

Section F — Organ Transplant & Supplemental

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

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

Conditions / procedures in this section: 114

Scope: Organ transplant plus supplemental surgical and medical procedures across multiple specialties.

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

HEART TRANSPLANT

ICD-10-CM / ICD-10-PCS / CPT: Z94.1 (heart transplant status), T86.20 (unspecified complication of heart transplant), T86.21 (heart transplant failure), T86.22 (heart transplant infection), T86.23 (heart transplant rejection), T86.290 (cardiac allograft vasculopathy), T86.298 (other complications of heart transplant) ICD-10-PCS: 02YA0Zx (transplantation of heart, open) CPT: 33945 (heart transplant with or without recipient cardiectomy)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL of the following:

- End-stage heart failure (NYHA Class III-IV) refractory to optimal medical therapy
- Listed on UNOS transplant waiting list with documented evaluation by transplant cardiology
- Cardiac index <2.0 L/min/m² despite inotropic support, OR LVEF <20%, OR peak VO₂ <12 mL/kg/min, OR recurrent life-threatening

arrhythmias

- No absolute contraindications (active malignancy, irreversible pulmonary hypertension PVR >5 Wood units fixed, active substance

abuse, BMI >35)

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

- Orthotopic heart transplant surgery with cardiopulmonary bypass
- Post-operative ICU/CVICU monitoring (hemodynamics, immunosuppression initiation)
- Induction immunosuppression (basiliximab or ATG) + maintenance (tacrolimus, mycophenolate, prednisone)
- Endomyocardial biopsy (surveillance for rejection)
- Infection prophylaxis (CMV, PCP, fungal)

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Patient not listed on UNOS transplant waiting list
- Absolute contraindication present (active malignancy <5yr, active infection untreated, irreversible PH, active substance abuse, severe

irreversible end-organ damage other than cardiac)

- Non-compliance with transplant evaluation/workup
- Post-transplant: stable on oral immunosuppression with no rejection, infection resolved, functionally independent → discharge

C. CONTINUED STAY / CONCURRENT REVIEW

REVIEW: Daily by transplant team. Expected LOS: 10-21 days. Continued stay justified if: active rejection, graft dysfunction, infection, surgical complication, unable to tolerate oral immunosuppression, hemodynamic instability.

D. DISCHARGE CRITERIA

- Graft functioning (organ-specific markers improving)
- Vital signs stable, afebrile ≥24h
- Tolerating oral immunosuppression at therapeutic levels
- No active untreated rejection or infection
- Surgical wound stable, drains removed or output minimal
- Ambulatory at expected post-surgical level

- Transplant follow-up 2x/week for first month, then per protocol
- Patient/caregiver educated on immunosuppression, infection prevention, rejection signs

E. EVIDENCE SOURCES

ISHLT Guidelines for Heart Transplant. JACC. 2022. | UNOS Policy 6: Allocation of Hearts. | ACC/AHA HF Guidelines 2022.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 001 (Heart Transplant or Implant of Heart Assist System w MCC, RW ~25.40), DRG 002 (w/o MCC, RW ~14.78) Rev 0200 (ICU/CVICU), 0360 (OR), 0250 (Pharmacy — immunosuppressants), 0300 (Lab — drug levels, biopsy), 0390 (Blood Products)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 14-21 days; longer with complications Source: OPTN/UNOS Policy 6; ISHLT Standards

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

- ICU: Immediate post-op (≥24–48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4–6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1–2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1–2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6–14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

LUNG TRANSPLANT / HEART-LUNG TRANSPLANT

ICD-10-CM / ICD-10-PCS / CPT: Z94.2 (lung transplant status), T86.810 (lung transplant rejection), T86.811 (lung transplant failure), T86.812 (lung transplant infection), T86.818 (other complications of lung transplant), T86.819 (unspecified complication) ICD-10-PCS: 0BYC0Zx (transplantation of bilateral lungs), 0BYD0Zx (right lung), 0BYF0Zx (left lung) CPT: 32851 (lung transplant single), 32852 (bilateral), 32853 (with cardiopulmonary bypass), 33935 (heart-lung transplant)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL of the following:

- End-stage lung disease (IPF, COPD, CF, PAH, bronchiectasis) refractory to medical therapy with ≤2-year predicted survival without

transplant

- FVC <50% predicted OR DLCO <40% OR O2 dependent at rest OR 6MWD <250m declining
- Listed on UNOS/LAS (Lung Allocation Score) waiting list

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

- Lung transplant surgery (single, bilateral, or heart-lung) with CPB
- Post-op ICU/ventilator management, chest tube management (multiple)
- Immunosuppression induction + maintenance
- Bronchoscopy with transbronchial biopsy (rejection surveillance)
- Intensive pulmonary rehab, infection prophylaxis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Not listed on transplant waiting list
- Active malignancy (except non-melanoma skin cancer)
- Active substance abuse within 6 months
- BMI >35 or <17 (relative contraindication)
- Severe deconditioning without rehabilitation potential
- Stable post-transplant on oral immunosuppression, no rejection, independent → discharge

C. CONTINUED STAY / CONCURRENT REVIEW

REVIEW: Daily by transplant team. Expected LOS: 14-28 days. Continued stay justified if: active rejection, graft dysfunction, infection, surgical complication, unable to tolerate oral immunosuppression, hemodynamic instability.

D. DISCHARGE CRITERIA

- Graft functioning (organ-specific markers improving)
- Vital signs stable, afebrile ≥24h
- Tolerating oral immunosuppression at therapeutic levels
- No active untreated rejection or infection
- Surgical wound stable, drains removed or output minimal
- Ambulatory at expected post-surgical level
- Transplant follow-up 2x/week for first month, then per protocol
- Patient/caregiver educated on immunosuppression, infection prevention, rejection signs

E. EVIDENCE SOURCES

ISHLT Consensus: Selection of Lung Transplant Candidates. JHLT. 2021. | UNOS Policy 10: Allocation of Lungs.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 007 (Lung Transplant, RW ~11.40) CPT 32851-32853, 33935 Rev 0200, 0360, 0410 (Respiratory), 0250, 0300

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 14-21 days; up to 30+ days Source: OPTN/UNOS Policy 10; ISHLT Standards

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

- ICU: Immediate post-op (≥24–48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4–6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1–2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1–2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6–14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

LIVER TRANSPLANT

ICD-10-CM / ICD-10-PCS / CPT: Z94.4 (liver transplant status), T86.40 (unspecified complication of liver transplant), T86.41 (liver transplant rejection), T86.42 (liver transplant failure), T86.43 (liver transplant infection), T86.49 (other complications), K76.7 (hepatorenal syndrome) ICD-10-PCS: 0FY00Zx (transplantation of liver, open) CPT: 47135 (liver transplant orthotopic, whole), 47136 (liver transplant orthotopic, partial/split)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL of the following:

- End-stage liver disease or acute liver failure meeting UNOS listing criteria
- MELD/PELD score documented (MELD \geq 15 for transplant benefit, or MELD exception for HCC/other)
- Evaluated and listed by transplant hepatology/surgery program
- For HCC: within Milan criteria (single lesion \leq 5cm or \leq 3 lesions each \leq 3cm, no extrahepatic spread, no vascular invasion) OR

approved downstaging protocol

INTENSITY OF SERVICE (IS) — Must meet \geq 1:

- Orthotopic liver transplant surgery
- Post-op ICU monitoring (hemodynamics, graft function, coagulopathy management)
- Immunosuppression induction + maintenance
- Bile duct/vascular anastomosis surveillance (Doppler US, labs)
- Post-transplant LFT monitoring (daily), drug levels (tacrolimus trough)

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Not listed on UNOS transplant waiting list
- Active alcohol/substance use without documented sustained sobriety (typically 6 months minimum per most programs)
- Active extrahepatic malignancy
- Uncontrolled sepsis
- Stable post-transplant on oral immunosuppression, LFTs trending normal, tolerating diet → discharge

C. CONTINUED STAY / CONCURRENT REVIEW

REVIEW: Daily by transplant team. Expected LOS: 10-21 days. Continued stay justified if: active rejection, graft dysfunction, infection, surgical complication, unable to tolerate oral immunosuppression, hemodynamic instability.

D. DISCHARGE CRITERIA

- Graft functioning (organ-specific markers improving)
- Vital signs stable, afebrile \geq 24h
- Tolerating oral immunosuppression at therapeutic levels
- No active untreated rejection or infection
- Surgical wound stable, drains removed or output minimal
- Ambulatory at expected post-surgical level
- Transplant follow-up 2x/week for first month, then per protocol
- Patient/caregiver educated on immunosuppression, infection prevention, rejection signs

E. EVIDENCE SOURCES

AASLD/AST Guidelines for Liver Transplant. Hepatology. 2023. | UNOS Policy 9: Allocation of Livers.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 005 (Liver Transplant w MCC or Intestinal Transplant, RW ~11.39), DRG 006 (Liver Transplant w/o MCC, RW ~5.80) CPT 47135-47136 Rev 0200 (ICU), 0360 (OR), 0250 (Pharmacy), 0300 (Lab), 0390 (Blood Products), 0402 (US — Doppler)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: OPTN/UNOS Policy 9; AASLD

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

- ICU: Immediate post-op (\geq 24–48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4–6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1–2 discharge per AST/OPTN.

- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1-2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6-14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

KIDNEY TRANSPLANT (DECEASED AND LIVING DONOR)

ICD-10-CM / ICD-10-PCS / CPT: Z94.0 (kidney transplant status), T86.10 (unspecified complication of kidney transplant), T86.11 (kidney transplant rejection), T86.12 (kidney transplant failure), T86.13 (kidney transplant infection), T86.19 (other complication), N18.6 (end-stage renal disease), Z99.2 (dependence on renal dialysis) ICD-10-PCS: 0TY00Zx (transplantation of right kidney), 0TY10Zx (left kidney) CPT: 50360 (renal transplant allotransplantation), 50365 (with recipient nephrectomy), 50380 (renal transplant reimplantation)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL of the following:

- ESRD (GFR <20 mL/min or on dialysis) OR pre-emptive transplant with GFR <20 declining
- Evaluated and listed on UNOS kidney transplant waiting list (deceased donor) OR living donor identified and cleared
- Immunologic workup complete: HLA typing, PRA/crossmatch, donor-specific antibodies (DSA)
- Medical/surgical clearance for transplant surgery

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

- Kidney transplant surgery (open, with vascular and ureteral anastomosis)
- Post-op monitoring: renal Doppler US within 24h, urine output monitoring, Cr trend
- Immunosuppression induction (basiliximab or ATG) + maintenance (tacrolimus, mycophenolate, prednisone)
- Infection prophylaxis (CMV, PCP, BK virus monitoring)

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Not listed or without living donor clearance
- Active uncontrolled infection
- Active malignancy (except non-melanoma skin cancer in remission >2-5 yrs)
- Severe cardiac disease that would not survive transplant surgery (cardiac clearance must be obtained)
- Stable post-transplant with declining Cr, adequate UOP, tolerating oral meds → discharge (typically POD 3-7)

C. CONTINUED STAY / CONCURRENT REVIEW

REVIEW: Daily by transplant team. Expected LOS: 3-7 days (living donor), 5-10 days (deceased donor). Continued stay justified if: active rejection, graft dysfunction, infection, surgical complication, unable to tolerate oral immunosuppression, hemodynamic instability.

D. DISCHARGE CRITERIA

- Graft functioning (organ-specific markers improving)
- Vital signs stable, afebrile ≥ 24 h
- Tolerating oral immunosuppression at therapeutic levels
- No active untreated rejection or infection
- Surgical wound stable, drains removed or output minimal
- Ambulatory at expected post-surgical level
- Transplant follow-up 2x/week for first month, then per protocol
- Patient/caregiver educated on immunosuppression, infection prevention, rejection signs

E. EVIDENCE SOURCES

KDIGO Guidelines: Kidney Transplant Recipients. 2009, updated 2024. | UNOS Policy 8: Allocation of Kidneys.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 652 (Kidney Transplant, RW ~3.42) CPT 50360-50380 Rev 0360 (OR), 0250, 0300 (Lab — Cr, tacrolimus levels, CMV PCR), 0402 (Renal US Doppler), 0800 (Dialysis if needed post-op)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days living; 5-7 days deceased Source: OPTN/UNOS Policy 8; AST

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

- ICU: Immediate post-op (≥24–48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4–6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1–2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1–2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6–14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

PANCREAS TRANSPLANT / SIMULTANEOUS PANCREAS-KIDNEY (SPK)

ICD-10-CM / ICD-10-PCS / CPT: Z94.83 (pancreas transplant status), T86.890 (unspecified complication of pancreas transplant), T86.891 (pancreas transplant failure), T86.892 (pancreas transplant infection), T86.898 (other complications), E10.65 (type 1 diabetes with hyperglycemia), E10.69 (type 1 DM with other complication), Z94.0 (kidney transplant status — if SPK) ICD-10-PCS: 0FYG0Zx (transplantation of pancreas) CPT: 48554 (pancreas transplant), 48556 (with pancreatectomy)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL of the following:

- Type 1 diabetes with hypoglycemia unawareness or metabolic instability despite optimized insulin therapy
- For SPK: concurrent ESRD meeting kidney transplant criteria
- Listed on UNOS waiting list with completed transplant evaluation
- No absolute contraindications

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

- Pancreas transplant (or SPK) surgery with vascular anastomosis
- Post-op: glucose monitoring (insulin drip → transition off as graft functions), Doppler US for graft perfusion, amylase/lipase trending
- Immunosuppression induction + maintenance

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Type 2 diabetes (pancreas transplant is for Type 1 DM)
- Not listed on UNOS
- Active cardiac disease precluding major surgery

- Severe peripheral vascular disease precluding graft placement
- Post-transplant: glucose stable off insulin, Cr stable (if SPK), tolerating oral → discharge

C. CONTINUED STAY / CONCURRENT REVIEW

REVIEW: Daily by transplant team. Expected LOS: 7-14 days (SPK), 5-10 days (pancreas alone). Continued stay justified if: active rejection, graft dysfunction, infection, surgical complication, unable to tolerate oral immunosuppression, hemodynamic instability.

D. DISCHARGE CRITERIA

- Graft functioning (organ-specific markers improving)
- Vital signs stable, afebrile ≥ 24 h
- Tolerating oral immunosuppression at therapeutic levels
- No active untreated rejection or infection
- Surgical wound stable, drains removed or output minimal
- Ambulatory at expected post-surgical level
- Transplant follow-up 2x/week for first month, then per protocol
- Patient/caregiver educated on immunosuppression, infection prevention, rejection signs

E. EVIDENCE SOURCES

ADA Standards of Care: Pancreas Transplantation. 2024. | UNOS Policy 11: Allocation of Pancreata.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 008 (Simultaneous Pancreas/Kidney Transplant, RW ~5.40), DRG 010 (Pancreas Transplant, RW ~4.89) CPT 48554-48556 Rev 0200, 0360, 0250, 0300

CARDIAC SURGERY

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: OPTN/UNOS Policy 11

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

- ICU: Immediate post-op (≥ 24 -48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4-6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1-2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1-2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6-14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

LVAD / VENTRICULAR ASSIST DEVICE IMPLANTATION

ICD-10-CM / ICD-10-PCS / CPT: I50.1 (left ventricular failure), I50.9 (heart failure unspecified), Z95.811 (presence of heart assist device), T82.511A (breakdown of surgically created AV fistula), T82.591A (mechanical complication of other cardiac device) ICD-10-PCS: 02HA0QZ (insertion of implantable heart assist system into heart, open) CPT: 33975 (insertion of ventricular assist device, extracorporeal), 33979 (insertion of ventricular assist device, implantable intracorporeal), 33990-33993 (insertion/removal of

percutaneous VAD)

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

SEVERITY OF ILLNESS (SI) — ALL:

- end-stage HF (NYHA III-IV) refractory to medical therapy
- INTERMACS profile 1-4
- bridge-to-transplant or destination therapy
- listed for heart transplant OR not transplant candidate

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 001-002 (Heart Transplant/Heart Assist, RW ~25.40/14.78) CPT 33975-33993 Rev 0200, 0360, 0270 (device ~\$80K-175K), 0250

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 10-21 days; longer if biventricular or complications Source: INTERMACS; ISHLT MCS Guidelines 2023

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

- ICU: VA-ECMO active, post-implant LVAD with hemodynamic instability, biventricular failure, refractory ventricular arrhythmia post-ICD generator change, sepsis with device.
- Stepdown (Telemetry/PCU): Post-LVAD implant routine course, continuous telemetry, vasoactive wean, anticoagulation initiation, driveline care education, biventricular CRT-D programming.
- Med-Surg: Stable LVAD \geq POD 5, ambulating with companion, INR therapeutic range, driveline site dry, completing rehab assessment.
- Observation: Uncomplicated single-chamber pacemaker/single-lead ICD generator change discharged same day or within 23 hours per HRS consensus.
- Post-Acute (SNF/IRF/LTAC): LVAD patients commonly require IRF for cardiac/strength rehab; LTAC if chronic vent or device complications.
- Home (with/without HHA): LVAD self-care competency demonstrated (patient + caregiver), local VAD team coverage, equipment delivered, INR/coag clinic established.

LOC Grid Sources: INTERMACS Registry; 2023 ISHLT Mechanical Circulatory Support Guidelines; HRS/EHRA Implant Guidelines; ELSO Guidelines 2023.

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.

- Driveline or pocket infection
- Post-implant arrhythmia storm requiring IV titration or ablation
- Right-heart failure post-LVAD requiring inotropes
- Pump thrombosis or device malfunction
- INR not therapeutic with bridging required
- Failure of patient/caregiver to demonstrate competency in device self-care

Extended Stay Sources: Sources: INTERMACS; ISHLT MCS Guidelines 2023; HRS device implant consensus.

PACEMAKER / ICD IMPLANTATION (COMPLEX)

ICD-10-CM / ICD-10-PCS / CPT: Z95.0 (presence of cardiac pacemaker), Z95.810 (presence of automatic implantable cardiac defibrillator), T82.110A-T82.199A (mechanical complications of cardiac electronic device) ICD-10-PCS: 0JH60xx (insertion of cardiac rhythm related device into chest subcutaneous tissue) CPT: 33206-33208 (insertion of pacemaker), 33249 (insertion of ICD), 33230-33231 (insertion of CRT-D/CRT-P)

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

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

- symptomatic bradycardia
- complete heart block
- VT/VF with ICD indication
- CRT indication (LVEF $\leq 35\%$ + LBBB + QRS ≥ 150 ms)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 222 (Cardiac Defib Implant w MCC, RW ~5.83), DRG 223 (w CC, RW ~4.19), DRG 224 (w/o CC/MCC, RW ~3.44), DRG 225-227 (Cardiac Pacemaker Implant, RW ~3.58/2.46/1.82) CPT 33206-33249

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days standard; 2-3 days complex/CRT-D Source: HRS/EHRA Implant Guidelines; CMS MS-DRG 242-244

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

- ICU: VA-ECMO active, post-implant LVAD with hemodynamic instability, biventricular failure, refractory ventricular arrhythmia post-ICD generator change, sepsis with device.
- Stepdown (Telemetry/PCU): Post-LVAD implant routine course, continuous telemetry, vasoactive wean, anticoagulation initiation, driveline care education, biventricular CRT-D programming.
- Med-Surg: Stable LVAD \geq POD 5, ambulating with companion, INR therapeutic range, driveline site dry, completing rehab assessment.
- Observation: Uncomplicated single-chamber pacemaker/single-lead ICD generator change discharged same day or within 23 hours per HRS consensus.
- Post-Acute (SNF/IRF/LTAC): LVAD patients commonly require IRF for cardiac/strength rehab; LTAC if chronic vent or device complications.
- Home (with/without HHA): LVAD self-care competency demonstrated (patient + caregiver), local VAD team coverage, equipment delivered, INR/coag clinic established.

LOC Grid Sources: INTERMACS Registry; 2023 ISHLT Mechanical Circulatory Support Guidelines; HRS/EHRA Implant Guidelines; ELSO Guidelines 2023.

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.

- Driveline or pocket infection
- Post-implant arrhythmia storm requiring IV titration or ablation
- Right-heart failure post-LVAD requiring inotropes
- Pump thrombosis or device malfunction
- INR not therapeutic with bridging required
- Failure of patient/caregiver to demonstrate competency in device self-care

Extended Stay Sources: Sources: INTERMACS; ISHLT MCS Guidelines 2023; HRS device implant consensus.

