains low output, ambulating, transitioning to oral analgesia per ERAS pathway.
- Observation: Uncomplicated laparoscopic appendectomy/cholecystectomy with rapid recovery may discharge within 1–2 midnights; falls under CMS 2-Midnight Rule.
- Post-Acute (SNF/IRF/LTAC): Major resection patients commonly require SNF for nutrition (TPN/enteral) management when home unsafe; LTAC for vent weaning or chronic wound.
- Home (with/without HHA): Tolerating diet, ambulating, drains managed, pain controlled on oral, follow-up surgery in 1–2 weeks; HHA for drain, wound, or TPN/enteral support.

LOC Grid Sources: ACS NSQIP benchmarks; ASCRS 2017 ERAS Colorectal Pathway; AHPBA HPB Guidelines; SAGES.

### 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.

- Anastomotic leak requiring imaging, drainage, or revision
- Postoperative ileus >5 days requiring NG decompression and TPN
- Surgical site infection or wound dehiscence
- Pancreatic fistula (post-Whipple/distal pancreatectomy) per ISGPF grade B/C
- Bile leak requiring drainage or ERCP

- Post-op hemorrhage requiring transfusion or re-operation

Extended Stay Sources: Sources: ACS NSQIP; ASCRS Practice Parameters; AHPBA Consensus.

## NEPHRECTOMY (RADICAL / PARTIAL)

ICD-10-CM: ICD-10-CM: C64.1-C64.9 (malignant neoplasm of kidney), C65.x (malignant neoplasm of renal pelvis), D30.0x (benign neoplasm of kidney), N28.0 (ischemia/infarction of kidney), Q60.x (renal agenesis/dysgenesis — for donor) | ICD-10-PCS: 0TT00ZZ-0TT10ZZ (resection of kidney, right/left, open), 0TB00ZZ-0TB10ZZ (excision of kidney — partial nephrectomy) | CPT: 50220 (nephrectomy radical), 50225 (nephrectomy radical with regional lymphadenectomy), 50230 (nephrectomy radical with vena cava thrombectomy), 50240 (nephrectomy partial), 50543-50548 (laparoscopic nephrectomy/partial)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society).

Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 652 (Kidney Transplant — if donor), DRG 673-675 (Other Kidney/Urinary Tract Procedures, RW 2.69/1.64/1.11), DRG 656-658 (Kidney & Ureter Procedures for Neoplasm, RW 2.82/1.80/1.32)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days open; 1-3 days laparoscopic/robotic Source: AUA Renal Mass Guideline 2021; NSQIP

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

- ICU: Post-radical cystectomy with hemodynamic instability, septic shock from pyonephrosis post-decompression, massive transfusion, ventilator support.
- Stepdown (Telemetry/PCU): Post-cystectomy with stoma care, drain monitoring, NG decompression, urinary diversion teaching.
- Med-Surg: Bowel function returning, tolerating diet, drains low, stoma/diversion functional, ambulating.
- Observation: Robotic prostatectomy commonly POD 1 discharge; partial nephrectomy may be 1–2 midnights when laparoscopic/robotic.
- Post-Acute (SNF/IRF/LTAC): Cystectomy with diversion may require SNF for ostomy care education; rarely LTAC.
- Home (with/without HHA): Tolerating diet, ambulating, foley/stent managed, ostomy independent (if applicable), follow-up urology in 1–2 weeks; HHA for ostomy and wound.

LOC Grid Sources: AUA Bladder Cancer Guideline 2024; AUA Localized Prostate Cancer 2022; ERAS Urology Consensus.

### 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.

- Urinary leak or stricture requiring repair
- Pyelonephritis or stoma infection requiring IV antibiotics
- Ileus delaying discharge
- Stomal complications requiring revision
- Failure of patient to demonstrate ostomy/diversion self-care

Extended Stay Sources: Sources: AUA Guidelines; ERAS Urology Consensus.

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## LUNG RESECTION (LOBECTOMY, PNEUMONECTOMY)

ICD-10-CM: ICD-10-CM: C34.00 (malignant neoplasm of unspecified main bronchus), C34.01 (right main bronchus), C34.02 (left main bronchus), C34.10 (malignant neoplasm of upper lobe unspecified side), C34.11 (right upper lobe), C34.12 (left upper lobe), C34.2 (middle lobe bronchus or lung), C34.30 (lower lobe unspecified), C34.31 (right lower lobe), C34.32 (left lower lobe), C34.80 (overlapping sites unspecified), C34.81 (right), C34.82 (left), C34.90 (unspecified part unspecified side), C34.91 (right), C34.92 (left) (malignant neoplasm of bronchus and lung — by lobe and laterality), C78.00-C78.02 (secondary malignant neoplasm of lung), D02.20-D02.22 (carcinoma in situ of bronchus/lung), D14.30-D14.32 (benign neoplasm of bronchus/lung) | ICD-10-PCS: 0BT30ZZ-0BT50ZZ (resection of lung lobe, open), 0BTCOZZ (resection of bilateral lungs — pneumonectomy), 0BB30ZZ-0BB50ZZ (excision of lung — wedge resection) | CPT: 32440 (pneumonectomy), 32480 (lobectomy), 32663 (VATS lobectomy), 32666 (VATS wedge resection), 32505 (wedge resection open)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 163 (Major Chest Procedures w MCC, RW ~4.71), DRG 164 (w CC, RW ~2.60), DRG 165 (w/o CC/MCC, RW ~1.81), DRG 166-168 (Other Cardiothoracic Procedures)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days VATS/robotic; 5-7 days open Source: STS General Thoracic Database; CTSNet

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

- ICU: Post-op pneumonectomy or esophagectomy (standard 24h), ventilator-dependent, hemodynamic instability, hemorrhage, anastomotic concerns, post-op arrhythmia requiring drip.
- Stepdown (Telemetry/PCU): Extubated, telemetry for AF/atrial flutter post-thoracotomy, epidural in place, chest tubes with air leak, NG tube post-esophagectomy.
- Med-Surg: Chest tubes without leak, tolerating tube feeds (post-esophagectomy) or oral, ambulating, transitioning epidural to oral analgesia.
- Observation: Generally not applicable for major lung/esophageal resection; rare for diagnostic procedures with uncomplicated course.
- Post-Acute (SNF/IRF/LTAC): Pulmonary rehab eligible; LTAC for prolonged vent weaning; SNF for complex wound care or jejunostomy management.
- Home (with/without HHA): Chest tubes out, tolerating diet (or stable on enteral feeds), ambulating, follow-up thoracic surgery in 1–2 weeks; HHA for wound, tube feeds, or oxygen.

LOC Grid Sources: STS General Thoracic Database; ECCG Esophagectomy Outcomes; ATS/ACCP Lung Cancer Guidelines; CMS MS-DRG 163–167, 405–407.

### 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 air leak >5 days from chest tube
- Anastomotic leak (esophagectomy) requiring drainage or revision
- Pneumonia or empyema requiring ongoing antibiotics and possible intervention
- Atrial fibrillation requiring IV rate/rhythm control
- Chylothorax requiring dietary intervention or thoracic duct ligation
- Failure to tolerate enteral or oral feeds (esophagectomy/gastrectomy)

Extended Stay Sources: Sources: STS General Thoracic Database; ECCG Esophagectomy Complication Consensus.

## ESOPHAGECTOMY

ICD-10-CM: ICD-10-CM: C15.3 (malignant neoplasm of upper third esophagus), C15.4 (middle third), C15.5 (lower third), C15.8 (overlapping), C15.9 (unspecified), C16.0 (malignant neoplasm of cardia/GEJ), K22.1 (ulcer of esophagus), K22.3 (perforation of esophagus) | ICD-10-PCS: 0DT10ZZ (resection of esophagus, upper), 0DT20ZZ (middle), 0DT30ZZ (lower), 0DT50ZZ (esophagus) | CPT: 43107-43113 (esophagectomy), 43116 (esophagectomy with total gastrectomy), 43287-43288 (laparoscopic/robotic esophagectomy)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge

- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society).

Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 154 (Other Ear/Nose/Mouth/Throat OR Procedures — sometimes misassigned), DRG 326-328 (Stomach/Esophageal/Duodenal Procedures, RW 5.84/2.97/1.77), DRG 163-165 (Major Chest if transthoracic approach)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: STS GTD; ECCG Outcomes; CMS MS-DRG 405-407

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

- ICU: Post-op pneumonectomy or esophagectomy (standard 24h), ventilator-dependent, hemodynamic instability, hemorrhage, anastomotic concerns, post-op arrhythmia requiring drip.
- Stepdown (Telemetry/PCU): Extubated, telemetry for AF/atrial flutter post-thoracotomy, epidural in place, chest tubes with air leak, NG tube post-esophagectomy.
- Med-Surg: Chest tubes without leak, tolerating tube feeds (post-esophagectomy) or oral, ambulating, transitioning epidural to oral analgesia.
- Observation: Generally not applicable for major lung/esophageal resection; rare for diagnostic procedures with uncomplicated course.
- Post-Acute (SNF/IRF/LTAC): Pulmonary rehab eligible; LTAC for prolonged vent weaning; SNF for complex wound care or jejunostomy management.
- Home (with/without HHA): Chest tubes out, tolerating diet (or stable on enteral feeds), ambulating, follow-up thoracic surgery in 1–2 weeks; HHA for wound, tube feeds, or oxygen.

LOC Grid Sources: STS General Thoracic Database; ECCG Esophagectomy Outcomes; ATS/ACCP Lung Cancer Guidelines; CMS MS-DRG 163–167, 405–407.

### 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 air leak >5 days from chest tube
- Anastomotic leak (esophagectomy) requiring drainage or revision
- Pneumonia or empyema requiring ongoing antibiotics and possible intervention
- Atrial fibrillation requiring IV rate/rhythm control
- Chylothorax requiring dietary intervention or thoracic duct ligation
- Failure to tolerate enteral or oral feeds (esophagectomy/gastrectomy)

Extended Stay Sources: Sources: STS General Thoracic Database; ECCG Esophagectomy Complication Consensus.

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## LIVER RESECTION (HEPATECTOMY)

ICD-10-CM: ICD-10-CM: C22.0 (hepatocellular carcinoma), C22.1 (intrahepatic bile duct carcinoma), C22.7 (other specified carcinomas of liver), C78.7 (secondary malignant neoplasm of liver), D13.4 (benign neoplasm of liver), K76.6 (portal hypertension — if cause of resection) | ICD-10-PCS: 0FT00ZZ (resection of liver), 0FB00ZZ-0FB04ZZ (excision of liver — partial hepatectomy), 0FT10ZZ (resection of liver right lobe), 0FT20ZZ (resection of liver left lobe) | CPT: 47120 (hepatectomy partial), 47122 (hepatectomy trisegmentectomy), 47125-47130 (hepatectomy total right/left)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management

- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society).

Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 405-407 (Pancreas/Liver/Shunt Procedures, RW 4.87/2.77/1.79)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-7 days Source: AHPBA/IHPBA; NSQIP HPB

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

- ICU: Post-Whipple/esophagectomy/HIPEC with hemodynamic instability, anastomotic leak with sepsis, ventilator-dependent, ongoing transfusion, planned re-look laparotomy.
- Stepdown (Telemetry/PCU): Post-op telemetry for AF, epidural in place, NG decompression, drain output significant, transitioning vasoactives off.
- Med-Surg: Bowel function returning (flatus/BM), tolerating clears → diet, drains low output, ambulating, transitioning to oral analgesia per ERAS pathway.
- Observation: Uncomplicated laparoscopic appendectomy/cholecystectomy with rapid recovery may discharge within 1–2 midnights; falls under CMS 2-Midnight Rule.
- Post-Acute (SNF/IRF/LTAC): Major resection patients commonly require SNF for nutrition (TPN/enteral) management when home unsafe; LTAC for vent weaning or chronic wound.
- Home (with/without HHA): Tolerating diet, ambulating, drains managed, pain controlled on oral, follow-up surgery in 1–2 weeks; HHA for drain, wound, or TPN/enteral support.