AORTIC ROOT REPLACEMENT (BENTALL PROCEDURE)

ICD-10-CM / ICD-10-PCS / CPT: I71.1 (thoracic aortic aneurysm ruptured), I71.2 (thoracic aortic aneurysm without rupture), I35.0- I35.2 (aortic valve disease), Q23.0 (congenital aortic stenosis), I77.810 (thoracic aortic ectasia) ICD-10-PCS: 02RFxxx (replacement of aortic valve), 02Rx (replacement of ascending aorta) CPT: 33863-33864 (ascending aortic graft with valve conduit — Bentall), 33860 (ascending aortic graft without valve)

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

SEVERITY OF ILLNESS (SI) — ALL:

- aortic root aneurysm \geq 5.5cm (or \geq 5.0cm with Marfan/Loeys-Dietz/bicuspid)
- concurrent aortic valve disease requiring replacement
- aortic dissection involving root

INTENSITY OF SERVICE (IS) — Must meet \geq 1:

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS \geq 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 216-219 (Cardiac Valve, RW 5.01-10.78) CPT 33860-33864 Rev 0200 (ICU/CVICU), 0360 (OR), 0270 (graft/valve ~\$30-50K)
GYNECOLOGIC SURGERY

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-8 days Source: STS Adult Cardiac Database; 2022 ACC/AHA Aortic Disease Guideline

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.

CESAREAN SECTION (SCHEDULED AND EMERGENT)

ICD-10-CM / ICD-10-PCS / CPT: O82 (encounter for cesarean delivery without indication), O34.21x (maternal care for cesarean scar from previous surgery), O36.x (maternal care for other fetal problems), O64.x (obstructed labor due to malposition), O65.x

(obstructed labor due to maternal pelvic abnormality), O68 (labor complicated by fetal stress) ICD-10-PCS: 10D00Z1 (extraction of products of conception, classical C-section), 10D00Z2 (low cervical C-section) CPT: 59510 (C-section including antepartum/postpartum), 59514 (C-section only), 59515 (C-section including postpartum), 59618-59622 (C-section after previous C-section)

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

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

- failed trial of labor
- fetal distress (Category III tracing)
- malpresentation (breech/transverse)
- placenta previa/accreta
- prior classical C-section
- failed induction
- cord prolapse
- maternal indication (active HSV)
- HIV with high viral load)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 765 (C-Section w CC/MCC, RW ~1.76), DRG 766 (C-Section w/o CC/MCC, RW ~1.20), DRG 774 (Vaginal Delivery w Complicating Diagnoses, RW ~0.92) CPT 59510-59622 Rev 0720 (L&D), 0360 (OR), 0250

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days uncomplicated; 3-4 days with complications Source: ACOG/AAP Guidelines for Perinatal Care 8th ed.; CMS MS-DRG 783-788

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

- ICU: Post-cesarean with massive hemorrhage, sepsis, amniotic fluid embolism, severe preeclampsia/eclampsia post-delivery with end-organ dysfunction.
- Stepdown (Telemetry/PCU): Magnesium infusion postpartum, transfusion-dependent hemorrhage, BP titration IV.

- Med-Surg: Routine post-cesarean course, ambulating, tolerating diet, foley out, breastfeeding initiation.
- Observation: Generally not applicable; cesarean is inpatient by Medicaid/commercial standards (LOS 2-3 days uncomplicated).
- Post-Acute: Rarely required.
- Home (with/without HHA): Ambulating, tolerating diet, lochia normal, pain controlled on PO, follow-up OB in 1-6 weeks per ACOG postpartum care; HHA for wound care if obese.

LOC Grid Sources: ACOG/AAP Guidelines for Perinatal Care 8th ed.; ACOG PB 199 (Cesarean Delivery on Maternal Request); CMS MS-DRG 783-788.

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.

- Postpartum hemorrhage requiring transfusion or surgical re-exploration
- Endometritis or wound infection requiring IV antibiotics
- DVT/PE postpartum requiring anticoagulation initiation
- Severe preeclampsia with extended magnesium course

Extended Stay Sources: Sources: ACOG/AAP Guidelines for Perinatal Care 8th ed.; ACOG PB 199 (Cesarean).

MYOMECTOMY (ABDOMINAL / COMPLEX LAPAROSCOPIC)

ICD-10-CM / ICD-10-PCS / CPT: D25.0 (submucous leiomyoma of uterus), D25.1 (intramural leiomyoma), D25.2 (subserosal leiomyoma), D25.9 (leiomyoma of uterus unspecified) ICD-10-PCS: 0UB90ZZ (excision of uterus, open), 0UB94ZZ (percutaneous endoscopic) CPT: 58140-58146 (abdominal myomectomy), 58545-58546 (laparoscopic myomectomy)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL:

- symptomatic uterine fibroids (menorrhagia with anemia
- pelvic pain/pressure
- urinary frequency
- infertility)
- failed or contraindicated medical management
- fertility preservation desired (otherwise hysterectomy considered)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 743 (Uterine/Adnexa Procedures for Non-Malignancy w MCC, RW ~1.77), DRG 744 (w CC, RW ~1.17), DRG 745 (w/o CC/MCC, RW ~0.85) CPT 58140-58546

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-3 days Source: ACOG Practice Bulletin 228 (Myomectomy); AAGL

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.

OOPHORECTOMY / SALPINGO-OOPHORECTOMY (ONCOLOGIC)

ICD-10-CM / ICD-10-PCS / CPT: C56.1 (malignant neoplasm of right ovary), C56.2 (left ovary), C56.9 (unspecified ovary), C57.00 (malignant neoplasm of unspecified fallopian tube), C57.01 (right), C57.02 (left), D27.0 (benign neoplasm of right ovary), D27.1 (left ovary), D27.9 (unspecified) ICD-10-PCS: 0UT20ZZ (resection of ovaries bilateral, open), 0UT10ZZ (right), 0UT00ZZ (left) CPT: 58940 (oophorectomy), 58943 (oophorectomy for malignancy with staging), 58950-58956 (bilateral salpingo-oophorectomy with staging/debulking)

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

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

- confirmed or suspected ovarian/tubal malignancy requiring surgical staging/debulking
- adnexal mass with high suspicion for malignancy (elevated CA-125)
- complex mass on imaging
- ascites)
- BRCA1/2 positive with risk-reducing surgery after counseling

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 740 (Uterine/Adnexa for Malignancy w MCC, RW ~3.13), DRG 741 (w CC, RW ~1.95), DRG 742 (w/o CC/MCC, RW ~1.32) CPT 58940-58956

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-3 days oncologic Source: SGO/NCCN Ovarian Cancer 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.

PELVIC EXENTERATION

ICD-10-CM / ICD-10-PCS / CPT: C53.0-C53.9 (cervical cancer), C54.0-C54.9 (uterine cancer), C57.x (other female genital organ cancer), C67.x (bladder cancer invading pelvis) ICD-10-PCS: 0UTN0ZZ (resection of uterus/cervix/vagina/bladder/rectum — multiple codes for total exenteration) CPT: 45126 (pelvic exenteration), 51597 (pelvic exenteration with ureteral transplantation)

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

SEVERITY OF ILLNESS (SI) — ALL:

- locally advanced or recurrent pelvic malignancy requiring multi-organ resection
- centralized tumor without distant metastasis
- patient physically fit for major surgery

- multidisciplinary tumor board recommendation

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 734 (Pelvic Evisceration/Radical Hysterectomy w CC/MCC, RW ~3.97), DRG 735 (w/o CC/MCC, RW ~2.23) CPT 45126, 51597 UROLOGIC SURGERY

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 10-14 days Source: SGO Pelvic Exenteration Outcomes

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

RADICAL PROSTATECTOMY (OPEN / ROBOTIC-ASSISTED)

ICD-10-CM / ICD-10-PCS / CPT: C61 (malignant neoplasm of prostate) ICD-10-PCS: 0VT00ZZ (resection of prostate, open), 0VT04ZZ (percutaneous endoscopic — robotic) CPT: 55840 (radical prostatectomy perineal), 55842-55845 (radical prostatectomy retropubic), 55866 (laparoscopic radical prostatectomy — includes robotic)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL:

- biopsy-confirmed prostate adenocarcinoma (Gleason 6-10)
- clinically localized or locally advanced (cT1-T3)
- life expectancy ≥ 10 years
- surgical candidate per urologic evaluation

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission > 1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 665 (Prostatectomy w MCC, RW ~2.61), DRG 666 (w CC, RW ~1.53), DRG 667 (w/o CC/MCC, RW ~1.07) CPT 55840-55866 Rev 0360, 0710

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days robotic; 2-3 days open Source: AUA Localized Prostate Cancer Guideline 2022

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.

RADICAL CYSTECTOMY WITH URINARY DIVERSION

ICD-10-CM / ICD-10-PCS / CPT: C67.0 (malignant neoplasm of trigone of bladder), C67.1 (dome), C67.2 (lateral wall), C67.3 (anterior wall), C67.4 (posterior wall), C67.5 (bladder neck), C67.6 (ureteric orifice), C67.7 (urachus), C67.8 (overlapping sites), C67.9 (bladder unspecified) ICD-10-PCS: 0TTB0ZZ (resection of bladder, open) CPT: 51570-51580 (radical cystectomy), 50800-50820 (ureteroileal conduit/neobladder construction)

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

SEVERITY OF ILLNESS (SI) — ALL:

- muscle-invasive bladder cancer (T2+) or high-risk non-muscle-invasive refractory to BCG
- neoadjuvant chemotherapy completed (if indicated)
- no distant metastasis
- multidisciplinary recommendation

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 656 (Kidney & Ureter Procedures for Neoplasm w MCC, RW ~2.82), DRG 657 (w CC, RW ~1.80), DRG 658 (w/o CC/MCC, RW ~1.32) CPT 51570-51580, 50800-50820 Rev 0360, 0200 (ICU), 0270 (ostomy supplies)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days; 7-10 with complications Source: AUA Bladder Cancer Guideline 2024; ERAS Urology

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.

ORCHIECTOMY (RADICAL FOR TESTICULAR CANCER)

ICD-10-CM / ICD-10-PCS / CPT: C62.00 (malignant neoplasm of undescended testis unspecified), C62.01 (right), C62.02 (left), C62.10 (malignant neoplasm of descended testis unspecified), C62.11 (right), C62.12 (left), C62.90 (unspecified laterality), C62.91 (right), C62.92 (left) CPT: 54520 (orchiectomy simple), 54530 (orchiectomy radical for tumor — inguinal approach), 54535 (radical orchiectomy with abdominal exploration)

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

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

- testicular mass suspicious for malignancy on US with elevated tumor markers (AFP
- beta-hCG
- LDH)
- confirmed testicular cancer requiring radical inguinal orchiectomy

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 710 (Testes Procedures w CC/MCC, RW ~1.56), DRG 711 (w/o CC/MCC, RW ~0.92) CPT 54530-54535 Note: Radical orchiectomy often outpatient/23h obs; inpatient if RPLND or complex

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: AUA/NCCN Testicular Cancer Guidelines

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.

RPLND (RETROPERITONEAL LYMPH NODE DISSECTION)

ICD-10-CM / ICD-10-PCS / CPT: C62.xx (testicular cancer), C77.2 (secondary malignant neoplasm of intra-abdominal lymph nodes) CPT: 38780 (retroperitoneal lymph node dissection), 38780-26 (RPLND extensive)

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

SEVERITY OF ILLNESS (SI) — ALL:

- post-chemotherapy residual retroperitoneal mass > 1 cm in nonseminomatous germ cell tumor
- OR primary RPLND for clinical Stage I/IIA nonseminoma per NCCN guidelines

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 820-822 or DRG 957 (Other OR Procedures for Multiple Significant Trauma) CPT 38780

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days open; 2-3 days robotic Source: AUA/NCCN Testicular Cancer

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.

ADRENALECTOMY

ICD-10-CM / ICD-10-PCS / CPT: C74.00 (malignant neoplasm of cortex of unspecified adrenal gland), C74.01 (right), C74.02 (left), C74.10 (malignant neoplasm of medulla of adrenal gland), C74.90 (unspecified), D35.00 (benign neoplasm of unspecified adrenal)

gland), D35.01 (right), D35.02 (left), E27.0 (other adrenocortical overactivity — Cushing), E27.5 (adrenomedullary hyperfunction — pheochromocytoma) ICD-10-PCS: 0GT20ZZ (resection of adrenal glands bilateral, open), 0GT30ZZ (right), 0GT40ZZ (left) CPT: 60540 (adrenalectomy open), 60545 (with excision of adjacent retroperitoneal tumor), 60650 (laparoscopic adrenalectomy)

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

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

- adrenal mass >4cm or growing
- functional tumor (pheochromocytoma)
- aldosteronoma
- cortisol-producing adenoma)
- suspected adrenocortical carcinoma
- metastatic disease to adrenal requiring resection

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 628 (Other Endocrine/Nutritional Procedures w MCC, RW ~3.33), DRG 629 (w CC, RW ~1.92), DRG 630 (w/o CC/MCC, RW ~1.32) CPT 60540-60650

GI SURGERY

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days laparoscopic; 3-5 days open Source: AAES Adrenal Surgery Guidelines

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.

GASTRECTOMY (TOTAL / SUBTOTAL)

ICD-10-CM / ICD-10-PCS / CPT: C16.0 (malignant neoplasm of cardia), C16.1 (fundus), C16.2 (body), C16.3 (pyloric antrum), C16.4 (pylorus), C16.5 (lesser curvature), C16.6 (greater curvature), C16.8 (overlapping sites), C16.9 (stomach unspecified), K25.0-K25.6 (gastric ulcer with hemorrhage/perforation), K31.A0-K31.A19 (gastric intestinal metaplasia) ICD-10-PCS: 0DT60ZZ (resection of stomach), 0DB60ZZ (excision of stomach) CPT: 43620 (gastrectomy total), 43631-43634 (gastrectomy subtotal), 43644 (laparoscopic Roux-en-Y if reconstruction)

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

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

- gastric cancer requiring resection (per NCCN staging)
- gastric perforation not amenable to repair
- refractory gastric ulcer with hemorrhage failing endoscopic management
- GIST >2cm or high mitotic rate

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 326 (Stomach/Esophageal/Duodenal Procedures w MCC, RW ~5.84), DRG 327 (w CC, RW ~2.97), DRG 328 (w/o CC/MCC, RW ~1.77) CPT 43620-43644

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days total; 3-5 days subtotal Source: NCCN Gastric Cancer; AHPBA

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.

RECTAL RESECTION / LOW ANTERIOR RESECTION (LAR) WITH TME

ICD-10-CM / ICD-10-PCS / CPT: C20 (malignant neoplasm of rectum), C19 (malignant neoplasm of rectosigmoid junction), C21.0 (anus unspecified), C21.1 (anal canal), K62.5 (hemorrhage of anus and rectum) ICD-10-PCS: 0DTN0ZZ (resection of sigmoid colon), 0DTP0ZZ (resection of rectum) CPT: 44145 (coloproctostomy — LAR), 44146 (with colostomy), 44207 (laparoscopic LAR), 45110 (proctectomy), 45111-45113 (proctectomy partial), 45395 (laparoscopic proctectomy with low pelvic anastomosis)

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

SEVERITY OF ILLNESS (SI) — ALL:

- rectal cancer requiring total mesorectal excision (TME) per NCCN
- neoadjuvant chemoradiation completed (if T3/T4 or N+)
- surgical candidate

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 329-331 (Major Small & Large Bowel Procedures, RW 4.44/2.23/1.42) CPT 44145-44146, 44207, 45110-45395

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-7 days Source: ASCRS Rectal Cancer Guidelines 2022; NCCN

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 \rightarrow 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.

ABDOMINOPERINEAL RESECTION (APR)

ICD-10-CM / ICD-10-PCS / CPT: C20 (malignant neoplasm of rectum), C21.0 (anus unspecified), C21.1 (anal canal), C21.2 (cloacogenic zone), C21.8 (overlapping sites of anus/anal canal) ICD-10-PCS: 0DTP0ZZ (resection of rectum, open) + 0DTQ0ZZ (resection of anus) CPT: 45110 (proctectomy complete with permanent colostomy), 45395 (laparoscopic proctectomy APR)

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

SEVERITY OF ILLNESS (SI) — ALL:

- low rectal or anal cancer not amenable to sphincter-sparing surgery

- tumor involves anal sphincter complex
- post-chemoradiation residual disease requiring APR per multidisciplinary tumor board

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission > 1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 329-331 (Major Bowel Procedures) CPT 45110, 45395 Rev 0360, 0270 (ostomy supplies)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: ASCRS 2022

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 \rightarrow 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.

SPLENECTOMY

ICD-10-CM / ICD-10-PCS / CPT: D73.0 (hypersplenism), D73.1 (abscess of spleen), D73.3 (abscess of spleen), D73.5 (infarction of spleen), C96.4 (sarcoma of dendritic cells), D69.3 (ITP — if refractory), D58.0 (hereditary spherocytosis — if indicated), S36.020A (contusion of spleen), S36.030A (laceration of spleen), S36.032A (major laceration of spleen) ICD-10-PCS: 07TP0ZZ (resection of spleen, open), 07TP4ZZ (percutaneous endoscopic) CPT: 38100 (splenectomy total), 38101 (splenectomy total with repair of ruptured spleen), 38102 (splenectomy total en bloc), 38120 (laparoscopic splenectomy)

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

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

- traumatic splenic injury (Grade III-V requiring surgery per AAST)
- refractory ITP (failed steroids)
- IVIG
- TPO agonists)
- hypersplenism with transfusion-dependent cytopenias
- splenic abscess not amenable to drainage
- staging splenectomy for lymphoma (rare)
- hereditary spherocytosis with severe hemolysis

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 393 (Other Digestive System OR Procedures w MCC, RW ~2.98), DRG 394 (w CC, RW ~1.75), DRG 395 (w/o CC/MCC, RW ~1.13) CPT 38100-38120

ORTHOPEDIC

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days open; 2-3 days laparoscopic Source: ACS NSQIP

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.

SHOULDER REPLACEMENT (TOTAL / REVERSE TSA)

ICD-10-CM / ICD-10-PCS / CPT: M19.011 (primary osteoarthritis right shoulder), M19.012 (left shoulder), M75.10 (rotator cuff syndrome unspecified), M75.11 (right), M75.12 (left), M75.120 (complete rotator cuff tear right), M75.121 (left), S42.201A (fracture upper end humerus right initial), S42.202A (left) ICD-10-PCS: 0RRJ0xx (replacement of right shoulder joint), 0RRK0xx (left shoulder joint) CPT: 23472 (total shoulder arthroplasty), 23473 (revision total shoulder), 23474 (reverse total shoulder arthroplasty)

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

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

- severe glenohumeral OA with bone-on-bone changes and failed conservative therapy
- proximal humerus fracture (3-4 part) not amenable to ORIF
- massive irreparable rotator cuff tear with arthropathy (reverse TSA)
- revision of failed prior arthroplasty

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones,

medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremity w CC/MCC, RW ~2.68), DRG 484 (w/o CC/MCC, RW ~1.90)
CPT 23472-23474

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days primary; 2-3 days revision/reverse Source: AAOS Shoulder Arthroplasty Registry

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 \rightarrow 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 \rightarrow 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.

PELVIC / ACETABULAR FRACTURE ORIF

ICD-10-CM / ICD-10-PCS / CPT: S32.10xA (fracture of sacrum initial), S32.111A-S32.119A (Zone I sacral fracture), S32.301A-S32.309A (fracture of ilium), S32.401A-S32.409A (fracture of acetabulum), S32.501A-S32.509A (fracture of pubis), S32.601A-S32.609A (fracture of ischium), S32.810A (multiple fractures of pelvis) ICD-10-PCS: 0QS1xxx (reposition sacrum), 0QS2xxx (reposition pelvic bone), 0QS3xxx (reposition acetabulum) CPT: 27215-27218 (pelvic fracture ORIF), 27226-27228 (acetabular fracture ORIF), 27244-27245 (intertrochanteric fracture)

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

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

- unstable pelvic ring fracture (Tile B/C or Young-Burgess type)
- displaced acetabular fracture with ≥ 2 mm articular incongruity
- open pelvic fracture
- hemodynamic instability from pelvic hemorrhage (pelvic binder)
- angioembolization
- external fixation)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission > 1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 480 (Hip & Femur Procedures w MCC, RW ~2.84), DRG 481 (w CC, RW ~1.89), DRG 482 (w/o CC/MCC, RW ~1.47) CPT 27215-27228

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-10 days Source: OTA Pelvic Fracture Guidelines

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 \rightarrow 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 \rightarrow 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.