LOC Grid Sources: ACS NSQIP benchmarks; ASCRS 2017 ERAS Colorectal Pathway; AHPBA HPB Guidelines; SAGES.

### 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.

- Anastomotic leak requiring imaging, drainage, or revision
- Postoperative ileus >5 days requiring NG decompression and TPN
- Surgical site infection or wound dehiscence
- Pancreatic fistula (post-Whipple/distal pancreatectomy) per ISGPF grade B/C
- Bile leak requiring drainage or ERCP
- Post-op hemorrhage requiring transfusion or re-operation

Extended Stay Sources: Sources: ACS NSQIP; ASCRS Practice Parameters; AHPBA Consensus.

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## AAA REPAIR (ABDOMINAL AORTIC ANEURYSM — OPEN AND EVAR)

ICD-10-CM: ICD-10-CM: I71.3 (AAA ruptured), I71.4 (AAA without rupture), I71.00 (dissection of unspecified site of aorta), I71.01 (dissection of thoracic aorta), I71.02 (dissection of abdominal aorta), I71.03 (dissection of thoracoabdominal aorta), Z95.828 (presence of other vascular implants — aortic graft) | ICD-10-PCS: 04R00xx (replacement of abdominal aorta — open repair with graft), 04V00xx (restriction of abdominal aorta — EVAR), 04U0xxx (supplement abdominal aorta) | CPT: 34701-34706 (EVAR infrarenal), 34707-34708 (EVAR with iliac extension), 35081 (open AAA repair with tube graft), 35082 (open AAA repair with bifurcated graft)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics

- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society).

Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 237 (Major Cardiovascular Procedures w MCC, RW ~7.70), DRG 238 (w/o MCC, RW ~4.50) — open repair. DRG 270-272 (Other Major Cardiovascular Procedures, RW 3.82/2.38/1.69) — EVAR

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-8 days open; 1-3 days EVAR Source: SVS 2018 AAA Guidelines; CMS MS-DRG 237-238

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

- ICU: Post-open aortic repair (≥24h standard), hemodynamic instability, ongoing transfusion, paralysis (spinal drain in place), ischemic bowel concerns, ventilator support, vasopressor requirement.
- Stepdown (Telemetry/PCU): Extubated post-open repair, spinal drain in place, telemetry for arrhythmia surveillance, antihypertensive titration, distal pulse checks q2–4h.
- Med-Surg: Distal perfusion confirmed, tolerating diet, ambulating, pain controlled on oral, anticoagulation/antiplatelet plan in place.
- Observation: Uncomplicated EVAR with stable groin sites, ambulatory pre-op baseline; carotid endarterectomy with stable neuro exam may discharge POD 1.
- Post-Acute (SNF/IRF/LTAC): Major amputation patients commonly require IRF for prosthetic training; LTAC for vent-dependent.
- Home (with/without HHA): Ambulating, distal perfusion confirmed, wound dry, follow-up vascular surgery in 1–2 weeks; HHA for wound care, drain management, or IV antibiotics when indicated.

LOC Grid Sources: SVS PAD Guidelines 2024; SVS AAA Guidelines 2018; 2022 ACC/AHA Aortic Disease Guideline; CMS MS-DRG 237–238.

### 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 limb ischemia despite revascularization requiring further intervention
- Compartment syndrome requiring fasciotomy with ongoing wound care
- Rhabdomyolysis with AKI requiring CRRT or dialysis access
- Spinal cord ischemia with paralysis requiring lumbar drain and inpatient rehab placement work-up
- Graft infection or anastomotic dehiscence
- Stroke or TIA in post-CEA period
- Failure of distal perfusion to recover requiring amputation discussion

Extended Stay Sources: Sources: SVS PAD Guidelines 2024; SVS AAA Guidelines 2018.