MAJOR AMPUTATION (ABOVE/BELOW KNEE, ABOVE/BELOW ELBOW)

ICD-10-CM / ICD-10-PCS / CPT: T87.30-T87.34 (neuroma of amputation stump), T87.40-T87.44 (infection of amputation stump), T87.50-T87.54 (necrosis of amputation stump), E11.52 (T2DM with diabetic peripheral angiopathy with gangrene), I70.261-I70.269 (atherosclerosis of native arteries of extremities with gangrene), L97.x (non-pressure chronic ulcer — if requiring amputation) CPT: 27590 (amputation thigh through femur), 27880 (amputation leg through tibia/fibula — BKA), 27882 (amputation BKA open), 24900 (amputation arm through humerus — AKE), 25900 (amputation forearm through radius/ulna — BKE)

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

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

- non-salvageable limb due to gangrene
- severe PAD/CLI with rest pain and tissue loss failing revascularization
- severe crush injury/mangled extremity
- life-threatening infection (gas gangrene)
- necrotizing fasciitis
- osteomyelitis refractory to treatment

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 492 (Lower Extrem & Humer Proc Except Hip/Foot/Femur w MCC, RW ~2.42), DRG 493 (w CC, RW ~1.43), DRG 494 (w/o CC/MCC, RW ~0.98), DRG 616-618 (Amputation for Circulatory System Disorders, RW 3.38/1.68/0.93) CPT 24900-27882
NEUROSURGERY

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-10 days; longer with rehab disposition Source: AAOS Amputation Outcomes; SVS

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.

VP SHUNT PLACEMENT / REVISION

ICD-10-CM / ICD-10-PCS / CPT: G91.0 (communicating hydrocephalus), G91.1 (obstructive hydrocephalus), G91.2 (normal pressure hydrocephalus), G91.3 (post-traumatic hydrocephalus), G91.4 (hydrocephalus in diseases classified elsewhere), G91.8 (other hydrocephalus), G91.9 (hydrocephalus unspecified), T85.01xA (breakdown of VP shunt), T85.09xA (other mechanical complication)
ICD-10-PCS: 00160J6 (bypass cerebral ventricle to peritoneal cavity with synthetic substitute, open), 00160JB (to atrium) CPT: 62220 (VP shunt creation), 62223 (VP shunt revision), 62230 (replacement of CSF shunt obstructed valve)

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

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

- symptomatic hydrocephalus (headache)
- AMS
- gait instability
- urinary incontinence
- papilledema
- enlarged ventricles on imaging)
- shunt malfunction (symptoms + CT showing increased ventricle size)
- shunt infection (fever + CSF positive)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery

- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023 (Craniotomy w MCC, RW ~5.75), DRG 024 (w CC, RW ~3.61), DRG 025 (w/o CC/MCC, RW ~2.59) CPT 62220-62230 Rev 0360, 0270 (shunt hardware)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days Source: AANS/CNS Pediatric Hydrocephalus Guidelines

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

DEEP BRAIN STIMULATION (DBS) IMPLANTATION

ICD-10-CM / ICD-10-PCS / CPT: G20 (Parkinson disease), G24.1 (genetic torsion dystonia), G25.0 (essential tremor), G40.x (epilepsy — selected refractory cases), F32.x-F33.x (depression — investigational) ICD-10-PCS: 00H00MZ (insertion of neurostimulator lead into brain), 0JH60PZ (insertion of pulse generator into chest subcutaneous tissue) CPT: 61863-61868 (stereotactic implantation of neurostimulator electrode), 61885-61886 (insertion of neurostimulator pulse generator)

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

SEVERITY OF ILLNESS (SI) — ALL:

- Parkinson disease with motor fluctuations/dyskinesia refractory to optimized medical therapy
- OR essential tremor refractory to medication
- OR primary dystonia refractory to medical therapy | Neuropsychological testing confirming no dementia | MRI-compatible anatomy

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy) or DRG 040-042 (Peripheral/Cranial Nerve Procedures) CPT 61863-61886 Rev 0360, 0270 (DBS hardware ~\$25K-40K)

VASCULAR SURGERY

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: AAN DBS Parameters; CNS Functional Neurosurgery

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

CAROTID ENDARTERECTOMY (CEA)

ICD-10-CM / ICD-10-PCS / CPT: I65.21 (occlusion and stenosis of right carotid artery), I65.22 (left carotid artery), I65.23 (bilateral carotid arteries), I65.29 (unspecified carotid artery), I63.031-I63.039 (cerebral infarction due to thrombosis of carotid) CPT: 35301 (carotid endarterectomy), 35390 (reoperation carotid), 37215-37217 (carotid stenting)

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

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

- symptomatic carotid stenosis $\geq 50\%$ (TIA or stroke within 6 months per NASCET criteria)
- OR asymptomatic carotid stenosis $\geq 70\%$ with acceptable surgical risk (per SVS/AHA guidelines)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 233-234 (Carotid Artery Stent Procedure) or DRG 252-254 (Other Vascular Procedures, RW 3.46/2.22/1.59) CPT 35301, 37215-37217

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: SVS Carotid Guidelines

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

- ICU: Post-open aortic repair (≥ 24 h 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.

PERIPHERAL ARTERIAL BYPASS (FEM-POP, FEM-TIBIAL)

ICD-10-CM / ICD-10-PCS / CPT: I70.201-I70.299 (atherosclerosis of native arteries of extremities), I70.311-I70.369 (atherosclerosis with intermittent claudication/rest pain/ulceration), I70.261-I70.269 (with gangrene), I73.9 (peripheral vascular disease unspecified)
CPT: 35556 (bypass graft femoral-popliteal with vein), 35566 (femoral-anterior tibial with vein), 35571 (femoral-peroneal with vein), 35583-35587 (bypass with synthetic graft)

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

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

- critical limb ischemia (rest pain)
- tissue loss Rutherford 4-6)
- failed or not amenable to endovascular intervention
- limb-threatening acute ischemia requiring surgical bypass
- claudication severely limiting function (Rutherford 3) failing exercise/medical therapy

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 252 (Other Vascular Procedures w MCC, RW ~3.46), DRG 253 (w CC, RW ~2.22), DRG 254 (w/o CC/MCC, RW ~1.59) CPT 35556-35587

ENT / HEAD & NECK

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: SVS PAD Guidelines 2024

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

- ICU: Post-open aortic repair (≥ 24 h 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.

LARYNGECTOMY (TOTAL / PARTIAL)

ICD-10-CM / ICD-10-PCS / CPT: C32.0 (malignant neoplasm of glottis), C32.1 (supraglottis), C32.2 (subglottis), C32.3 (laryngeal cartilage), C32.8 (overlapping sites of larynx), C32.9 (larynx unspecified) CPT: 31360 (laryngectomy total without radical neck dissection), 31365 (total with radical neck dissection), 31367-31368 (laryngectomy subtotal supraglottic)

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

SEVERITY OF ILLNESS (SI) — ALL:

- laryngeal cancer requiring surgical resection per NCCN (T3-T4 glottic/supraglottic)

- failed chemoradiation
- salvage laryngectomy for recurrence)
- multidisciplinary tumor board recommendation

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission > 1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 129 (Major Head & Neck Procedures w CC/MCC, RW ~ 3.10), DRG 130 (w/o CC/MCC, RW ~ 1.67) CPT 31360-31368 Rev 0360, 0270 (tracheostomy supplies, voice prosthesis)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-10 days Source: AHNS Larynx Cancer Guidelines; NCCN H&N

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.

THYROIDECTOMY (TOTAL — FOR CANCER)

ICD-10-CM / ICD-10-PCS / CPT: C73 (malignant neoplasm of thyroid gland), D34 (benign neoplasm of thyroid gland), E04.0-E04.9 (nontoxic goiter), E05.00-E05.91 (thyrotoxicosis) CPT: 60240 (thyroidectomy total), 60252 (thyroidectomy total with limited neck dissection), 60254 (thyroidectomy total with radical neck dissection), 60260 (thyroidectomy subtotal)

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

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

- confirmed or suspected thyroid carcinoma (≥ 1 cm papillary)
- follicular
- medullary
- or anaplastic)
- Bethesda V-VI on FNA
- compressive goiter with airway compromise
- refractory Graves disease (relative surgical indication)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission > 1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 625 (Thyroid/Parathyroid/Thyroglossal Procedures w MCC, RW ~2.33), DRG 626 (w CC, RW ~1.33), DRG 627 (w/o CC/MCC, RW ~0.87) CPT 60240-60260 Note: Often outpatient or 23h obs; inpatient if total thyroidectomy with neck dissection, or parathyroid/airway concern

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days; 2-3 days with neck dissection Source: AAES/ATA Thyroid Surgery Guidelines

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.

NECK DISSECTION (RADICAL / MODIFIED RADICAL)

ICD-10-CM / ICD-10-PCS / CPT: C00-C14 (malignant neoplasms of lip/oral cavity/pharynx), C30-C32 (nasal/larynx), C77.0 (secondary malignant neoplasm of lymph nodes of head/face/neck) CPT: 38700 (radical neck dissection unilateral), 38720 (radical neck dissection bilateral), 38724 (modified radical neck dissection)

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

SEVERITY OF ILLNESS (SI) — ALL:

- confirmed head/neck cancer with cervical lymph node involvement (N1-N3) per NCCN staging
- planned as part of definitive surgical treatment or salvage after chemoradiation failure

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented

- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 129-130 (Major Head & Neck Procedures, RW 3.10/1.67) CPT 38700-38724

MEDICAL ADMISSIONS

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-4 days standalone; 5-7 days with primary tumor Source: AHNS Neck Dissection Consensus

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.

STEVENS-JOHNSON SYNDROME / TOXIC EPIDERMAL NECROLYSIS (SJS/TEN)

ICD-10-CM / ICD-10-PCS / CPT: L51.1 (Stevens-Johnson syndrome), L51.2 (toxic epidermal necrolysis — Lyell syndrome), L51.3 (SJS-TEN overlap syndrome), L51.8 (other erythema multiforme), L51.9 (erythema multiforme unspecified), T88.7xxA (unspecified adverse effect of drug initial encounter)

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

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

- mucous membrane involvement (≥ 2 sites)

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 602-604 (Cellulitis) or DRG 927-935 (Burns DRGs for TEN with large BSA) Rev 0200 (ICU/Burn unit for TEN), 0270 (wound care), 0250, 0300

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 10-21 days Source: American Burn Association SJS/TEN Consensus; AAD Guidelines

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

- ICU: Severe DTs with refractory delirium and autonomic storming, severe overdose with mechanical ventilation, NMS with hyperthermia $>40^{\circ}\text{C}$, SJS/TEN with $>30\%$ BSA, anaphylaxis with refractory shock, malignant hyperthermia with metabolic crisis.
- Stepdown (Telemetry/PCU): CIWA q1-2h with frequent benzo titration, naloxone drip, IV antidote administration (NAC/octreotide/digibind), SJS/TEN with $<30\%$ BSA, BiPAP-eligible without intubation criteria.
- Med-Surg: CIWA <8 , off drip, transitioning to PO, tolerating diet, completing antibiotics/antivirals, wound care for SJS/TEN healing phase.
- Observation: Anaphylaxis with rapid response and no biphasic concerns may discharge within 4-8 hours; uncomplicated acetaminophen overdose with completed NAC course.
- Post-Acute (SNF/IRF/LTAC): SJS/TEN patients may need IRF or specialized burn unit; substance use disorder patients may need residential addiction treatment (not covered under skilled level).
- Home (with/without HHA): Stable VS, tolerating PO, no withdrawal, addiction medicine follow-up arranged, follow-up PCP in 1-2 weeks; HHA for wound care (SJS/TEN).

LOC Grid Sources: ASAM National Practice Guideline 2020; AACT/EAPCCT Position Statements; AAAAI/ACAAI 2020 Anaphylaxis Practice Parameter; ABA SJS/TEN 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.

- Persistent withdrawal symptoms (CIWA >8 , COWS >12) despite taper
- Aspiration pneumonia or new infection requiring antibiotics
- Refractory autonomic instability (DTs, NMS, serotonin syndrome)
- Continued SJS/TEN BSA progression requiring burn-level care
- Biphasic anaphylaxis recurrence

Extended Stay Sources: Sources: ASAM National Practice Guideline 2020; AACT Position Statements; AAAAI/ACAAI 2020.

ANAPHYLAXIS (REQUIRING INPATIENT OBSERVATION)

ICD-10-CM / ICD-10-PCS / CPT: T78.2xxA (anaphylactic shock unspecified, initial), T78.00xA (anaphylactic reaction due to unspecified food), T78.01xA (peanuts), T78.02xA (shellfish), T78.03xA (other fish), T78.04xA (fruits and vegetables), T78.05xA (tree nuts and seeds), T78.06xA (food additives), T78.09xA (other food), T80.52xA (anaphylactic reaction due to vaccination), T88.6xxA (anaphylactic reaction due to adverse effect of correct drug)

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

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

- acute onset (minutes to hours) of ≥ 2 organ system involvement

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 916 (Allergic Reactions w MCC, RW ~ 1.13), DRG 917 (w/o MCC, RW ~ 0.56) Rev 0250 (epinephrine, steroids), 0300 (tryptase level) Note: Most anaphylaxis is observation status; inpatient if: severe/prolonged, required multiple epinephrine doses, biphasic reaction, significant comorbidity

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: AAAAI/ACAAI 2020 Anaphylaxis Practice Parameter

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

- ICU: Severe DTs with refractory delirium and autonomic storming, severe overdose with mechanical ventilation, NMS with hyperthermia $>40^{\circ}\text{C}$, SJS/TEN with $>30\%$ BSA, anaphylaxis with refractory shock, malignant hyperthermia with metabolic crisis.
- Stepdown (Telemetry/PCU): CIWA q1-2h with frequent benzo titration, naloxone drip, IV antidote administration (NAC/octreotide/digibind), SJS/TEN with $<30\%$ BSA, BiPAP-eligible without intubation criteria.
- Med-Surg: CIWA <8 , off drip, transitioning to PO, tolerating diet, completing antibiotics/antivirals, wound care for SJS/TEN healing phase.
- Observation: Anaphylaxis with rapid response and no biphasic concerns may discharge within 4-8 hours; uncomplicated acetaminophen overdose with completed NAC course.
- Post-Acute (SNF/IRF/LTAC): SJS/TEN patients may need IRF or specialized burn unit; substance use disorder patients may need residential addiction treatment (not covered under skilled level).
- Home (with/without HHA): Stable VS, tolerating PO, no withdrawal, addiction medicine follow-up arranged, follow-up PCP in 1-2 weeks; HHA for wound care (SJS/TEN).

LOC Grid Sources: ASAM National Practice Guideline 2020; AACT/EAPCCT Position Statements; AAAAI/ACAAI 2020 Anaphylaxis Practice Parameter; ABA SJS/TEN 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.

- Persistent withdrawal symptoms (CIWA >8, COWS >12) despite taper
- Aspiration pneumonia or new infection requiring antibiotics
- Refractory autonomic instability (DTs, NMS, serotonin syndrome)
- Continued SJS/TEN BSA progression requiring burn-level care
- Biphasic anaphylaxis recurrence

Extended Stay Sources: Sources: ASAM National Practice Guideline 2020; AACT Position Statements; AAAAI/ACAAI 2020.

NEUROLEPTIC MALIGNANT SYNDROME (NMS)

ICD-10-CM / ICD-10-PCS / CPT: G21.0 (malignant neuroleptic syndrome) Related: T43.3x5A (adverse effect of phenothiazines), T43.4x5A (adverse effect of butyrophenones), T43.595A (adverse effect of other antipsychotics)

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

SEVERITY OF ILLNESS (SI) — SEVERITY OF ILLNESS (SI) — Must meet ≥ 3 (Levenson criteria):

- fever $>38^{\circ}\text{C}$ (or $>40^{\circ}\text{C}$ in severe NMS)
- muscle rigidity (lead-pipe)
- altered mental status (confusion)
- agitation
- catatonia
- coma)
- autonomic instability (tachycardia)
- labile BP
- diaphoresis
- tachypnea)
- elevated CK (>1000)
- often $>10,000$)
- leukocytosis (WBC $>10,000$) | IS — Must meet ≥ 1

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile $\geq 24\text{h}$
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 091 (Other Disorders of Nervous System w MCC, RW ~1.52) Rev 0200 (ICU), 0250 (dantrolene, bromocriptine), 0300 (CK serial, CMP, UA myoglobin)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-10 days Source: APA Practice Guidelines; AACT

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

- ICU: Severe DTs with refractory delirium and autonomic storming, severe overdose with mechanical ventilation, NMS with hyperthermia >40°C, SJS/TEN with >30% BSA, anaphylaxis with refractory shock, malignant hyperthermia with metabolic crisis.
- Stepdown (Telemetry/PCU): CIWA q1-2h with frequent benzo titration, naloxone drip, IV antidote administration (NAC/octreotide/digibind), SJS/TEN with <30% BSA, BiPAP-eligible without intubation criteria.
- Med-Surg: CIWA <8, off drip, transitioning to PO, tolerating diet, completing antibiotics/antivirals, wound care for SJS/TEN healing phase.
- Observation: Anaphylaxis with rapid response and no biphasic concerns may discharge within 4-8 hours; uncomplicated acetaminophen overdose with completed NAC course.
- Post-Acute (SNF/IRF/LTAC): SJS/TEN patients may need IRF or specialized burn unit; substance use disorder patients may need residential addiction treatment (not covered under skilled level).
- Home (with/without HHA): Stable VS, tolerating PO, no withdrawal, addiction medicine follow-up arranged, follow-up PCP in 1-2 weeks; HHA for wound care (SJS/TEN).

LOC Grid Sources: ASAM National Practice Guideline 2020; AACT/EAPCCT Position Statements; AAAAI/ACAAI 2020 Anaphylaxis Practice Parameter; ABA SJS/TEN 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.

- Persistent withdrawal symptoms (CIWA >8, COWS >12) despite taper
- Aspiration pneumonia or new infection requiring antibiotics
- Refractory autonomic instability (DTs, NMS, serotonin syndrome)
- Continued SJS/TEN BSA progression requiring burn-level care
- Biphasic anaphylaxis recurrence

Extended Stay Sources: Sources: ASAM National Practice Guideline 2020; AACT Position Statements; AAAAI/ACAAI 2020.

SEROTONIN SYNDROME

ICD-10-CM / ICD-10-PCS / CPT: G25.79 (other drug-induced movement disorder — may be coded here) T43.205A (adverse effect of unspecified antidepressant), T43.215A (adverse effect of SSRI), T43.225A (adverse effect of SNRI)

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

SEVERITY OF ILLNESS (SI) — SEVERITY OF ILLNESS (SI) — Hunter Criteria:

- must meet ≥1 set

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones,

medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 917-918 (Poisoning/Toxic Effects, RW 1.36/0.67) Rev 0200 (ICU if severe), 0250 (cyproheptadine, benzos, dantrolene if malignant)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-5 days Source: AACT Position Statement

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

- ICU: Severe DTs with refractory delirium and autonomic storming, severe overdose with mechanical ventilation, NMS with hyperthermia $>40^{\circ}\text{C}$, SJS/TEN with $>30\%$ BSA, anaphylaxis with refractory shock, malignant hyperthermia with metabolic crisis.
- Stepdown (Telemetry/PCU): CIWA q1-2h with frequent benzo titration, naloxone drip, IV antidote administration (NAC/octreotide/digibind), SJS/TEN with $<30\%$ BSA, BiPAP-eligible without intubation criteria.
- Med-Surg: CIWA <8 , off drip, transitioning to PO, tolerating diet, completing antibiotics/antivirals, wound care for SJS/TEN healing phase.
- Observation: Anaphylaxis with rapid response and no biphasic concerns may discharge within 4-8 hours; uncomplicated acetaminophen overdose with completed NAC course.
- Post-Acute (SNF/IRF/LTAC): SJS/TEN patients may need IRF or specialized burn unit; substance use disorder patients may need residential addiction treatment (not covered under skilled level).
- Home (with/without HHA): Stable VS, tolerating PO, no withdrawal, addiction medicine follow-up arranged, follow-up PCP in 1-2 weeks; HHA for wound care (SJS/TEN).

LOC Grid Sources: ASAM National Practice Guideline 2020; AACT/EAPCCT Position Statements; AAAAI/ACAAI 2020 Anaphylaxis Practice Parameter; ABA SJS/TEN 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.

- Persistent withdrawal symptoms (CIWA >8 , COWS >12) despite taper
- Aspiration pneumonia or new infection requiring antibiotics
- Refractory autonomic instability (DTs, NMS, serotonin syndrome)
- Continued SJS/TEN BSA progression requiring burn-level care
- Biphasic anaphylaxis recurrence

Extended Stay Sources: Sources: ASAM National Practice Guideline 2020; AACT Position Statements; AAAAI/ACAAI 2020.

MALIGNANT HYPERTHERMIA

ICD-10-CM / ICD-10-PCS / CPT: T88.3xxA (malignant hyperthermia due to anesthesia, initial encounter)

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

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

- unexplained rise in end-tidal CO₂
- tachycardia
- muscle rigidity (masseter spasm or generalized)

- hyperthermia (rapid rise)
- often >40°C)
- metabolic acidosis (pH <7.25)
- hyperkalemia
- elevated CK
- myoglobinuria
- DIC | IS — Must meet ALL

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled
- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 091-093 (Other Disorders of Nervous System) or 917-918 (Poisoning/Toxic Effects) Rev 0200 (ICU), 0250 (dantrolene — requires 36 vials at ~\$50-100 each = \$2000-3600), 0300 (Lab — CK, ABG, K+, Cr, coags serial)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: MHAUS Guidelines

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

- ICU: Severe DTs with refractory delirium and autonomic storming, severe overdose with mechanical ventilation, NMS with hyperthermia >40°C, SJS/TEN with >30% BSA, anaphylaxis with refractory shock, malignant hyperthermia with metabolic crisis.
- Stepdown (Telemetry/PCU): CIWA q1-2h with frequent benzo titration, naloxone drip, IV antidote administration (NAC/octreotide/digibind), SJS/TEN with <30% BSA, BiPAP-eligible without intubation criteria.
- Med-Surg: CIWA <8, off drip, transitioning to PO, tolerating diet, completing antibiotics/antivirals, wound care for SJS/TEN healing phase.
- Observation: Anaphylaxis with rapid response and no biphasic concerns may discharge within 4-8 hours; uncomplicated acetaminophen overdose with completed NAC course.
- Post-Acute (SNF/IRF/LTAC): SJS/TEN patients may need IRF or specialized burn unit; substance use disorder patients may need residential addiction treatment (not covered under skilled level).
- Home (with/without HHA): Stable VS, tolerating PO, no withdrawal, addiction medicine follow-up arranged, follow-up PCP in 1-2 weeks; HHA for wound care (SJS/TEN).

LOC Grid Sources: ASAM National Practice Guideline 2020; AACT/EAPCCT Position Statements; AAAAI/ACAAI 2020 Anaphylaxis

Practice Parameter; ABA SJS/TEN 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.

- Persistent withdrawal symptoms (CIWA >8, COWS >12) despite taper
- Aspiration pneumonia or new infection requiring antibiotics
- Refractory autonomic instability (DTs, NMS, serotonin syndrome)
- Continued SJS/TEN BSA progression requiring burn-level care
- Biphasic anaphylaxis recurrence

Extended Stay Sources: Sources: ASAM National Practice Guideline 2020; AACT Position Statements; AAAAI/ACAAI 2020.

HEAT STROKE

ICD-10-CM / ICD-10-PCS / CPT: T67.01xA (heatstroke with exertional heat stroke, initial), T67.02xA (heatstroke NOS, initial), T67.09xA (other heatstroke and sunstroke)

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

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

- core body temperature $>40^{\circ}\text{C}$ (104°F)
- altered mental status (confusion)
- delirium
- seizures
- coma)
- anhidrosis (classic) or diaphoresis (exertional)
- tachycardia
- hypotension
- multiorgan dysfunction (AKI)
- rhabdomyolysis
- DIC
- hepatic injury
- ARDS) | IS — Must meet ≥ 1

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

- Surgical procedure performed or planned requiring post-operative inpatient recovery
- Post-operative monitoring requirements exceed outpatient/observation capability
- Expected post-operative LOS ≥ 2 midnights

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone not requiring overnight recovery
- Pre-operative admission >1 day before surgery for non-medical reasons
- Continued post-operative stay when ALL discharge criteria met
- Continued stay solely awaiting facility placement when medically ready

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical/medical team review. Continued stay justified if: post-operative complication, unable to meet functional milestones, medical co-management of unstable comorbidities, active treatment ongoing.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile $\geq 24\text{h}$
- Pain controlled on oral analgesics (or adequate pain management plan)
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound/surgical site clean, drains removed or minimal output
- Ambulatory at expected post-procedure level
- Bowel function returned (if GI procedure)
- DVT prophylaxis plan documented
- Follow-up appointments scheduled

- Discharge education completed

E. EVIDENCE SOURCES

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

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 640-642 (Misc Disorders Nutrition/Metabolism/Fluids, RW 1.42/0.85/0.58) Rev 0200 (ICU), 0250, 0300 (CK, CMP, coags, LFTs serial)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-7 days Source: ACSM/Wilderness Medical Society Heat Stroke Guidelines

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

- ICU: Severe DTs with refractory delirium and autonomic storming, severe overdose with mechanical ventilation, NMS with hyperthermia >40°C, SJS/TEN with >30% BSA, anaphylaxis with refractory shock, malignant hyperthermia with metabolic crisis.
- Stepdown (Telemetry/PCU): CIWA q1-2h with frequent benzo titration, naloxone drip, IV antidote administration (NAC/octreotide/digibind), SJS/TEN with <30% BSA, BiPAP-eligible without intubation criteria.
- Med-Surg: CIWA <8, off drip, transitioning to PO, tolerating diet, completing antibiotics/antivirals, wound care for SJS/TEN healing phase.
- Observation: Anaphylaxis with rapid response and no biphasic concerns may discharge within 4-8 hours; uncomplicated acetaminophen overdose with completed NAC course.
- Post-Acute (SNF/IRF/LTAC): SJS/TEN patients may need IRF or specialized burn unit; substance use disorder patients may need residential addiction treatment (not covered under skilled level).
- Home (with/without HHA): Stable VS, tolerating PO, no withdrawal, addiction medicine follow-up arranged, follow-up PCP in 1-2 weeks; HHA for wound care (SJS/TEN).

LOC Grid Sources: ASAM National Practice Guideline 2020; AACT/EAPCCT Position Statements; AAAAI/ACAAI 2020 Anaphylaxis Practice Parameter; ABA SJS/TEN 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.

- Persistent withdrawal symptoms (CIWA >8, COWS >12) despite taper
- Aspiration pneumonia or new infection requiring antibiotics
- Refractory autonomic instability (DTs, NMS, serotonin syndrome)
- Continued SJS/TEN BSA progression requiring burn-level care
- Biphasic anaphylaxis recurrence

Extended Stay Sources: Sources: ASAM National Practice Guideline 2020; AACT Position Statements; AAAAI/ACAAI 2020.

VSD REPAIR — ADULT (VENTRICULAR SEPTAL DEFECT)

ICD-10-CM / ICD-10-PCS / CPT: Q21.0 (ventricular septal defect), I23.2 (post-MI VSD as complication) ICD-10-PCS: 02Q40ZZ (repair ventricular septum, open) CPT: 33545 (repair ventricular septal defect with CPB)

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

SEVERITY OF ILLNESS (SI) — ALL:

- ALL: hemodynamically significant VSD with Qp:Qs \geq 1.5:1 or LV volume overload
- symptomatic or progressive dilation
- OR post-MI VSD (surgical emergency)
- no irreversible Eisenmenger syndrome

INTENSITY OF SERVICE (IS) — Must meet \geq 1:

- Surgical procedure requiring post-operative inpatient recovery \geq 2 midnights
- Post-operative ICU/CVICU monitoring with hemodynamic monitoring
- Post-operative services not available at lower level of care

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

STS Guidelines. AHA/ACC Practice Guidelines. CMS IPO List FY2024. ERAS Cardiac Surgery Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 216-219 (Cardiac Valve, RW 5.01-10.78) CPT 33545

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: STS Adult Cardiac Database; AHA/ACC

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.

PERICARDIECTOMY

ICD-10-CM / ICD-10-PCS / CPT: I31.0 (chronic adhesive pericarditis), I31.1 (chronic constrictive pericarditis), I31.8 (other specified pericardial disease), I31.9 (pericardial disease unspecified) ICD-10-PCS: 02QN0ZZ (repair pericardium, open), 02BN0ZZ (excision of pericardium) CPT: 33030 (pericardiectomy subtotal), 33031 (pericardiectomy complete)

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

SEVERITY OF ILLNESS (SI) — ALL:

- ALL: constrictive pericarditis confirmed by echo/CT/MRI and hemodynamics (elevated JVP)
- equalization of diastolic pressures
- Kussmaul sign)
- NYHA II-IV symptoms refractory to medical therapy
- diuretics inadequate

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative ICU/CVICU monitoring with hemodynamic monitoring
- Post-operative services not available at lower level of care

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

STS Guidelines. AHA/ACC Practice Guidelines. CMS IPO List FY2024. ERAS Cardiac Surgery Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 216-219 (Cardiac Valve/Major Cardiothoracic) CPT 33030-33031 LOS 7-14 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: STS

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.

CARDIAC TUMOR EXCISION (ATRIAL MYXOMA)

ICD-10-CM / ICD-10-PCS / CPT: D15.1 (benign neoplasm of heart), C38.0 (malignant neoplasm of heart) ICD-10-PCS: 02B50ZZ (excision of atrial septum), 02BA0ZZ (excision of heart) CPT: 33120 (excision of intracardiac tumor, resection with CPB)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- ≥ 1 : intracardiac mass on echo (LA myxoma most common)
- symptomatic (embolic events)
- obstruction
- constitutional symptoms)
- high embolic risk (mobile)
- pedunculated)

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative ICU/CVICU monitoring with hemodynamic monitoring
- Post-operative services not available at lower level of care

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

STS Guidelines. AHA/ACC Practice Guidelines. CMS IPO List FY2024. ERAS Cardiac Surgery Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 216-219 (Cardiac Valve/Major Cardiothoracic) CPT 33120

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: STS

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.

ECMO CANNULATION / DECANNULATION

ICD-10-CM / ICD-10-PCS / CPT: T81.10xA (postprocedural shock unspecified), I46.9 (cardiac arrest), J96.00 (acute respiratory failure unspecified), J96.01 (with hypoxia), J96.02 (with hypercapnia), Z99.11 (dependence on respirator, ECMO status) ICD-10-PCS: 5A1522F (extracorporeal membrane oxygenation, veno-arterial), 5A1522G (veno-venous) CPT: 33946 (ECMO initiation veno-venous), 33947 (veno-arterial), 33948 (daily management), 33949 (removal/decannulation)

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

SEVERITY OF ILLNESS (SI) — ALL:

- ALL: refractory cardiogenic shock (VA-ECMO) or refractory respiratory failure (VV-ECMO) despite maximal conventional therapy
- reversible underlying condition OR bridge to transplant/VAD
- ELSO criteria met

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative ICU/CVICU monitoring with hemodynamic monitoring
- Post-operative services not available at lower level of care

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

STS Guidelines. AHA/ACC Practice Guidelines. CMS IPO List FY2024. ERAS Cardiac Surgery Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 003 (ECMO or Tracheostomy w MV ≥ 96 h or PDx Except Face/Mouth/Neck w Major OR, RW ~18.57), DRG 004 (Tracheostomy w MV ≥ 96 h or PDx Except Face/Mouth/Neck w/o Major OR, RW ~12.14) CPT 33946-33949 Rev 0200 (ICU), 0270 (ECMO circuits ~\$30K-50K), 0300 (Lab), 0390 (Blood — massive transfusion common)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: Variable; ECMO run typically 5-21 days Source: ELSO Guidelines 2023

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

- ICU: VA-ECMO active, post-implant LVAD with hemodynamic instability, biventricular failure, refractory ventricular arrhythmia post-ICD generator change, sepsis with device.
- Stepdown (Telemetry/PCU): Post-LVAD implant routine course, continuous telemetry, vasoactive wean, anticoagulation initiation, driveline care education, biventricular CRT-D programming.
- Med-Surg: Stable LVAD \geq POD 5, ambulating with companion, INR therapeutic range, driveline site dry, completing rehab assessment.
- Observation: Uncomplicated single-chamber pacemaker/single-lead ICD generator change discharged same day or within 23 hours per HRS consensus.
- Post-Acute (SNF/IRF/LTAC): LVAD patients commonly require IRF for cardiac/strength rehab; LTAC if chronic vent or device complications.
- Home (with/without HHA): LVAD self-care competency demonstrated (patient + caregiver), local VAD team coverage, equipment delivered, INR/coag clinic established.

LOC Grid Sources: INTERMACS Registry; 2023 ISHLT Mechanical Circulatory Support Guidelines; HRS/EHRA Implant Guidelines; ELSO Guidelines 2023.

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.

- Driveline or pocket infection
- Post-implant arrhythmia storm requiring IV titration or ablation
- Right-heart failure post-LVAD requiring inotropes
- Pump thrombosis or device malfunction
- INR not therapeutic with bridging required
- Failure of patient/caregiver to demonstrate competency in device self-care

Extended Stay Sources: Sources: INTERMACS; ISHLT MCS Guidelines 2023; HRS device implant consensus.

THROMBOENDARTERECTOMY (PTE) FOR CTEPH

ICD-10-CM / ICD-10-PCS / CPT: I27.24 (chronic thromboembolic pulmonary hypertension), I26.99 (other PE) ICD-10-PCS: 02CC0ZZ (extirpation of matter from pulmonary artery), 02CD0ZZ (pulmonary vein) CPT: 33916 (pulmonary endarterectomy with CPB)

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

SEVERITY OF ILLNESS (SI) — ALL:

- ALL: chronic thromboembolic pulmonary hypertension (CTEPH) confirmed by V/Q scan
- CT angiography
- and right heart catheterization; surgically accessible disease (main/lobar/segmental)
- PVR >300 dyn·s/cm⁵
- NYHA II-IV
- evaluated at CTEPH expert center

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

- Surgical procedure requiring post-operative inpatient recovery ≥2 midnights
- Post-operative ICU/CVICU monitoring with hemodynamic monitoring
- Post-operative services not available at lower level of care

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

STS Guidelines. AHA/ACC Practice Guidelines. CMS IPO List FY2024. ERAS Cardiac Surgery Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 163-165 (Major Chest Procedures, RW 4.71/2.60/1.81) CPT 33916 LOS 10-14 days ICU required Deep hypothermic circulatory arrest used

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 10-14 days Source: AHA/ACCP CTEPH Guidelines

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.

MITRAL VALVE REPAIR (STANDALONE / MITRACLIP)

ICD-10-CM / ICD-10-PCS / CPT: I34.0 (nonrheumatic mitral insufficiency), I34.1 (mitral valve prolapse), I05.1 (rheumatic mitral insufficiency), I34.8 (other nonrheumatic mitral valve disorders) ICD-10-PCS: 02QG0ZZ (repair mitral valve, open), X2QG0A7 (repair mitral valve, percutaneous — MitraClip) CPT: 33420-33427 (mitral valve repair open), 0345T (transcatheter mitral valve repair — MitraClip)

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

SEVERITY OF ILLNESS (SI) — ALL:

- ALL: severe mitral regurgitation (ERO ≥ 0.40 cm²)
- regurgitant volume ≥ 60 mL
- vena contracta ≥ 7 mm)
- symptomatic (NYHA II-IV) or asymptomatic with LV dysfunction (LVEF $\leq 60\%$ or LVESD ≥ 40 mm)
- valve anatomy amenable to repair (degenerative > functional)

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative ICU/CVICU monitoring with hemodynamic monitoring
- Post-operative services not available at lower level of care

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge

- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

STS Guidelines. AHA/ACC Practice Guidelines. CMS IPO List FY2024. ERAS Cardiac Surgery Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 216-219 (Cardiac Valve, RW 5.01-10.78) for open; DRG 266-267 (Endovascular Valve, RW 4.24-5.82) for MitraClip CPT 33420-33427, 0345T

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-6 days open; 1-3 days MitraClip Source: STS Adult Cardiac Database; ACC/AHA Valvular Heart Disease 2020

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.

HEART RETRANSPLANT

ICD-10-CM / ICD-10-PCS / CPT: T86.20 (unspecified complication of heart transplant), T86.21 (heart transplant failure), T86.23 (heart transplant rejection), Z94.1 (heart transplant status) ICD-10-PCS: 02YA0Zx (transplantation of heart) CPT: 33945 (heart transplant)

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

SEVERITY OF ILLNESS (SI) — ALL:

- ALL: graft failure (primary or chronic rejection/CAV) in prior heart transplant recipient
- relisted on UNOS
- no absolute contraindications
- evaluated by transplant center
- survival benefit expected

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative ICU/CVICU monitoring with hemodynamic monitoring
- Post-operative services not available at lower level of care

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

STS Guidelines. AHA/ACC Practice Guidelines. CMS IPO List FY2024. ERAS Cardiac Surgery Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 001-002 (Heart Transplant/Assist, RW 25.40/14.78) CPT 33945

THORACIC SURGERY — ADDITIONAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 14-21 days Source: OPTN/UNOS Policy 6; ISHLT

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

- ICU: Immediate post-op (≥ 24 –48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4–6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1–2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1–2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6–14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

THYMECTOMY (MYASTHENIA GRAVIS / THYMOMA)

ICD-10-CM / ICD-10-PCS / CPT: G70.00 (myasthenia gravis without acute exacerbation), G70.01 (with acute exacerbation), C37 (malignant neoplasm of thymus), D15.0 (benign neoplasm of thymus), D38.4 (neoplasm of uncertain behavior of thymus) ICD-10-PCS: 07T20ZZ (resection of thymus, open), 07T24ZZ (thoroscopic) CPT: 60520 (thymectomy partial/total, transcervical), 60521 (thymectomy partial/total, sternal split), 60522 (thymectomy partial/total, thoroscopic)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- thymoma requiring resection regardless of MG status (all thymomas are potentially malignant)
- OR generalized myasthenia gravis (non-thymomatous) in appropriate surgical candidate per MGTX trial criteria (age 18-65)
- anti-AChR antibody positive
- MGFA Class II-IV
- disease duration <5 years)
- OR refractory MG on maximal medical therapy

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

- Thoracic surgical procedure requiring post-operative inpatient recovery
- Chest tube management with ongoing air leak or drainage monitoring
- Post-operative ICU or step-down monitoring as clinically indicated
- Pain management (epidural, PCA, or multimodal) beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Diagnostic VATS biopsy that can be done as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Chest tube with ongoing air leak or drainage >200mL/day

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Chest tubes removed or output <100mL/24h with no air leak

E. EVIDENCE SOURCES

NCCN Guidelines (if oncologic). STS Guidelines. ERAS Thoracic Surgery.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 163-165 (Major Chest Procedures, RW 4.71/2.60/1.81) CPT 60520-60522 LOS 2-5 days (VATS) to 5-7 (sternotomy)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: AATS Thymic Disease Consensus; STS GTD

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.

DECORTICATION / PLEURECTOMY

ICD-10-CM / ICD-10-PCS / CPT: J86.0 (pyothorax with fistula), J86.9 (pyothorax without fistula — empyema), J91.0 (malignant pleural effusion), J94.0 (chylous effusion), J94.1 (fibrothorax), J93.0 (spontaneous tension pneumothorax) ICD-10-PCS: 0BNP0ZZ (release right pleura, open), 0BNQ0ZZ (release left pleura) CPT: 32220 (decortication pulmonary), 32320 (decortication/parietal pleurectomy), 32651 (thoracoscopy with pleurodesis)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- organized empyema (Stage III) not draining with chest tube/fibrinolytics
- trapped lung with symptomatic pleural thickening
- recurrent malignant pleural effusion for pleurodesis/pleurectomy
- recurrent pneumothorax for pleurectomy

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

- Thoracic surgical procedure requiring post-operative inpatient recovery
- Chest tube management with ongoing air leak or drainage monitoring
- Post-operative ICU or step-down monitoring as clinically indicated
- Pain management (epidural, PCA, or multimodal) beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Diagnostic VATS biopsy that can be done as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Chest tube with ongoing air leak or drainage >200mL/day

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Chest tubes removed or output < 100 mL/24h with no air leak

E. EVIDENCE SOURCES

NCCN Guidelines (if oncologic). STS Guidelines. ERAS Thoracic Surgery.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 163-165 (Major Chest Procedures) CPT 32220, 32320, 32651

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: STS GTD; ATS Pleural Disease

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.