## BARIATRIC SURGERY (GASTRIC BYPASS, SLEEVE GASTRECTOMY)

ICD-10-CM: ICD-10-CM: E66.01 (morbid obesity due to excess calories), E66.2 (morbid obesity with alveolar hypoventilation), E66.09 (other obesity due to excess calories), Z68.35-Z68.45 (BMI 35-45+), K91.850 (pouchitis — if revision) | ICD-10-PCS: 0D160ZA (bypass stomach to jejunum — Roux-en-Y), 0DB60Z3 (excision of stomach longitudinal — sleeve gastrectomy), 0DV64CZ (restriction of stomach with extraluminal device — adjustable band) | CPT: 43644 (laparoscopic Roux-en-Y gastric bypass), 43645 (open Roux-en-Y), 43775 (laparoscopic sleeve gastrectomy), 43770 (laparoscopic adjustable gastric band), 43848 (revision of gastric restrictive procedure)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 619 (OR Procedures for Obesity w MCC, RW ~3.25), DRG 620 (w CC, RW ~2.02), DRG 621 (w/o CC/MCC, RW ~1.58)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days sleeve; 2-3 days RYGB Source: ASMBS Bariatric Surgery Standards 2023; CMS MS-DRG 619-621

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

- ICU: Post-Whipple/esophagectomy/HIPEC with hemodynamic instability, anastomotic leak with sepsis, ventilator-dependent, ongoing transfusion, planned re-look laparotomy.
- Stepdown (Telemetry/PCU): Post-op telemetry for AF, epidural in place, NG decompression, drain output significant, transitioning vasoactives off.
- Med-Surg: Bowel function returning (flatus/BM), tolerating clears → diet, drains low output, ambulating, transitioning to oral

analgesia per ERAS pathway.

- Observation: Uncomplicated laparoscopic appendectomy/cholecystectomy with rapid recovery may discharge within 1–2 midnights; falls under CMS 2-Midnight Rule.
- Post-Acute (SNF/IRF/LTAC): Major resection patients commonly require SNF for nutrition (TPN/enteral) management when home unsafe; LTAC for vent weaning or chronic wound.
- Home (with/without HHA): Tolerating diet, ambulating, drains managed, pain controlled on oral, follow-up surgery in 1–2 weeks; HHA for drain, wound, or TPN/enteral support.

LOC Grid Sources: ACS NSQIP benchmarks; ASCRS 2017 ERAS Colorectal Pathway; AHPBA HPB Guidelines; SAGES.

### 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.

- Anastomotic leak requiring imaging, drainage, or revision
- Postoperative ileus >5 days requiring NG decompression and TPN
- Surgical site infection or wound dehiscence
- Pancreatic fistula (post-Whipple/distal pancreatectomy) per ISGPF grade B/C
- Bile leak requiring drainage or ERCP
- Post-op hemorrhage requiring transfusion or re-operation

Extended Stay Sources: Sources: ACS NSQIP; ASCRS Practice Parameters; AHPBA Consensus.

## MASTECTOMY WITH RECONSTRUCTION

ICD-10-CM: ICD-10-CM: C50.011-C50.019 (malignant neoplasm of nipple right/left/unspecified breast), C50.111-C50.119 (central portion), C50.211-C50.219 (upper-inner quadrant), C50.311-C50.319 (lower-inner quadrant), C50.411-C50.419 (upper-outer quadrant), C50.511-C50.519 (lower-outer quadrant), C50.611-C50.619 (axillary tail), C50.811-C50.819 (overlapping sites), C50.911-C50.919 (unspecified site) — each with right (1), left (2), unspecified (9) laterality (malignant neoplasm of breast — by site and laterality), D05.00-D05.92 (carcinoma in situ of breast), Z40.01 (encounter for prophylactic removal of breast), Z85.3 (personal history of malignant neoplasm of breast), Z42.1 (encounter for breast reconstruction following mastectomy) | ICD-10-PCS: 0HTV0ZZ (resection of bilateral breast), 0HTU0ZZ (resection of right breast), 0HTT0ZZ (resection of left breast), 0HRVx7x (replacement of breast with autologous tissue), 0JR60xx-0JR80xx (replacement of subcutaneous tissue chest with synthetic substitute — implant) | CPT: 19303 (simple complete mastectomy), 19305 (radical mastectomy), 19307 (modified radical mastectomy), 19340 (immediate insertion of breast prosthesis), 19357 (breast reconstruction with tissue flap), 19361 (breast reconstruction with TRAM flap), 19364 (breast reconstruction with free flap)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 582 (Mastectomy for Malignancy w CC/MCC, RW ~1.75), DRG 583 (w/o CC/MCC, RW ~1.19), DRG 584-585 (Breast Biopsy/Local Excision — if not full mastectomy)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-4 days Source: ASBrS/NCCN Breast Cancer Guidelines v2.2024