MEDIASTINAL MASS / TUMOR RESECTION

ICD-10-CM / ICD-10-PCS / CPT: C38.1 (malignant neoplasm of anterior mediastinum), C38.2 (posterior mediastinum), C38.3 (mediastinum unspecified), D15.2 (benign neoplasm of mediastinum), D38.3 (neoplasm of uncertain behavior of mediastinum) ICD-10-PCS: 0WT30ZZ (resection of mediastinum), 0WB30ZZ (excision) CPT: 39220 (resection of mediastinal tumor)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- anterior mediastinal mass (thymoma)
- teratoma
- lymphoma

- thyroid)
- posterior mediastinal mass (neurogenic tumor
- esophageal duplication)
- symptomatic (SVC syndrome
- airway compression
- dysphagia)
- OR tissue diagnosis needed and biopsy insufficient

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

- Thoracic surgical procedure requiring post-operative inpatient recovery
- Chest tube management with ongoing air leak or drainage monitoring
- Post-operative ICU or step-down monitoring as clinically indicated
- Pain management (epidural, PCA, or multimodal) beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Diagnostic VATS biopsy that can be done as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Chest tube with ongoing air leak or drainage $>200\text{mL/day}$

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile $\geq 24\text{h}$
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Chest tubes removed or output $<100\text{mL}/24\text{h}$ with no air leak

E. EVIDENCE SOURCES

NCCN Guidelines (if oncologic). STS Guidelines. ERAS Thoracic Surgery.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 163-165 (Major Chest Procedures) CPT 39220

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: STS GTD; NCCN Mediastinal Tumors

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.

TRACHEAL RESECTION / RECONSTRUCTION

ICD-10-CM / ICD-10-PCS / CPT: J39.8 (other specified diseases of upper respiratory tract), C33 (malignant neoplasm of trachea), D14.0 (benign neoplasm of trachea), D38.1 (neoplasm of uncertain behavior of trachea), J95.03 (tracheal stenosis due to tracheostomy), Q32.1 (congenital tracheal stenosis) ICD-10-PCS: 0B110ZZ (resection of trachea, open), 0BB10ZZ (excision of trachea) CPT: 31780 (tracheal resection with anastomosis), 31781 (tracheal resection with graft)

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

SEVERITY OF ILLNESS (SI) — ALL:

- symptomatic tracheal stenosis (>50% luminal narrowing) or tracheal tumor
- failed conservative management (dilation/stenting for benign)
- surgically resectable (\leq 50% of tracheal length)
- evaluated at center with tracheal surgery expertise

INTENSITY OF SERVICE (IS) — Must meet \geq 1:

- Thoracic surgical procedure requiring post-operative inpatient recovery
- Chest tube management with ongoing air leak or drainage monitoring
- Post-operative ICU or step-down monitoring as clinically indicated
- Pain management (epidural, PCA, or multimodal) beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Diagnostic VATS biopsy that can be done as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Chest tube with ongoing air leak or drainage >200mL/day

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile \geq 24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge

- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Chest tubes removed or output <100mL/24h with no air leak

E. EVIDENCE SOURCES

NCCN Guidelines (if oncologic). STS Guidelines. ERAS Thoracic Surgery.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 163-165 (Major Chest Procedures) CPT 31780-31781 LOS 5-10 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: STS GTD; AATS Tracheal Surgery

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.

CHEST WALL RESECTION / RECONSTRUCTION

ICD-10-CM / ICD-10-PCS / CPT: C41.3 (malignant neoplasm of rib, sternum, clavicle), C49.3 (malignant neoplasm of connective tissue of thorax), C79.51 (secondary malignant neoplasm of bone) ICD-10-PCS: 0PB10ZZ (excision of sternum), 0PT10ZZ (resection of sternum), 0PP10xx (reposition of rib) CPT: 21600-21615 (excision of rib), 21620-21632 (sternal reconstruction)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- primary chest wall tumor (chondrosarcoma)
- Ewing
- Askin)
- metastatic disease to chest wall/rib requiring resection
- full-thickness chest wall defect requiring reconstruction
- radiation necrosis of chest wall

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

- Thoracic surgical procedure requiring post-operative inpatient recovery
- Chest tube management with ongoing air leak or drainage monitoring
- Post-operative ICU or step-down monitoring as clinically indicated

- Pain management (epidural, PCA, or multimodal) beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Diagnostic VATS biopsy that can be done as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Chest tube with ongoing air leak or drainage >200mL/day

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Chest tubes removed or output <100mL/24h with no air leak

E. EVIDENCE SOURCES

NCCN Guidelines (if oncologic). STS Guidelines. ERAS Thoracic Surgery.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 163-165 (Major Chest Procedures) CPT 21600-21632

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: STS GTD

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.

DIAPHRAGM REPAIR / PLICATION

ICD-10-CM / ICD-10-PCS / CPT: J98.6 (disorders of diaphragm), Q79.0 (congenital diaphragmatic hernia), Q79.1 (other congenital malformations of diaphragm), K44.0 (diaphragmatic hernia with obstruction), K44.1 (diaphragmatic hernia with gangrene), S27.800A (traumatic diaphragm injury) ICD-10-PCS: 0BQS0ZZ (repair diaphragm, open), 0BTS0ZZ (resection of diaphragm) CPT: 39501 (repair diaphragmatic hernia), 39540 (repair diaphragmatic hernia, abdominal approach), 39545 (plication of diaphragm for eventration)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- traumatic diaphragm rupture (surgical emergency)
- symptomatic eventration or paralysis with respiratory compromise (FVC drop $>25\%$ supine vs upright)
- congenital diaphragmatic hernia in neonate (already in NICU policy)
- paraesophageal hernia with obstruction or gangrene

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

- Thoracic surgical procedure requiring post-operative inpatient recovery
- Chest tube management with ongoing air leak or drainage monitoring
- Post-operative ICU or step-down monitoring as clinically indicated
- Pain management (epidural, PCA, or multimodal) beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Diagnostic VATS biopsy that can be done as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Chest tube with ongoing air leak or drainage $>200\text{mL/day}$

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile $\geq 24\text{h}$
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Chest tubes removed or output $<100\text{mL/24h}$ with no air leak

E. EVIDENCE SOURCES

NCCN Guidelines (if oncologic). STS Guidelines. ERAS Thoracic Surgery.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 163-165 (Major Chest Procedures) or DRG 326-328 (if abdominal approach) CPT 39501-39545

GYNECOLOGIC SURGERY — ADDITIONAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: STS GTD

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.

RADICAL VULVECTOMY

ICD-10-CM / ICD-10-PCS / CPT: C51.0 (malignant neoplasm of labium majus), C51.1 (labium minus), C51.2 (clitoris), C51.8 (overlapping sites of vulva), C51.9 (vulva unspecified) CPT: 56630 (vulvectomy radical partial), 56631 (with inguinofemoral lymphadenectomy unilateral), 56632 (bilateral), 56633 (vulvectomy radical complete), 56634 (with inguinofemoral lymphadenectomy unilateral), 56637 (bilateral)

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

SEVERITY OF ILLNESS (SI) — ALL:

- biopsy-confirmed vulvar squamous cell carcinoma (or melanoma) requiring radical surgical excision per NCCN staging
- \geq T1b or any node-positive
- includes inguinofemoral lymphadenectomy when indicated

INTENSITY OF SERVICE (IS) — Must meet \geq 1:

- Surgical procedure requiring post-operative inpatient recovery \geq 2 midnights
- Post-operative monitoring: hemodynamics, wound/drain management, pain control
- Post-operative services not available at outpatient level

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (if peritoneal/GI surgery)

E. EVIDENCE SOURCES

ACOG Practice Bulletins. SGO Guidelines. NCCN Gynecologic Oncology. ERAS Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 740-742 (Uterine/Adnexa for Malignancy, RW 3.13/1.95/1.32) CPT 56630-56637 LOS 3-7 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: SGO/NCCN Vulvar Cancer

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.

RADICAL TRACHELECTOMY (CERVICAL CANCER — FERTILITY-SPARING)

ICD-10-CM / ICD-10-PCS / CPT: C53.0 (malignant neoplasm of endocervix), C53.1 (exocervix), C53.8 (overlapping sites), C53.9 (cervix unspecified) CPT: 57531 (radical trachelectomy), 57540 (radical trachelectomy abdominal with pelvic lymphadenectomy)

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

SEVERITY OF ILLNESS (SI) — ALL:

- biopsy-confirmed early-stage cervical cancer (Stage IA2-IB1)
- tumor ≤ 2 cm)
- desire for fertility preservation
- no lymphovascular space invasion on biopsy
- negative pelvic lymph nodes on sentinel node or full lymphadenectomy
- evaluated by gynecologic oncologist at high-volume center

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative monitoring: hemodynamics, wound/drain management, pain control

- Post-operative services not available at outpatient level

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (if peritoneal/GI surgery)

E. EVIDENCE SOURCES

ACOG Practice Bulletins. SGO Guidelines. NCCN Gynecologic Oncology. ERAS Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 740-742 (Uterine/Adnexa for Malignancy) CPT 57531, 57540 LOS 2-4 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: SGO/NCCN Cervical Cancer

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.

SACROCOLPOPEXY (PELVIC ORGAN PROLAPSE — COMPLEX/OPEN)

ICD-10-CM / ICD-10-PCS / CPT: N81.0 (urethrocele), N81.10 (cystocele unspecified), N81.11 (cystocele midline), N81.12 (cystocele

lateral), N81.2 (incomplete uterovaginal prolapse), N81.3 (complete uterovaginal prolapse), N81.4 (uterovaginal prolapse unspecified), N81.5 (vaginal enterocele), N81.6 (rectocele) ICD-10-PCS: 0U510ZZ (reposition vagina), 0UB90ZZ (excision of uterus if concurrent hysterectomy) CPT: 57425 (laparoscopic colpopexy/suspension), 57280 (colpopexy abdominal), 57283 (sacrospinous vaginal vault fixation)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- symptomatic pelvic organ prolapse (POP-Q Stage III-IV)
- failed or not candidate for pessary management
- failed prior prolapse repair
- significant impact on quality of life (urinary retention)
- defecatory dysfunction
- erosion of prolapsed tissue)

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative monitoring: hemodynamics, wound/drain management, pain control
- Post-operative services not available at outpatient level

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (if peritoneal/GI surgery)

E. EVIDENCE SOURCES

ACOG Practice Bulletins. SGO Guidelines. NCCN Gynecologic Oncology. ERAS Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 743-745 (Uterine/Adnexa Non-Malignancy, RW 1.77/1.17/0.85) CPT 57280, 57425, 57283 Note: laparoscopic sacrocolpopexy increasingly outpatient; inpatient if open, complex, or combined procedures

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days open; 1-2 days laparoscopic/robotic Source: AUGS/ACOG Pelvic Organ Prolapse Practice Bulletin 214

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.

OVARIAN DEBULKING / CYTOREDUCTION FOR PERITONEAL CARCINOMATOSIS

ICD-10-CM / ICD-10-PCS / CPT: C56.1 (malignant neoplasm of right ovary), C56.2 (left), C56.9 (unspecified), C48.1 (malignant neoplasm of peritoneum specified parts), C48.2 (peritoneum unspecified), C78.6 (secondary malignant neoplasm of retroperitoneum and peritoneum) CPT: 58950-58956 (initial surgical staging/debulking), 58957-58958 (resection of recurrent ovarian carcinoma), 49000 (exploratory laparotomy)

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

SEVERITY OF ILLNESS (SI) — ALL:

- advanced epithelial ovarian cancer (Stage IIIC-IV)
- goal of optimal cytoreduction (residual disease <1cm)
- multidisciplinary tumor board recommendation
- patient fit for major surgery (ECOG 0-2)
- neoadjuvant chemotherapy completed if interval debulking

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative monitoring: hemodynamics, wound/drain management, pain control
- Post-operative services not available at outpatient level

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (if peritoneal/GI surgery)

E. EVIDENCE SOURCES

ACOG Practice Bulletins. SGO Guidelines. NCCN Gynecologic Oncology. ERAS Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 734-735 (Pelvic Exenteration/Radical Hysterectomy, RW 3.97/2.23) or DRG 740-742 (Uterine/Adnexa Malignancy) CPT 58950-58958 LOS 5-10 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: SGO/NCCN Ovarian Cancer 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.

HIPEC (HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY)

ICD-10-CM / ICD-10-PCS / CPT: C48.1 (malignant neoplasm of peritoneum), C48.2 (peritoneum unspecified), C56.x (ovarian cancer), C18.x (colon cancer with peritoneal spread), C78.6 (secondary malignant neoplasm of peritoneum) CPT: 96446 (chemotherapy administration into peritoneal cavity via indwelling port/catheter), 49000 (exploratory laparotomy), 58957 (cytoreduction)

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

SEVERITY OF ILLNESS (SI) — ALL:

- peritoneal carcinomatosis from appendiceal
- colorectal
- ovarian
- or mesothelioma origin; cytoreductive surgery (CRS) achieving completeness of cytoreduction score (CC-0 or CC-1); administered at

HIPEC-experienced center; patient fit for 8-12 hour combined surgery; multidisciplinary tumor board approval

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

- Surgical procedure requiring post-operative inpatient recovery ≥ 2 midnights
- Post-operative monitoring: hemodynamics, wound/drain management, pain control
- Post-operative services not available at outpatient level

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (if peritoneal/GI surgery)

E. EVIDENCE SOURCES

ACOG Practice Bulletins. SGO Guidelines. NCCN Gynecologic Oncology. ERAS Society.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 329-331 (Major Bowel Procedures) or DRG 734-735 (if gynecologic primary) CPT 96446 + cytoreduction codes Rev 0335 (Chemotherapy), 0360 (OR) LOS 7-14 days Total cost \$50K-100K

UROLOGIC SURGERY — ADDITIONAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-10 days Source: ASPSM HIPEC Consensus

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 \rightarrow 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.

PARTIAL CYSTECTOMY

ICD-10-CM / ICD-10-PCS / CPT: C67.0 (trigone), C67.1 (dome), C67.2 (lateral wall), C67.3 (anterior wall), C67.4 (posterior wall), C67.5 (bladder neck), C67.8 (overlapping), C67.9 (unspecified) CPT: 51550 (partial cystectomy simple), 51555 (partial cystectomy complicated), 51565 (partial cystectomy with reimplantation of ureter)

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

SEVERITY OF ILLNESS (SI) — ALL:

- muscle-invasive bladder cancer limited to dome or mobile segment amenable to partial resection with ≥ 2 cm margins
- negative random biopsies of remaining bladder
- no CIS
- adequate remaining bladder capacity expected

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

- Surgical procedure requiring post-operative inpatient recovery
- Urinary catheter/stent management, drain monitoring
- Post-operative monitoring beyond outpatient/observation capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

AUA/SUO Guidelines. NCCN Genitourinary Oncology. EAU Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 656-658 (Kidney/Ureter Procedures for Neoplasm, RW 2.82/1.80/1.32) CPT 51550-51565

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: AUA Bladder Cancer 2024

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.

URETERAL REIMPLANTATION (COMPLEX)

ICD-10-CM / ICD-10-PCS / CPT: N13.1 (hydronephrosis with ureteral stricture), N28.82 (megaloureter), Q62.0 (congenital hydronephrosis), Q62.2 (congenital megaloureter), Q62.31 (congenital ureterocele, orthotopic), N13.5 (ureteral kinking/stricture without hydronephrosis) CPT: 50780 (ureteroneocystostomy), 50782 (with vesico-psoas hitch), 50783 (with Boari flap)

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

SEVERITY OF ILLNESS (SI) — ALL:

- ureteral stricture or injury requiring surgical reimplantation
- congenital anomaly with recurrent UTI or renal function compromise
- iatrogenic ureteral injury (post-surgical)
- vesicoureteral reflux refractory to endoscopic treatment

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

- Surgical procedure requiring post-operative inpatient recovery
- Urinary catheter/stent management, drain monitoring
- Post-operative monitoring beyond outpatient/observation capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

AUA/SUO Guidelines. NCCN Genitourinary Oncology. EAU Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 673-675 (Other Kidney/Urinary Tract Procedures, RW 2.69/1.64/1.11) CPT 50780-50783

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days Source: AUA Reconstructive Urology

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.

PENECTOMY (PARTIAL / TOTAL FOR PENILE CANCER)

ICD-10-CM / ICD-10-PCS / CPT: C60.0 (malignant neoplasm of prepuce), C60.1 (glans penis), C60.2 (body of penis), C60.8 (overlapping sites), C60.9 (penis unspecified) CPT: 54120 (amputation of penis partial), 54125 (amputation of penis complete), 54130 (amputation of penis radical with bilateral inguino-femoral lymphadenectomy)

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

SEVERITY OF ILLNESS (SI) — ALL:

- biopsy-confirmed penile squamous cell carcinoma requiring surgical excision per NCCN
- adequate surgical margins (≥ 2 cm for invasive disease)
- inguinal lymphadenectomy when indicated (palpable nodes or high-risk primary)

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

- Surgical procedure requiring post-operative inpatient recovery
- Urinary catheter/stent management, drain monitoring
- Post-operative monitoring beyond outpatient/observation capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

AUA/SUO Guidelines. NCCN Genitourinary Oncology. EAU Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 707-709 (Major Reproductive System Procedures, RW 2.16/1.38/0.96) CPT 54120-54130

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: AUA/NCCN Penile Cancer

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.

PYELOPLASTY (COMPLEX / REDO)

ICD-10-CM / ICD-10-PCS / CPT: Q62.11 (congenital UPJ obstruction), N13.0 (hydronephrosis with UPJ obstruction), N13.1 (with ureteral stricture) CPT: 50400 (pyeloplasty open), 50544 (laparoscopic pyeloplasty)

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

SEVERITY OF ILLNESS (SI) — ALL:

- symptomatic ureteropelvic junction (UPJ) obstruction confirmed by diuretic renogram (T1/2 >20 min)
- recurrent infections
- progressive renal function decline
- failed prior endoscopic management or redo after prior pyeloplasty

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

- Surgical procedure requiring post-operative inpatient recovery
- Urinary catheter/stent management, drain monitoring
- Post-operative monitoring beyond outpatient/observation capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

AUA/SUO Guidelines. NCCN Genitourinary Oncology. EAU Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 673-675 (Other Kidney/Urinary Tract Procedures) CPT 50400, 50544 Note: primary laparoscopic pyeloplasty often outpatient; inpatient if open, redo, or complex

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days open; 1-2 days robotic Source: AUA UPJ Obstruction

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.

RETROPERITONEAL TUMOR RESECTION (NON-RPLND)

ICD-10-CM / ICD-10-PCS / CPT: C48.0 (malignant neoplasm of retroperitoneum), C49.4 (connective tissue of abdomen), D48.3 (neoplasm of uncertain behavior of retroperitoneum) CPT: 49203 (excision retroperitoneal tumor <5cm), 49205 (5-10cm), 49215 (>10cm)

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

SEVERITY OF ILLNESS (SI) — ALL:

- retroperitoneal tumor requiring surgical excision (liposarcoma)
- leiomyosarcoma
- other soft tissue sarcoma)
- imaging confirms resectable disease
- multidisciplinary tumor board recommendation

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

- Surgical procedure requiring post-operative inpatient recovery
- Urinary catheter/stent management, drain monitoring
- Post-operative monitoring beyond outpatient/observation capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

AUA/SUO Guidelines. NCCN Genitourinary Oncology. EAU Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 820-822 (Other OR Procedures for Multiple Significant Conditions) or DRG 957 (Other OR Procedures) CPT 49203-49215 LOS 5-10 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days open; 2-3 days robotic Source: AUA/NCCN Testicular Cancer

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 \rightarrow 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.

URINARY DIVERSION REVISION

ICD-10-CM / ICD-10-PCS / CPT: N99.520 (infection of ileal conduit), N99.538 (other complication of continent stoma of urinary tract), T83.098A (other mechanical complication of urinary catheter), Z93.6 (other artificial openings of urinary tract status) CPT: 50830 (urinary undiversion), 51580 (cystectomy complete with continent diversion), 50820 (construction of ileal conduit)

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

SEVERITY OF ILLNESS (SI) — ALL:

- failed or complicated prior urinary diversion (stricture)
- stomal stenosis
- recurrent infection
- metabolic complications
- renal function decline
- requires surgical revision or conversion to different diversion type

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

- Surgical procedure requiring post-operative inpatient recovery
- Urinary catheter/stent management, drain monitoring
- Post-operative monitoring beyond outpatient/observation capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

E. EVIDENCE SOURCES

AUA/SUO Guidelines. NCCN Genitourinary Oncology. EAU Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 656-658 (Kidney/Ureter Procedures) CPT 50820, 50830, 51580

GI / HEPATOBILIARY SURGERY — ADDITIONAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: AUA Bladder Cancer 2024

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.