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

- ICU: Free flap immediate post-op (≥24–48h flap monitoring), tracheostomy with new airway, post-laryngectomy, mediastinal/airway concerns, hemorrhage, ventilator support.
- Stepdown (Telemetry/PCU): Free flap monitoring q1h with Doppler, JP/Penrose drains, tube feeds initiating, tracheostomy care education.
- Med-Surg: Flap stable, drains low output, tracheostomy stable, tolerating tube feeds or PO, transitioning analgesia.
- Observation: Uncomplicated thyroidectomy may discharge same day per AAES; parotidectomy 1–2 midnights.
- Post-Acute (SNF/IRF/LTAC): Tracheostomy/laryngectomy patients commonly need SNF for trach care and SLP; LTAC for vent weaning.
- Home (with/without HHA): Drains low output or removed, tube feeds tolerated, tracheostomy managed, follow-up H&N in 1 week; HHA for tube feeds, wound, and SLP.

LOC Grid Sources: AHNS Practice Guidelines; ASRM Microsurgery; AAO-HNS Tracheostomy Consensus; NCCN Head & Neck v3.2024.

### 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.

- Free flap compromise requiring re-exploration or revision
- Tracheostomy site bleeding or infection
- Inability to swallow or manage secretions delaying decannulation
- Wound dehiscence or fistula formation (orocutaneous, pharyngocutaneous)
- Failure of caregiver to demonstrate tracheostomy and/or tube feed competency

Extended Stay Sources: Sources: AHNS Practice Guidelines; ASRM Microsurgery Consensus.

## HYSTERECTOMY — COMPLEX / ONCOLOGIC

ICD-10-CM: ICD-10-CM: C53.0-C53.9 (malignant neoplasm of cervix), C54.0-C54.9 (malignant neoplasm of uterine body), C55 (malignant neoplasm of uterus unspecified), C56.1-C56.9 (malignant neoplasm of ovary), C57.0-C57.4 (malignant neoplasm of

fallopian tube/broad ligament/parametrium), D25.0-D25.9 (leiomyoma of uterus), D26.0-D26.9 (other benign neoplasm of uterus), N80.0 (endometriosis of uterus — adenomyosis), N85.x (other noninflammatory disorders of uterus) | ICD-10-PCS: 0UT90ZZ (resection of uterus, open), 0UT94ZZ (resection of uterus, percutaneous endoscopic), 0UT9FZZ (resection of uterus, via natural opening), 0UTC0ZZ (resection of cervix), 0UT20ZZ (resection of ovaries bilateral) | CPT: 58150 (total abdominal hysterectomy), 58152 (with lymph node biopsy), 58200 (radical hysterectomy), 58210 (radical hysterectomy with pelvic/para-aortic lymphadenectomy), 58541-58544 (laparoscopic supracervical/total hysterectomy), 58548 (laparoscopic radical hysterectomy), 58571-58573 (laparoscopic TLH with/without tubes/ovaries)