BILE DUCT RESECTION / RECONSTRUCTION (KLATSKIN TUMOR / CHOLANGIOCARCINOMA)

ICD-10-CM / ICD-10-PCS / CPT: C22.1 (intrahepatic bile duct carcinoma), C24.0 (extrahepatic bile duct), C24.1 (ampulla of Vater), C24.8 (overlapping biliary), C24.9 (biliary tract unspecified) CPT: 47610 (cholecystectomy with exploration of common duct), 47711 (excision of bile duct tumor with repair), 47712 (excision with hepaticojejunostomy/Roux-en-Y)

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

SEVERITY OF ILLNESS (SI) — ALL:

- biopsy or imaging-confirmed cholangiocarcinoma (Klatskin/hilar
- distal
- or intrahepatic)
- surgically resectable per cross-sectional imaging and staging
- no distant metastasis
- adequate future liver remnant (FLR >30-40%)
- multidisciplinary tumor board

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 405-407 (Pancreas/Liver/Shunt Procedures, RW 4.87/2.77/1.79) CPT 47711-47712

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-10 days Source: AHPBA Cholangiocarcinoma; NCCN HepatoBiliary

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 \rightarrow 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.

SMALL BOWEL RESECTION (CROHN'S / ISCHEMIA / TUMOR)

ICD-10-CM / ICD-10-PCS / CPT: K50.00 (Crohn's disease of small intestine without complications), K50.011 (with rectal bleeding), K50.012 (with intestinal obstruction), K50.013 (with fistula), K50.014 (with abscess), K55.011 (focal acute ischemia of small intestine), K55.012 (diffuse), K63.1 (perforation of intestine), C17.0 (malignant neoplasm of duodenum), C17.1 (jejunum), C17.2 (ileum), C17.3 (Meckel diverticulum), C17.8 (overlapping), C17.9 (small intestine unspecified) CPT: 44120 (enterectomy resection of small intestine), 44121 (with anastomosis), 44202 (laparoscopic small bowel resection)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- Crohn's disease with stricture causing obstruction refractory to medical therapy
- acute mesenteric ischemia with non-viable bowel

- small bowel tumor requiring resection
- small bowel perforation
- enterocutaneous fistula requiring resection

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 329-331 (Major Small/Large Bowel Procedures, RW 4.44/2.23/1.42) CPT 44120-44202

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-7 days open; 3-5 days laparoscopic Source: NSQIP; ASCRS 2017

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 \rightarrow 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.

TOTAL PROCTOCOLECTOMY WITH IPAA (J-POUCH)

ICD-10-CM / ICD-10-PCS / CPT: K51.00 (ulcerative pancolitis without complications), K51.011 (with rectal bleeding), K51.012 (with intestinal obstruction), K51.013 (with fistula), K51.014 (with abscess), K51.018 (with other complication), C18.0-C18.9 (colon cancer if total colectomy), C20 (rectal cancer) CPT: 44150 (colectomy total with ileostomy), 44211 (laparoscopic total colectomy with ileostomy), 44157 (colectomy total with ileal pouch-anal anastomosis — IPAA/J-pouch), 44158 (IPAA with loop ileostomy)

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

SEVERITY OF ILLNESS (SI) — ALL:

- medically refractory ulcerative colitis (failed biologics)
- corticosteroid-dependent
- fulminant colitis/toxic megacolon
- UC with dysplasia/cancer
- FAP (familial adenomatous polyposis) requiring prophylactic colectomy

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 329-331 (Major Bowel Procedures) CPT 44150-44158, 44211 LOS 5-10 days

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.

CHOLECYSTECTOMY WITH CBD EXPLORATION (COMPLEX/CONVERTED)

ICD-10-CM / ICD-10-PCS / CPT: K80.00 (cholelithiasis with acute cholecystitis without obstruction), K80.01 (with obstruction), K80.10 (cholelithiasis with chronic cholecystitis), K80.42 (choledocholithiasis with cholecystitis without obstruction), K80.43 (with obstruction), K80.50 (choledocholithiasis without cholecystitis or obstruction), K80.51 (with obstruction), K83.1 (obstruction of bile duct) CPT: 47562 (laparoscopic cholecystectomy), 47563 (with cholangiography), 47564 (with exploration of common duct), 47610 (cholecystectomy with exploration of common duct, open)

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

SEVERITY OF ILLNESS (SI) — ≥1:

- choledocholithiasis with CBD stone not cleared by ERCP
- converted laparoscopic to open cholecystectomy due to inflammation/anatomy
- CBD injury requiring repair
- gangrenous or perforated gallbladder
- Mirizzi syndrome

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge

- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 411-413 (Cholecystectomy, RW 2.28/1.36/0.89) for cholecystectomy; DRG 405-407 if CBD reconstruction CPT 47562-47610
Note: uncomplicated laparoscopic cholecystectomy is outpatient; inpatient only if complex/converted/CBD exploration

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: SAGES Cholecystitis Guidelines

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.

RECTAL PROLAPSE REPAIR (ABDOMINAL RECTOPEXY)

ICD-10-CM / ICD-10-PCS / CPT: K62.3 (rectal prolapse), K62.2 (anal prolapse) CPT: 45400 (laparoscopic rectopexy), 45540 (abdominal rectopexy with sigmoid resection — Frykman-Goldberg), 45541 (abdominal rectopexy without resection)

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

SEVERITY OF ILLNESS (SI) — ≥ 1 :

- complete rectal prolapse (full-thickness) causing fecal incontinence
- recurrent prolapse after prior perineal repair
- symptomatic internal rectal prolapse/intussusception with obstructed defecation refractory to conservative measures

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 329-331 (Major Bowel) or DRG 393-395 (Other Digestive System OR) CPT 45400-45541

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days abdominal Source: ASCRS Rectal Prolapse Guidelines

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 \rightarrow 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.

PERFORATED VISCUS REPAIR (BOERHAAVE / PERFORATED ULCER / PERFORATION NOS)

ICD-10-CM / ICD-10-PCS / CPT: K25.1 (gastric ulcer with perforation), K25.5 (chronic gastric ulcer with perforation), K26.1 (duodenal ulcer with perforation), K26.5 (chronic duodenal ulcer with perforation), K63.1 (perforation of intestine NOS), K22.3 (perforation of esophagus — Boerhaave syndrome) CPT: 43030 (cricopharyngeal myotomy), 43405 (closure of esophageal perforation), 43840 (gastrorrhaphy — suture of perforated gastric ulcer), 44602 (closure of small bowel perforation), 44604 (closure of large bowel perforation)

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

SEVERITY OF ILLNESS (SI) — ALWAYS INPATIENT — Surgical emergency. ≥ 1 :

- pneumoperitoneum on imaging
- peritonitis on exam
- hemodynamic instability
- sepsis from peritoneal contamination

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan

- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 326-328 (Stomach/Esophageal/Duodenal Procedures, RW 5.84/2.97/1.77) or DRG 329-331 (Bowel) CPT 43405-44604 Note: Boerhaave syndrome mortality 20-40% if delayed >24h

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: WSES Perforated Peptic Ulcer Guidelines

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.

DISTAL PANCREATECTOMY WITH SPLENECTOMY

ICD-10-CM / ICD-10-PCS / CPT: C25.1 (malignant neoplasm of body of pancreas), C25.2 (tail of pancreas), C25.8 (overlapping sites), D13.7 (benign neoplasm of endocrine pancreas), D37.8 (neoplasm of uncertain behavior of other digestive organs) CPT: 48140 (pancreatectomy distal subtotal), 48145 (pancreatectomy distal subtotal with splenectomy), 48146 (pancreatectomy distal near-total), 48548 (laparoscopic distal pancreatectomy)

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

SEVERITY OF ILLNESS (SI) — ALL:

- pancreatic body/tail malignancy (adenocarcinoma)
- neuroendocrine tumor ≥2cm
- IPMN with high-risk features)
- resectable on imaging without vascular involvement (or borderline with neoadjuvant)
- adequate performance status

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 405-407 (Pancreas/Liver/Shunt Procedures, RW 4.87/2.77/1.79) CPT 48140-48548 LOS 5-7 days (laparoscopic) to 7-10 (open)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days open; 2-3 days laparoscopic Source: ACS NSQIP

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.

HIPEC — GI PRIMARY (APPENDICEAL / COLORECTAL / MESOTHELIOMA)

ICD-10-CM / ICD-10-PCS / CPT: C18.1 (malignant neoplasm of appendix), C18.0-C18.9 (colon), C45.1 (mesothelioma of peritoneum), C48.1 (malignant neoplasm of peritoneum), C78.6 (secondary malignant neoplasm of peritoneum) CPT: 96446 (intraperitoneal chemotherapy), 49000 (exploratory laparotomy), plus cytoreduction codes per organs resected

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

SEVERITY OF ILLNESS (SI) — ALL:

- peritoneal carcinomatosis from appendiceal (PMP/DPAM/PMCA)
- colorectal
- or peritoneal mesothelioma; CRS achieving CC-0 or CC-1; PCI (Peritoneal Carcinomatosis Index) within operable range per disease

type; HIPEC-experienced center; multidisciplinary tumor board

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

- Surgical procedure requiring post-operative inpatient recovery
- NPO with IV fluids/TPN during post-operative ileus recovery
- Surgical drain management, NG tube if indicated
- Post-operative monitoring for anastomotic leak, hemorrhage, sepsis

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Post-operative ileus not resolved (no flatus/BM, distension, nausea)

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Bowel function returned (flatus and/or BM)
- Tolerating regular diet without nausea/emesis

E. EVIDENCE SOURCES

ACS NSQIP. NCCN GI Oncology. ASCRS Guidelines. ERAS Colorectal/Hepatobiliary.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 329-331 (Major Bowel Procedures) CPT 96446 + organ-specific resection codes Rev 0335 (Chemotherapy), 0360 (OR) LOS 7-14 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-10 days Source: ASPSM HIPEC Consensus

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

- ICU: Post-open aortic repair (≥ 24 h 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.

ANKLE REPLACEMENT / ANKLE FUSION (ARTHRODESIS)

ICD-10-CM / ICD-10-PCS / CPT: M19.071 (primary OA right ankle), M19.072 (left ankle), M87.071 (idiopathic aseptic necrosis right ankle), M87.072 (left), T84.04xA (periprosthetic fracture around ankle prosthesis) CPT: 27700 (arthroplasty ankle), 27702 (total ankle replacement), 27870 (arthrodesis ankle, open)

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

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

- end-stage ankle arthritis (OA)
- post-traumatic
- inflammatory) with bone-on-bone changes and failed conservative therapy (≥ 6 months PT)
- injections
- bracing)
- AVN of talus
- failed prior ankle replacement requiring revision or conversion to fusion

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 469-470 (Major Joint Replacement, RW 3.37/2.15) or DRG 492-494 (Lower Extremity Procedures)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days Source: AAOS Foot & Ankle Society

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 \rightarrow 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 \rightarrow 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.

ELBOW REPLACEMENT

ICD-10-CM / ICD-10-PCS / CPT: M19.021 (primary OA right elbow), M19.022 (left), M05.x (rheumatoid arthritis), S42.201A (fracture upper end humerus right), T84.01xA (broken prosthesis of elbow joint) CPT: 24360 (arthroplasty elbow with implant), 24361 (arthroplasty elbow with distal humeral prosthetic replacement), 24363 (total elbow arthroplasty)

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

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

- severe elbow arthritis (RA)
- OA
- post-traumatic) refractory to medical/conservative management
- unreconstructable distal humerus fracture in elderly
- failed prior fixation requiring arthroplasty

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 483-484 (Major Joint Upper Extremity, RW 2.68/1.90) CPT 24360-24363

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days Source: AAOS

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 \rightarrow 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 \rightarrow 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.

SCOLIOSIS CORRECTION (COMPLEX MULTI-LEVEL POSTERIOR SPINAL FUSION)

ICD-10-CM / ICD-10-PCS / CPT: M41.00 (infantile idiopathic scoliosis), M41.20 (other idiopathic scoliosis, cervical), M41.24 (thoracic), M41.25 (thoracolumbar), M41.26 (lumbar), M41.30 (thoracogenic scoliosis), M41.40 (neuromuscular scoliosis), M41.50 (other secondary scoliosis), Q67.5 (congenital deformity of spine) CPT: 22800 (arthrodesis posterior for spinal deformity ≤ 6 segments), 22802 (7-12 segments), 22804 (>12 segments), 22840-22844 (instrumentation)

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

SEVERITY OF ILLNESS (SI) — ALL:

- progressive scoliosis with Cobb angle $\geq 40-50^\circ$ (adolescent) or $\geq 50-60^\circ$ (adult)
- documented curve progression despite bracing (if applicable)
- significant functional impairment or cardiopulmonary compromise from curve
- pre-operative planning complete (bending films)
- MRI
- pulmonary function testing)

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 459-461 (Spinal Fusion Except Cervical w Spinal Curvature/Malignancy, RW 8.43/5.25/4.03) CPT 22800-22804, 22840-22844
LOS 5-7 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: Scoliosis Research Society Outcomes

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

BONE TUMOR RESECTION / LIMB SALVAGE WITH ENDOPROSTHESIS

ICD-10-CM / ICD-10-PCS / CPT: C40.00 (malignant neoplasm of scapula/long bones upper limb), C40.10 (short bones upper limb), C40.20 (long bones lower limb), C40.30 (short bones lower limb), C40.80 (overlapping sites), C40.90 (unspecified), C41.2 (vertebral column), C41.4 (pelvic bones), D16.00 (benign neoplasm of scapula/long bones upper limb), D48.0 (neoplasm of uncertain behavior of bone) CPT: 27365 (radical resection of tumor, femur or knee), 27645 (radical resection of tumor, tibia), 23220 (radical resection of tumor, proximal humerus), 27077 (radical resection of tumor, innominate bone) + endoprosthesis: 27132 (conversion to total hip), 27447 (total knee)

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

SEVERITY OF ILLNESS (SI) — ALL:

- primary malignant bone tumor (osteosarcoma
- Ewing sarcoma
- chondrosarcoma) requiring wide excision
- neoadjuvant chemotherapy completed (if indicated per NCCN)
- limb salvage feasible with adequate margins and endoprosthetic reconstruction
- orthopedic oncology evaluation

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge

- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 480-482 (Hip/Femur Procedures, RW 2.84/1.89/1.47) or DRG 492-494 (Lower Extremity) CPT varies by site LOS 5-10 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: MSTs/ISOLS Limb Salvage Outcomes; NCCN Bone Cancer

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 \rightarrow 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 \rightarrow 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.

TIBIAL PLATEAU FRACTURE ORIF

ICD-10-CM / ICD-10-PCS / CPT: S82.101A (unspecified fracture upper end right tibia initial), S82.102A (left), S82.109A (unspecified),

S82.111A (fracture of right tibial spine), S82.121A (fracture of lateral condyle right tibia), S82.122A (left), S82.131A (fracture of medial condyle right tibia), S82.132A (left), S82.141A (bicondylar fracture right tibia), S82.142A (left), S82.191A (other fracture of upper end right tibia), S82.192A (left) CPT: 27535 (ORIF tibial fracture proximal), 27536 (ORIF tibial fracture proximal bicondylar)

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

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

- displaced tibial plateau fracture (Schatzker III-VI) with ≥ 2 mm articular step-off
- bicondylar fracture
- fracture with vascular injury
- open fracture
- compartment syndrome

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 492-494 (Lower Extremity, RW 2.42/1.43/0.98) CPT 27535-27536

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-4 days Source: OTA Tibial Plateau Guidelines

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 \rightarrow 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.

DISTAL FEMUR FRACTURE ORIF

ICD-10-CM / ICD-10-PCS / CPT: S72.401A (unspecified fracture lower end right femur initial), S72.402A (left), S72.411A (displaced unspecified condyle fracture right femur), S72.412A (left), S72.421A (displaced fracture of lateral condyle right femur), S72.422A (left), S72.431A (displaced fracture of medial condyle right femur), S72.432A (left), S72.441A (displaced fracture of lower epiphysis right femur), S72.442A (left), S72.451A (displaced supracondylar fracture right femur without intercondylar extension), S72.452A (left), S72.461A (displaced supracondylar fracture right femur with intercondylar extension), S72.462A (left) CPT: 27511 (ORIF distal femur fracture), 27513 (ORIF distal femur fracture intercondylar), 27514 (ORIF distal femur fracture with prosthetic replacement)

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

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

- displaced distal femur fracture requiring operative fixation
- intra-articular fracture with step-off ≥ 2 mm
- periprosthetic fracture
- open fracture
- vascular compromise

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge

- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 480-482 (Hip/Femur Procedures, RW 2.84/1.89/1.47) CPT 27511-27514

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: OTA Distal Femur

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.

CALCANEUS FRACTURE ORIF

ICD-10-CM / ICD-10-PCS / CPT: S92.001A (unspecified fracture of right calcaneus initial), S92.002A (left), S92.011A (displaced fracture body right calcaneus), S92.012A (left), S92.021A (displaced fracture anterior process right calcaneus), S92.031A (displaced fracture tuberosity right calcaneus), S92.041A (other fracture tuberosity right calcaneus), S92.051A (other extraarticular fracture right calcaneus), S92.061A (intraarticular fracture right calcaneus) CPT: 28415 (ORIF calcaneus, open treatment), 28420 (ORIF calcaneus, open treatment with bone graft)

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

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

- displaced intraarticular calcaneus fracture (Sanders Type II-IV) with ≥2mm articular depression
- bilateral calcaneus fractures
- open calcaneus fracture
- fracture with compartment syndrome of foot

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 492-494 (Lower Extremity Procedures) CPT 28415-28420 Note: many calcaneus fractures managed non-operatively; ORIF only for displaced intraarticular

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-3 days Source: OTA Calcaneus

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 \rightarrow 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 \rightarrow 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.

MULTIPLE LONG BONE FRACTURE FIXATION (POLYTRAUMA)

ICD-10-CM / ICD-10-PCS / CPT: S72.301A-S72.399A (femoral shaft fractures), S82.101A-S82.199A (tibial plateau), S82.201A-S82.299A (tibial shaft), S42.201A-S42.299A (humeral fractures), S52.001A-S52.099A (ulna/radius fractures), T07 (unspecified multiple injuries) CPT: 27506-27514 (femur ORIF), 27535-27536 (tibia ORIF), 24515-24516 (humerus ORIF), plus applicable fixation codes

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

SEVERITY OF ILLNESS (SI) — ALWAYS INPATIENT:

- polytrauma with ≥ 2 long bone fractures requiring operative fixation
- ISS (Injury Severity Score) typically ≥ 16
- hemodynamic assessment for damage control orthopedics vs definitive fixation

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 480-482 (Hip/Femur), DRG 492-494 (Lower Extremity), DRG 957 (Other OR for Multiple Significant Trauma) Multiple CPT codes per fractures treated Rev 0200 (ICU if unstable), 0360 (OR — may require multiple OR trips), 0390 (Blood)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-10 days Source: OTA Polytrauma; EAST Polytrauma

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 \rightarrow 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.

SPINAL CORD STIMULATOR IMPLANTATION

ICD-10-CM / ICD-10-PCS / CPT: G89.4 (chronic pain syndrome), G89.29 (other chronic pain), M54.5 (low back pain), G57.x (mononeuropathies of lower limb), G90.50 (complex regional pain syndrome I) CPT: 63650 (percutaneous implantation of neurostimulator electrode), 63655 (laminectomy for implantation of electrode), 63685 (insertion of pulse generator)

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

SEVERITY OF ILLNESS (SI) — ALL:

- chronic intractable pain (≥ 6 months) refractory to conservative management (PT medications injections)
- successful spinal cord stimulator trial ($\geq 50\%$ pain reduction during trial period per CMS/payer requirements)
- psychological evaluation completed
- no contraindication to implant

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level

- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 029-030 (Spinal Procedures w CC/MCC or w/o, RW 2.57/1.79) CPT 63650-63685 Note: trial is outpatient; permanent implant may be outpatient or inpatient depending on patient factors

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: NANS/NACC Neuromodulation Appropriateness Consensus

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.

WRIST FUSION / TOTAL WRIST ARTHROPLASTY

ICD-10-CM / ICD-10-PCS / CPT: M19.031 (primary OA right wrist), M19.032 (left), M12.531 (traumatic arthropathy right wrist), M12.532 (left), M05.x (rheumatoid arthritis affecting wrist) CPT: 25800 (arthrodesis wrist complete without bone graft), 25805 (with bone graft), 25810 (arthrodesis wrist with sliding graft), 25446 (arthroplasty wrist with prosthetic replacement)

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

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

- end-stage wrist arthritis (SLAC/SNAC wrist)
- RA
- post-traumatic) with bone-on-bone changes refractory to conservative management
- scapholunate advanced collapse
- failed prior limited fusion
- Kienbock disease (Stage IIIB-IV)

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability

- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 483-484 (Major Joint Upper Extremity, RW 2.68/1.90) CPT 25446-25810 Note: many wrist procedures are outpatient; inpatient if total wrist arthroplasty or complex reconstruction

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: ASSH Wrist Guidelines

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

SACROILIAC JOINT FUSION

ICD-10-CM / ICD-10-PCS / CPT: M46.1 (sacroiliitis NEC), M53.3 (sacrococcygeal disorders NEC), S33.2xxA (dislocation of sacroiliac joint), S32.10xA (fracture of sacrum) CPT: 27279 (arthrodesis sacroiliac joint, percutaneous/minimally invasive), 27280 (arthrodesis sacroiliac joint, open)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL:

- SI joint dysfunction confirmed by ≥ 3 provocative tests AND diagnostic SI joint injection with $\geq 75\%$ pain relief
- failed conservative management (≥ 6 months PT medications injections)
- pre-operative imaging confirms SI joint pathology

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative mobilization with PT/OT requiring inpatient setting
- Pain management requiring IV/PCA beyond outpatient capability
- Neurovascular monitoring post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Weight-bearing status established and patient ambulatory with appropriate assistive device

E. EVIDENCE SOURCES

AAOS Clinical Practice Guidelines. OTA Fracture Classification. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 459-461 (Spinal Fusion with Curvature/Malignancy) or DRG 456-458 (Spinal Fusion Except Cervical) CPT 27279-27280 Note: percutaneous SI fusion increasingly outpatient; inpatient if open or complex

NEUROSURGERY — ADDITIONAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: ISASS SI Fusion Consensus

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.

EPILEPSY SURGERY (TEMPORAL LOBECTOMY / CORPUS CALLOSOTOMY / HEMISPHERECTOMY)

ICD-10-CM / ICD-10-PCS / CPT: G40.101 (localization-related epilepsy with complex partial seizures, intractable with status epilepticus), G40.109 (without status), G40.111 (intractable with status), G40.119 (intractable without status), G40.209 (localization-related epilepsy not intractable), G40.211 (intractable with status), G40.219 (intractable without status) CPT: 61537 (craniotomy temporal lobectomy for seizure), 61538 (craniotomy frontal lobectomy for seizure), 61541 (craniotomy transection of corpus callosum), 61542 (craniotomy for hemispherectomy), 61760 (stereotactic implantation of depth electrodes)

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

SEVERITY OF ILLNESS (SI) — ALL:

- medically refractory epilepsy (failed ≥2 appropriate AEDs at therapeutic doses)
- epilepsy surgery evaluation completed (video-EEG)
- MRI epilepsy protocol
- neuropsychological testing
- PET
- SPECT
- WADA test as indicated)
- seizure focus localized and resectable
- multidisciplinary epilepsy surgery conference recommendation

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy, RW 5.75/3.61/2.59) CPT 61537-61542, 61760

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.

CHIARI DECOMPRESSION / SUBOCCIPITAL CRANIECTOMY

ICD-10-CM / ICD-10-PCS / CPT: Q07.0 (Arnold-Chiari syndrome), G93.5 (compression of brain), G95.0 (syringomyelia) CPT: 61343 (craniectomy suboccipital with cervical laminectomy for decompression of medulla and spinal cord), 61345 (craniectomy suboccipital with cervical laminectomy for decompression with dural graft)

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

SEVERITY OF ILLNESS (SI) — ALL:

- Chiari I malformation with ≥ 5 mm cerebellar tonsillar herniation on MRI
- symptomatic (occipital headache worse with Valsalva)
- dysphagia
- ataxia
- myelopathy
- syringomyelia)
- failed conservative management
- neurological symptoms progressing or syrinx expanding

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy) CPT 61343-61345 LOS 2-4 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-7 days Source: AANS/CNS

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

MICROVASCULAR DECOMPRESSION (TRIGEMINAL NEURALGIA / HEMIFACIAL SPASM)

ICD-10-CM / ICD-10-PCS / CPT: G50.0 (trigeminal neuralgia), G51.0 (Bell palsy), G51.3 (clonic hemifacial spasm), G51.8 (other disorders of facial nerve) CPT: 61458 (craniectomy suboccipital for exploration/decompression of cranial nerve), 61530 (subdural implantation of transducer)

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

SEVERITY OF ILLNESS (SI) — ALL:

- trigeminal neuralgia (Type 1 typical) refractory to medical management (carbamazepine)
- oxcarbazepine
- baclofen)
- MRI confirming neurovascular conflict
- patient fit for posterior fossa surgery
- hemifacial spasm refractory to botulinum toxin

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan

- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy) CPT 61458

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 2-4 days Source: AANS/CNS Functional Section

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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 CORD TUMOR RESECTION (INTRADURAL / INTRAMEDULLARY)

ICD-10-CM / ICD-10-PCS / CPT: C72.0 (malignant neoplasm of spinal cord), D33.4 (benign neoplasm of spinal cord), D43.4 (neoplasm of uncertain behavior of spinal cord), G95.20 (unspecified cord compression) CPT: 63275-63278 (laminectomy for excision intradural extramedullary tumor), 63280-63283 (laminectomy for excision intramedullary tumor), 63290 (combined approach for excision of intraspinal lesion)

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

SEVERITY OF ILLNESS (SI) — ALL:

- symptomatic spinal cord tumor (ependymoma
- astrocytoma
- meningioma
- schwannoma) with progressive neurological deficit (weakness
- sensory loss
- bowel/bladder dysfunction)
- imaging confirming resectable intradural lesion
- neurosurgical evaluation

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring

- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy) or DRG 029-030 (Spinal Procedures) CPT 63275-63290 LOS 3-7 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: CNS Spine Guidelines

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

ANTERIOR CERVICAL CORPECTOMY WITH RECONSTRUCTION

ICD-10-CM / ICD-10-PCS / CPT: M48.01 (spinal stenosis cervical region), M50.01 (cervical disc disorder with myelopathy, high cervical region), M50.021 (mid-cervical), M50.03 (cervicothoracic), S12.000A (unspecified fracture of first cervical vertebra), S12.100A (unspecified fracture of second cervical vertebra) CPT: 63081 (vertebral corpectomy anterior approach, cervical, single segment), 63082 (each additional segment), 22554 (arthrodesis anterior interbody cervical), 22845 (anterior instrumentation 2-3 vertebral segments)

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

SEVERITY OF ILLNESS (SI) — ALL:

- cervical myelopathy from multi-level disc disease/stenosis not amenable to ACDF
- cervical burst fracture with retropulsed fragment and cord compression
- cervical tumor requiring corpectomy
- OPLL (ossification of posterior longitudinal ligament) with cord compression

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 471-473 (Cervical Spinal Fusion, RW 3.67/2.14/1.59) CPT 63081-63082, 22554, 22845

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: NASS Cervical Spine Guidelines

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

POSTERIOR FOSSA TUMOR RESECTION

ICD-10-CM / ICD-10-PCS / CPT: C71.6 (malignant neoplasm of cerebellum), C71.7 (brain stem), D33.1 (benign neoplasm of brain infratentorial), D43.1 (neoplasm of uncertain behavior infratentorial) CPT: 61510 (craniectomy for excision of brain tumor, infratentorial), 61518 (craniectomy for excision of brain tumor, infratentorial with additional procedure), 61520 (craniectomy CPA tumor excision — acoustic neuroma)

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

SEVERITY OF ILLNESS (SI) — ALL:

- posterior fossa tumor (medulloblastoma
- acoustic neuroma
- meningioma
- hemangioblastoma
- ependymoma) symptomatic or growing
- neurosurgical evaluation confirms resectable
- pre-operative imaging (MRI with contrast) complete

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy, RW 5.75/3.61/2.59) CPT 61510-61520 LOS 5-10 days ICU post-op required

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: AANS/CNS Tumor Section

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

CEREBRAL ANEURYSM CLIPPING (OPEN SURGICAL)

ICD-10-CM / ICD-10-PCS / CPT: I67.1 (cerebral aneurysm nonruptured), I60.0-I60.9 (subarachnoid hemorrhage — if ruptured) CPT: 61697 (clipping intracranial aneurysm, complex), 61700 (clipping intracranial aneurysm, simple), 61702 (clipping intracranial aneurysm, vertebrobasilar)

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

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

- ruptured cerebral aneurysm not amenable to endovascular coiling (morphology
- location)

- unruptured aneurysm ≥ 7 mm (or ≥ 5 mm with risk factors: family history)
- prior SAH
- posterior circulation
- morphology)
- symptomatic unruptured aneurysm (mass effect)
- cranial nerve palsy)
- coil failure/recurrence requiring surgical clip

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy) CPT 61697-61702 LOS 7-14 days (ruptured) or 3-5 days (elective unruptured)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: AANS/CNS; AHA/ASA aSAH Guidelines 2023

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

AVM RESECTION

ICD-10-CM / ICD-10-PCS / CPT: Q28.2 (arteriovenous malformation of cerebral vessels), I67.1 (cerebral aneurysm if associated), I60.8 (other nontraumatic SAH — if ruptured AVM) CPT: 61680 (craniotomy for excision of AVM, supratentorial simple), 61682 (supratentorial complex), 61684 (infratentorial simple), 61686 (infratentorial complex), 61690 (dural AVM), 61692 (dural AVM complex)

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

SEVERITY OF ILLNESS (SI) — ALL:

- symptomatic cerebral AVM (hemorrhage
- seizure
- progressive neurological deficit)
- Spetzler-Martin Grade I-III (surgically accessible)
- young patient with long life expectancy
- evaluated by cerebrovascular neurosurgeon
- considered vs radiosurgery/embolization alternatives

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance
- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level

- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy) CPT 61680-61692

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-10 days Source: AANS/CNS Cerebrovascular Section

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

SKULL BASE MENINGIOMA / COMPLEX MENINGIOMA RESECTION

ICD-10-CM / ICD-10-PCS / CPT: C70.0 (malignant neoplasm of cerebral meninges), D32.0 (benign neoplasm of cerebral meninges), D42.0 (neoplasm of uncertain behavior of cerebral meninges) CPT: 61519 (craniectomy for excision meningioma, infratentorial), 61512 (craniotomy for excision meningioma, supratentorial), 61600 (resection of mucosal lesion of skull base anterior approach), 61601 (resection of neoplasm of skull base, anterior approach extradural), 61605-61608 (middle/posterior cranial fossa approach for skull base lesion)

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

SEVERITY OF ILLNESS (SI) — ALL:

- symptomatic meningioma causing mass effect
- progressive cranial nerve deficit
- growing on serial imaging
- WHO Grade II-III (atypical/malignant) requiring resection
- skull base location requiring specialized approach
- multidisciplinary skull base team evaluation

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

- Intracranial/spinal surgical procedure requiring post-operative inpatient monitoring
- Neuro checks q1-2h post-operatively (neurological status, GCS, pupil reactivity)
- ICU or step-down monitoring for hemodynamic and neurological surveillance

- Post-operative imaging (CT or MRI) to confirm surgical result and rule out complications

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Stereotactic biopsy that can be performed as outpatient/23h observation

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- New or worsening neurological deficit requiring evaluation and treatment

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Neurologically stable at or near pre-operative baseline ≥ 24 h
- Post-operative imaging satisfactory

E. EVIDENCE SOURCES

CNS/AANS Guidelines. NCCN CNS Tumors. AAN Practice Parameters.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy) CPT 61512-61608 LOS 3-7 days (convexity) to 7-14 days (skull base complex)

VASCULAR SURGERY — ADDITIONAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: NANS/CNS Tumor Section; NCCN CNS

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

THORACIC AORTIC REPAIR (OPEN — ASCENDING / ARCH / DESCENDING)

ICD-10-CM / ICD-10-PCS / CPT: I71.1 (thoracic aortic aneurysm ruptured), I71.2 (thoracic aortic aneurysm without rupture), I71.01 (dissection of thoracic aorta), I71.03 (dissection of thoracoabdominal aorta) CPT: 33860 (ascending aortic graft), 33863 (ascending aortic graft with cardiopulmonary bypass and valve conduit), 33870 (transverse aortic arch graft), 33875 (descending thoracic aorta graft with CPB)

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

SEVERITY OF ILLNESS (SI) — ALL:

- thoracic aortic aneurysm ≥ 5.5 cm (or ≥ 5.0 cm with connective tissue disorder)
- symptomatic aneurysm any size
- contained or free rupture (emergent)
- Type A aortic dissection (emergent surgical)
- Type B complicated dissection (malperfusion)
- rupture) not amenable to TEVAR

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 237-238 (Major Cardiovascular Procedures, RW 7.70/4.50) CPT 33860-33875 ICU required Deep hypothermic circulatory arrest for arch

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-10 days Source: STS/AATS; 2022 ACC/AHA Aortic Disease Guideline

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

- ICU: Post-open aortic repair (≥ 24 h 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.

THORACOABDOMINAL AORTIC ANEURYSM REPAIR

ICD-10-CM / ICD-10-PCS / CPT: I71.5 (thoracoabdominal aortic aneurysm ruptured), I71.6 (thoracoabdominal without rupture) CPT: 35091 (repair of thoracoabdominal aneurysm with graft), 35092 (ruptured thoracoabdominal aneurysm repair)

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

SEVERITY OF ILLNESS (SI) — ALL:

- thoracoabdominal aneurysm ≥ 6.0 cm (Crawford classification I-IV)
- symptomatic
- ruptured (emergent)
- not amenable to endovascular/branched repair
- evaluated by aortic surgery specialist

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 237-238 (Major Cardiovascular Procedures, RW 7.70/4.50) CPT 35091-35092 LOS 10-21 days Highest complexity vascular procedure

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-8 days open; 1-3 days EVAR Source: SVS 2018

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

- ICU: Post-open aortic repair (≥ 24 h 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.

MESENTERIC ARTERY REVASCULARIZATION

ICD-10-CM / ICD-10-PCS / CPT: K55.011 (focal acute ischemia of small intestine), K55.031 (focal acute ischemia of large intestine), K55.1 (chronic vascular disorders of intestine), I74.09 (embolism of other artery — mesenteric) CPT: 35531 (bypass graft aorta to celiac/SMA), 35631 (bypass graft iliac to mesenteric), 37220 (iliac artery revascularization)

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

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

- acute mesenteric ischemia (AMI) with peritoneal signs (surgical emergency)

- chronic mesenteric ischemia with postprandial pain and weight loss refractory to endovascular intervention
- failed endovascular treatment of mesenteric stenosis

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 252-254 (Other Vascular Procedures, RW 3.46/2.22/1.59) CPT 35531-35631

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: SVS Mesenteric Ischemia Guidelines

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

- ICU: Post-open aortic repair (≥ 24 h 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.

ARTERY BYPASS / RECONSTRUCTION

ICD-10-CM / ICD-10-PCS / CPT: I70.1 (atherosclerosis of renal artery), I77.3 (arteritis unspecified — fibromuscular dysplasia), I15.0 (renovascular hypertension) CPT: 35536 (bypass graft aorta to renal artery), 35636 (bypass graft iliac to renal artery), 35560 (bypass graft aorta to renal with autogenous vein)

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

SEVERITY OF ILLNESS (SI) — ALL:

- renovascular hypertension refractory to medical therapy AND failed endovascular intervention (angioplasty/stent)
- OR renal artery aneurysm ≥ 2 cm
- OR renal artery fibromuscular dysplasia not amenable to PTA
- OR complex atherosclerotic disease with declining renal function

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 252-254 (Other Vascular Procedures) CPT 35536-35636 Note: most renal artery disease managed endovascularly; open surgery reserved for failures

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: SVS

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

- ICU: Post-open aortic repair (≥ 24 h 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.

VENOUS THROMBECTOMY (ILIOFEMORAL)

ICD-10-CM / ICD-10-PCS / CPT: I82.401 (acute embolism/thrombosis of unspecified deep veins of right lower extremity), I82.402 (left), I82.411 (acute embolism/thrombosis of right femoral vein), I82.412 (left), I82.421 (acute embolism/thrombosis of right iliac vein), I82.422 (left) CPT: 34401 (thrombectomy with vein bypass — iliofemoral), 37187 (percutaneous transluminal mechanical thrombectomy), 37212 (transcatheter therapy, venous infusion for thrombolysis)

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

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

- acute extensive iliofemoral DVT with phlegmasia cerulea dolens (limb-threatening)
- phlegmasia alba dolens with impending venous gangrene
- massive iliofemoral DVT in young patient with low bleeding risk (consider catheter-directed thrombolysis per ATTRACT trial data)

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)

- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 252-254 (Other Vascular Procedures) CPT 34401, 37187, 37212

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: SVS/AVF Venous Thrombectomy

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

- ICU: Post-open aortic repair (≥ 24 h 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.

IVC RECONSTRUCTION / THROMBECTOMY

ICD-10-CM / ICD-10-PCS / CPT: I82.210 (acute embolism/thrombosis of IVC), I82.211 (chronic embolism/thrombosis of IVC), C64.x (renal cell carcinoma with IVC tumor thrombus), T82.818A (embolism due to vena cava device) CPT: 37192 (repositioning of IVC filter), 37193 (retrieval of IVC filter), 34401 (thrombectomy), 49329 (laparoscopic IVC thrombus removal — with tumor)

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

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

- IVC tumor thrombus extending from renal cell carcinoma requiring surgical extraction
- IVC filter complications (perforation
- migration
- caval penetration)
- IVC thrombosis causing bilateral lower extremity edema and renal failure

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 237-238 (Major Cardiovascular) or DRG 252-254 (Other Vascular) depending on approach CPT varies

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: SVS

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

- ICU: Post-open aortic repair (≥ 24 h 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.

AORTOBIFEMORAL BYPASS

ICD-10-CM / ICD-10-PCS / CPT: I70.0 (atherosclerosis of aorta), I70.201 (atherosclerosis of native arteries of extremities, unspecified), I74.09 (embolism/thrombosis of abdominal aorta) CPT: 35546 (bypass graft aortobifemoral), 35646 (bypass graft aortobifemoral with prosthetic)

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

SEVERITY OF ILLNESS (SI) — ALL:

- aortoiliac occlusive disease (Leriche syndrome or TASC II C/D lesions)
- critical limb ischemia (CLI) or severe lifestyle-limiting claudication (Rutherford 3-6)
- failed or not amenable to endovascular intervention
- adequate cardiac/pulmonary risk for major surgery

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria

- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 237-238 (Major Cardiovascular Procedures, RW 7.70/4.50) CPT 35546-35646 LOS 7-10 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: SVS PAD

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

- ICU: Post-open aortic repair (≥ 24 h 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.

DIALYSIS ACCESS SURGERY (AV FISTULA/GRAFT — WHEN INPATIENT)

ICD-10-CM / ICD-10-PCS / CPT: N18.6 (end-stage renal disease), Z99.2 (dependence on renal dialysis), T82.41xA (breakdown of vascular dialysis catheter), T82.49xA (other complication of vascular dialysis catheter) CPT: 36818-36821 (arteriovenous fistula creation), 36825-36830 (arteriovenous graft), 36831 (thrombectomy of AV fistula/graft), 36833 (revision of AV fistula/graft)

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

SEVERITY OF ILLNESS (SI) — Must meet ≥ 1 for INPATIENT (most dialysis access is outpatient):

- complicated access creation in patient already admitted for other indication
- access thrombectomy/revision in patient with hemodynamic instability
- infected dialysis graft requiring excision AND new access creation
- dialysis access surgery in patient requiring post-operative monitoring for cardiac or bleeding risk

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

- Vascular surgical procedure requiring post-operative inpatient recovery
- Post-operative pulse/vascular checks (Doppler ABI, pulse assessment q4h)
- Anticoagulation management post-operatively
- ICU monitoring for major aortic/thoracic procedures

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge

- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Graft/anastomosis patency confirmed by clinical exam or Doppler

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Pulses/perfusion documented at baseline post-op level

E. EVIDENCE SOURCES

SVS Clinical Practice Guidelines. AHA/ACC Peripheral Arterial Disease. ESVS.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 673-675 (Other Kidney/Urinary Tract, RW 2.69/1.64/1.11) CPT 36818-36833 NOTE: Uncomplicated AV fistula/graft creation is OUTPATIENT. Inpatient only with documented medical justification.