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

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

- Surgical indication confirmed by appropriate specialist based on clinical, laboratory, and imaging evaluation
- Condition severity requires surgical intervention (not manageable with conservative/medical treatment alone)
- Patient risk factors and comorbidities assessed and optimized for surgery (pre-operative clearance completed)
- Expected post-operative recovery requires inpatient stay ≥2 midnights (not ASC-eligible)

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

- Surgical procedure performed (or scheduled for next available OR) requiring post-operative inpatient recovery
- Post-operative monitoring: vital signs q4h minimum, wound assessment, drain/tube management, pain management
- Post-operative services: IV antibiotics, VTE prophylaxis, PT/OT mobilization, dietary advancement
- ICU/step-down level monitoring if: major cardiac/thoracic/vascular surgery, hemodynamic instability, ventilator required post-op
- Procedure is on CMS Inpatient-Only List or institutional equivalent requiring inpatient stay

### B. OBSERVATION vs INPATIENT DECISION MATRIX

ALWAYS INPATIENT for this procedure — Not appropriate for ambulatory surgery center or observation status

DOES NOT MEET CRITERIA:

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone (biopsy, endoscopy) not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons (admit day of surgery unless medical optimization required)
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting SNF/IRF bed when medically ready (activate case management)
- Post-operative stay for uncomplicated procedure extending beyond expected LOS without documented medical justification

### C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. POST-OP DAY 1: Pain controlled? Tolerating diet (or clear plan)? Ambulatory? Wound stable? No complications? POST-OP DAY 2+: Daily progress toward discharge milestones. Document barriers and plan for each.

CONTINUED STAY JUSTIFIED IF: Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities

NOT JUSTIFIED: Awaiting elective testing, social/placement delays when medically ready, extending stay beyond expected LOS without clinical reason

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

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (unless NPO with nutrition plan)
- Wound clean, dry, intact — no signs of infection
- Drains removed or output minimal with clear plan
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled
- Discharge education: wound care, activity restrictions, medication changes, return-to-ED criteria

### E. EVIDENCE SOURCES

Procedure-specific surgical society guidelines (ACS, STS, AAOS, ACS NSQIP, ERAS Society). Enhanced Recovery After Surgery (ERAS) protocols where applicable. CMS Inpatient Only (IPO) List — FY2024.

### F. MS-DRG CROSSWALK & REVENUE CODES

DRG 740 (Uterine/Adnexa Procedures for Malignancy w MCC, RW ~3.13), DRG 741 (w CC, RW ~1.95), DRG 742 (w/o CC/MCC, RW

~1.32), DRG 743-745 (Uterine/Adnexa Procedures for Non-Malignancy, RW 1.77/1.17/0.85)

### G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-4 days open; 1-2 days minimally invasive Source: ACOG/SGO Gynecologic Oncology Guidelines

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

- ICU: Pelvic exenteration with hemodynamic instability, HIPEC immediate post-op (24h standard), massive blood loss requiring transfusion, ventilator support.
- Stepdown (Telemetry/PCU): Post-extensive debulking with drain monitoring, epidural in place, transfusion ongoing, NG tube.
- Med-Surg: Drains low output, tolerating diet, ambulating, transitioning epidural to oral, ostomy/diversion teaching.
- Observation: Laparoscopic hysterectomy/myomectomy with rapid recovery may discharge within 1–2 midnights.
- Post-Acute (SNF/IRF/LTAC): Pelvic exenteration patients commonly need SNF for ostomy care and rehab; rarely LTAC.
- Home (with/without HHA): Ambulating, tolerating diet, drains managed, ostomy independent or with HHA, follow-up gyn-onc in 1–2 weeks.

LOC Grid Sources: SGO/NCCN Gynecologic Oncology Guidelines; ACOG/AUGS Pelvic Organ Prolapse; ASPSM HIPEC Consensus.

### 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.

- Anastomotic or ureteral leak requiring imaging and intervention
- Postoperative ileus with TPN requirement
- Pelvic abscess requiring drainage
- Surgical site infection or wound dehiscence
- Fistula formation requiring further intervention

Extended Stay Sources: Sources: SGO/NCCN Gynecologic Oncology; ACOG Practice Bulletins.