ENT / HEAD & NECK SURGERY — ADDITIONAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days when inpatient Source: KDOQI Vascular Access Guidelines 2019; SVS

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

- ICU: Post-open aortic repair (≥ 24 h 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

PAROTIDECTOMY (TOTAL WITH FACIAL NERVE DISSECTION)

ICD-10-CM / ICD-10-PCS / CPT: C07 (malignant neoplasm of parotid gland), D11.0 (benign neoplasm of parotid gland), D37.030 (neoplasm of uncertain behavior of parotid gland) CPT: 42410 (excision of parotid tumor lateral lobe without nerve dissection), 42415 (excision of parotid tumor lateral lobe with dissection and preservation of facial nerve), 42420 (excision of parotid tumor total with dissection and preservation of facial nerve), 42426 (excision of parotid tumor total with unilateral radical neck dissection)

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

SEVERITY OF ILLNESS (SI) — ALL:

- parotid tumor requiring excision (mucoepidermoid carcinoma)
- adenoid cystic
- acinic cell
- pleomorphic adenoma >3cm or deep lobe)
- malignant parotid tumor requiring total parotidectomy with facial nerve dissection/sacrifice
- recurrent pleomorphic adenoma requiring revision surgery

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

- Surgical procedure requiring post-operative inpatient monitoring
- Airway management (tracheostomy care, secretion management)
- Wound/flap monitoring (q1h Doppler checks for free flaps x 72h)
- Speech/swallowing evaluation and dietary management post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Free flap with compromised perfusion requiring return to OR

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Airway stable (if tracheostomy: capping trial or home trach care teaching)
- Swallowing safe or tube feeding plan in place

E. EVIDENCE SOURCES

AAO-HNS Guidelines. NCCN Head and Neck Cancers. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 129-130 (Major Head & Neck Procedures, RW 3.10/1.67) CPT 42410-42426

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-2 days Source: AAO-HNS Parotid Surgery

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.

MANDIBULECTOMY / MAXILLECTOMY

ICD-10-CM / ICD-10-PCS / CPT: C03.0 (malignant neoplasm of upper gum), C03.1 (lower gum), C04.0 (anterior floor of mouth), C04.1 (lateral floor of mouth), C05.0 (hard palate), C41.0 (malignant neoplasm of bones of skull and face), C41.1 (mandible) CPT: 21045 (extensive excision of mandible), 21046 (mandibular condylectomy), 21048 (excision of benign tumor of mandible requiring osteotomy), 31225 (maxillectomy without orbital exenteration), 31230 (maxillectomy with orbital exenteration)

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

SEVERITY OF ILLNESS (SI) — ALL:

- malignant tumor of mandible or maxilla requiring resection (SCC)
- osteosarcoma
- ameloblastoma aggressive)
- NCCN-recommended surgical treatment
- reconstruction planned (fibula free flap)
- iliac crest)
- multidisciplinary H&N tumor board

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

- Surgical procedure requiring post-operative inpatient monitoring
- Airway management (tracheostomy care, secretion management)
- Wound/flap monitoring (q1h Doppler checks for free flaps x 72h)
- Speech/swallowing evaluation and dietary management post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Free flap with compromised perfusion requiring return to OR

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Airway stable (if tracheostomy: capping trial or home trach care teaching)
- Swallowing safe or tube feeding plan in place

E. EVIDENCE SOURCES

AAO-HNS Guidelines. NCCN Head and Neck Cancers. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 129-130 (Major Head & Neck Procedures) CPT 21045-21048, 31225-31230 LOS 7-14 days with reconstruction

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days with reconstruction Source: AHNS; AAO-HNS

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.

GLOSSECTOMY (PARTIAL / TOTAL FOR ORAL CANCER)

ICD-10-CM / ICD-10-PCS / CPT: C01 (malignant neoplasm of base of tongue), C02.0 (dorsal surface of tongue), C02.1 (tip/lateral border of tongue), C02.2 (ventral surface of tongue), C02.3 (anterior 2/3 of tongue unspecified), C02.4 (lingual tonsil), C02.8 (overlapping sites), C02.9 (tongue unspecified) CPT: 41120 (glossectomy less than half), 41130 (glossectomy hemiglossectomy), 41135 (glossectomy partial with unilateral radical neck dissection), 41140 (glossectomy complete), 41145 (glossectomy complete with radical neck dissection)

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

SEVERITY OF ILLNESS (SI) — ALL:

- biopsy-confirmed SCC of tongue requiring surgical resection per NCCN staging
- pre-operative speech/swallowing evaluation
- reconstruction planned if hemiglossectomy or larger
- neck dissection for node-positive disease or primary T3-T4

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

- Surgical procedure requiring post-operative inpatient monitoring
- Airway management (tracheostomy care, secretion management)
- Wound/flap monitoring (q1h Doppler checks for free flaps x 72h)
- Speech/swallowing evaluation and dietary management post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Free flap with compromised perfusion requiring return to OR

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Airway stable (if tracheostomy: capping trial or home trach care teaching)
- Swallowing safe or tube feeding plan in place

E. EVIDENCE SOURCES

AAO-HNS Guidelines. NCCN Head and Neck Cancers. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 129-130 (Major Head & Neck Procedures) CPT 41120-41145

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days total; 3-5 days partial Source: AHNS; NCCN H&N

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.

FREE FLAP RECONSTRUCTION (HEAD & NECK — RADIAL FOREARM / FIBULA / ALT)

ICD-10-CM / ICD-10-PCS / CPT: Z48.1 (encounter for planned post-procedural wound closure), C00-C14 (malignant neoplasms lip/oral cavity/pharynx) as primary, C30-C32 (nasal/larynx) CPT: 15757 (free flap with microvascular anastomosis), 15758 (additional perforators), 20969 (free osteocutaneous flap with microvascular anastomosis), 20970 (free osteocutaneous flap, iliac crest)

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

SEVERITY OF ILLNESS (SI) — ALL:

- defect from ablative surgery of head/neck cancer requiring microvascular free tissue transfer for reconstruction (functional and cosmetic)
- type of flap selected based on defect (radial forearm for soft tissue)
- fibula for mandible reconstruction
- ALT for large soft tissue)

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

- Surgical procedure requiring post-operative inpatient monitoring
- Airway management (tracheostomy care, secretion management)
- Wound/flap monitoring (q1h Doppler checks for free flaps x 72h)
- Speech/swallowing evaluation and dietary management post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Free flap with compromised perfusion requiring return to OR

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Airway stable (if tracheostomy: capping trial or home trach care teaching)
- Swallowing safe or tube feeding plan in place

E. EVIDENCE SOURCES

AAO-HNS Guidelines. NCCN Head and Neck Cancers. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 129-130 (Major Head & Neck Procedures) CPT 15757-15758, 20969-20970 LOS 7-14 days ICU monitoring for flap perfusion q1h x 72h

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: ASRM Microsurgery Guidelines

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.

ORBITAL EXENTERATION

ICD-10-CM / ICD-10-PCS / CPT: C69.60 (malignant neoplasm of unspecified orbit), C69.61 (right orbit), C69.62 (left orbit), C31.0 (malignant neoplasm of maxillary sinus extending to orbit), C44.x (skin cancer involving orbit) CPT: 65110 (exenteration of orbit), 65112 (exenteration of orbit with removal of bone), 65114 (exenteration of orbit with therapeutic removal of bone — radical)

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

SEVERITY OF ILLNESS (SI) — ALL:

- malignancy invading orbit requiring total orbital clearance (SCC
- basal cell carcinoma
- melanoma
- lacrimal gland carcinoma
- sarcoma)
- tumor not amenable to globe-sparing surgery
- no distant metastasis
- evaluated by multidisciplinary team (ophthalmology
- H&N surgery
- oculoplastics)

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

- Surgical procedure requiring post-operative inpatient monitoring
- Airway management (tracheostomy care, secretion management)
- Wound/flap monitoring (q1h Doppler checks for free flaps x 72h)
- Speech/swallowing evaluation and dietary management post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Free flap with compromised perfusion requiring return to OR

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Airway stable (if tracheostomy: capping trial or home trach care teaching)
- Swallowing safe or tube feeding plan in place

E. EVIDENCE SOURCES

AAO-HNS Guidelines. NCCN Head and Neck Cancers. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 113-115 (Orbital Procedures, RW 2.02/1.31/0.88) or DRG 129-130 if combined with H&N procedure CPT 65110-65114

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: AAO; AHNS

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.

SKULL BASE SURGERY (ANTERIOR / LATERAL APPROACHES)

ICD-10-CM / ICD-10-PCS / CPT: C30.0 (malignant neoplasm of nasal cavity), C31.0 (maxillary sinus), C31.1 (ethmoidal sinus), C31.2 (frontal sinus), C31.3 (sphenoid sinus), C41.0 (malignant neoplasm of bones of skull and face), D16.4 (benign neoplasm of bones of skull and face) CPT: 61580-61598 (craniofacial approach for anterior skull base), 61600-61616 (resection of neoplasm skull base anterior approach), 61590-61592 (infratemporal fossa approach), 61595-61598 (transtemporal approach)

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

SEVERITY OF ILLNESS (SI) — ALL:

- skull base tumor requiring multidisciplinary resection (meningioma)
- esthesioneuroblastoma
- chordoma
- chondrosarcoma
- SCC extending to skull base)
- imaging confirms resectable disease
- combined neurosurgery + H&N surgery approach planned
- pre-operative embolization if indicated

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

- Surgical procedure requiring post-operative inpatient monitoring
- Airway management (tracheostomy care, secretion management)
- Wound/flap monitoring (q1h Doppler checks for free flaps x 72h)
- Speech/swallowing evaluation and dietary management post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Free flap with compromised perfusion requiring return to OR

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Airway stable (if tracheostomy: capping trial or home trach care teaching)
- Swallowing safe or tube feeding plan in place

E. EVIDENCE SOURCES

AAO-HNS Guidelines. NCCN Head and Neck Cancers. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 023-025 (Craniotomy, RW 5.75/3.61/2.59) CPT 61580-61616 LOS 7-14 days ICU required

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-10 days Source: AANS/CNS Tumor Section; NASBS

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

- ICU: Immediate post-op (≥ 24 h 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 \rightarrow 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.

TRACHEOSTOMY (SURGICAL — WHEN PRIMARY PROCEDURE)

ICD-10-CM / ICD-10-PCS / CPT: J95.00 (unspecified tracheostomy complication), J95.01 (hemorrhage from tracheostomy stoma), J95.02 (infection of tracheostomy stoma), J95.03 (malfunction of tracheostomy), J95.04 (tracheo-esophageal fistula following tracheostomy), Z93.0 (tracheostomy status) CPT: 31600 (tracheostomy planned), 31601 (tracheostomy planned, under 2 years), 31603 (tracheostomy emergency), 31605 (tracheostomy emergency cricothyroid)

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

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

- prolonged mechanical ventilation requiring tracheostomy (typically at day 7-14 when extubation not anticipated)
- upper airway obstruction (tumor)
- bilateral vocal cord paralysis
- severe laryngeal edema)
- prophylactic before major H&N surgery
- failed extubation with anticipated prolonged ventilator weaning

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

- Surgical procedure requiring post-operative inpatient monitoring
- Airway management (tracheostomy care, secretion management)
- Wound/flap monitoring (q1h Doppler checks for free flaps x 72h)
- Speech/swallowing evaluation and dietary management post-operatively

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

- Free flap with compromised perfusion requiring return to OR

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks

- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Airway stable (if tracheostomy: capping trial or home trach care teaching)
- Swallowing safe or tube feeding plan in place

E. EVIDENCE SOURCES

AAO-HNS Guidelines. NCCN Head and Neck Cancers. ACS NSQIP.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 003-004 (Tracheostomy, RW 18.57/12.14) if MV >96h; DRG 129-130 if part of H&N procedure CPT 31600-31605
PLASTIC / RECONSTRUCTIVE SURGERY

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days when primary Source: AAO-HNS Tracheostomy Consensus

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.

FREE TISSUE TRANSFER / FREE FLAP (TRUNK / EXTREMITY)

ICD-10-CM / ICD-10-PCS / CPT: L89.x (pressure ulcer), L97.x (non-pressure chronic ulcer), T79.A (traumatic compartment syndrome — post-reconstruction), T87.x (complications of reattached body part) CPT: 15757 (free flap with microvascular anastomosis), 15758 (additional perforators), 15734-15738 (muscle/myocutaneous flap), 15756 (free muscle flap)

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

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

- soft tissue defect not amenable to primary closure
- skin graft
- or local/regional flap; exposed bone/tendon/hardware/vessel requiring well-vascularized coverage; traumatic defect
- oncologic defect
- pressure ulcer reconstruction

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

- Microsurgical/complex reconstructive procedure requiring post-operative inpatient monitoring
- Flap perfusion monitoring (clinical/Doppler checks q1h x 72h for free tissue transfer)
- Wound management requiring inpatient nursing (VAC therapy, dressing changes)
- Pain management, mobilization, and rehabilitation beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge

- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Flap/graft viable and perfused
- Wound stable with clear wound care plan for outpatient

E. EVIDENCE SOURCES

ASPS Practice Parameters. ABA Burn Guidelines. ACS Trauma Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 573-574 (Skin Graft/Wound Debridement for Musculoskeletal Conditions, RW 2.81/1.93) CPT 15734-15758 LOS 5-7 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: ASRM

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

- ICU: Major burns >20% TBSA, inhalation injury, hemodynamic instability, mechanical ventilation, fasciotomies pending or completed, vasoactive requirement, ongoing transfusion.
- Stepdown (Telemetry/PCU): Stable burns with frequent dressing changes, fluid resuscitation per Parkland or modified, post-fasciotomy with limb monitoring, large-volume wound care.
- Med-Surg: Stable fluid balance, transitioning to enteral nutrition, wound care q12-24h, transitioning to PO analgesia.
- Observation: Small burns not meeting ABA inpatient criteria; soft tissue injuries with rapid stabilization.
- Post-Acute (SNF/IRF/LTAC): Burn IRF for ≥ 3 hours/day rehab; LTAC for vent weaning or extensive wound care; SNF for skilled wound management.
- Home (with/without HHA): Wounds healing, pain on PO, ambulating, ADLs achievable, follow-up burn/plastics weekly; HHA for wound care, PT/OT.

LOC Grid Sources: American Burn Association Burn Care Quality Platform; ABA Practice Guidelines.

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.

- Burn-related fluid resuscitation ongoing per Parkland with diuretic phase not reached
- Wound care requiring serial debridements or VAC changes
- Infection (cellulitis, sepsis, fungal) requiring escalation
- Inhalation injury with prolonged ventilator wean
- Compartment syndrome with persistent rhabdomyolysis
- Failure to engage in rehab for IRF placement

Extended Stay Sources: Sources: American Burn Association Burn Care Quality Platform; OTA Compartment Syndrome Consensus.

DIAPHRAGMATIC FLAP / TRAM FLAP (BREAST RECONSTRUCTION)

ICD-10-CM / ICD-10-PCS / CPT: Z42.1 (encounter for breast reconstruction following mastectomy), N65.1 (disproportion of reconstructed breast), Z90.10 (acquired absence of unspecified breast) CPT: 19364 (breast reconstruction with free flap — DIEP/SIEA), 19367 (breast reconstruction with transverse rectus abdominis myocutaneous flap — pedicled TRAM), 19368 (free TRAM), 19369 (breast reconstruction with other technique)

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

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

- post-mastectomy breast reconstruction (immediate or delayed)
- implant failure/complication requiring autologous reconstruction
- radiation damage requiring autologous tissue
- patient preference for autologous vs implant after informed consent

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

- Microsurgical/complex reconstructive procedure requiring post-operative inpatient monitoring
- Flap perfusion monitoring (clinical/Doppler checks q1h x 72h for free tissue transfer)
- Wound management requiring inpatient nursing (VAC therapy, dressing changes)
- Pain management, mobilization, and rehabilitation beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Flap/graft viable and perfused
- Wound stable with clear wound care plan for outpatient

E. EVIDENCE SOURCES

ASPS Practice Parameters. ABA Burn Guidelines. ACS Trauma Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 582-583 (Mastectomy for Malignancy, RW 1.75/1.19) or DRG 579-581 (Other Skin Procedures) CPT 19364-19369 LOS 3-5 days
Federal mandate: WHCRA requires coverage of breast reconstruction

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: ASPS Breast Reconstruction Guidelines

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.

MAJOR BURN EXCISION AND GRAFTING (>20% TBSA)

ICD-10-CM / ICD-10-PCS / CPT: T31.20 (burns 20-29% TBSA), T31.30 (30-39%), T31.40 (40-49%), T31.50 (50-59%), T31.60 (60-69%), T31.70 (70-79%), T31.80 (80-89%), T31.90 (90%+) CPT: 16035 (escharotomy), 16036 (each additional incision), 15002-15005 (surgical preparation for skin graft), 15040 (harvest of skin for autografting), 15100-15101 (split-thickness skin graft — trunk), 15120-15121 (STSG extremities)

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

SEVERITY OF ILLNESS (SI) — ALWAYS INPATIENT:

- burns >20% TBSA (ABA criteria for burn center referral)
- full-thickness burns \geq 10% TBSA
- burns involving face/hands/feet/genitalia/perineum/major joints
- inhalation injury
- electrical/chemical burns
- burns with fractures or major trauma

INTENSITY OF SERVICE (IS) — Must meet \geq 1:

- Microsurgical/complex reconstructive procedure requiring post-operative inpatient monitoring
- Flap perfusion monitoring (clinical/Doppler checks q1h x 72h for free tissue transfer)
- Wound management requiring inpatient nursing (VAC therapy, dressing changes)
- Pain management, mobilization, and rehabilitation beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile \geq 24h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge

- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Flap/graft viable and perfused
- Wound stable with clear wound care plan for outpatient

E. EVIDENCE SOURCES

ASPS Practice Parameters. ABA Burn Guidelines. ACS Trauma Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 927 (Extensive Burns w MV >96h w Skin Graft, RW ~18.55), DRG 928-929 (Full Thickness Burns w Graft, RW 5.90/3.03), DRG 933-935 (Non-Extensive Burns, RW 2.85/1.42/0.80) ABA Burn Center Criteria apply

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: Variable; 1 day per %TBSA approximate Source: American Burn Association Burn Care Quality Platform

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

- ICU: Major burns >20% TBSA, inhalation injury, hemodynamic instability, mechanical ventilation, fasciotomies pending or completed, vasoactive requirement, ongoing transfusion.
- Stepdown (Telemetry/PCU): Stable burns with frequent dressing changes, fluid resuscitation per Parkland or modified, post-fasciotomy with limb monitoring, large-volume wound care.
- Med-Surg: Stable fluid balance, transitioning to enteral nutrition, wound care q12-24h, transitioning to PO analgesia.
- Observation: Small burns not meeting ABA inpatient criteria; soft tissue injuries with rapid stabilization.
- Post-Acute (SNF/IRF/LTAC): Burn IRF for ≥3 hours/day rehab; LTAC for vent weaning or extensive wound care; SNF for skilled wound management.
- Home (with/without HHA): Wounds healing, pain on PO, ambulating, ADLs achievable, follow-up burn/plastics weekly; HHA for wound care, PT/OT.

LOC Grid Sources: American Burn Association Burn Care Quality Platform; ABA Practice Guidelines.

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.

- Burn-related fluid resuscitation ongoing per Parkland with diuretic phase not reached
- Wound care requiring serial debridements or VAC changes
- Infection (cellulitis, sepsis, fungal) requiring escalation
- Inhalation injury with prolonged ventilator wean
- Compartment syndrome with persistent rhabdomyolysis
- Failure to engage in rehab for IRF placement

Extended Stay Sources: Sources: American Burn Association Burn Care Quality Platform; OTA Compartment Syndrome Consensus.

COMPLEX WOUND CLOSURE WITH FLAP COVERAGE

ICD-10-CM / ICD-10-PCS / CPT: L89.x (pressure ulcer by stage/site), L97.x (non-pressure chronic ulcer), T81.31xA (disruption of external operation wound), E11.621 (type 2 DM with foot ulcer) CPT: 15734-15738 (muscle/myocutaneous flap by location), 15740 (island pedicle flap), 15750 (neurovascular pedicle flap)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL:

- wound not amenable to primary closure or skin grafting
- exposed critical structures (bone
- tendon
- hardware
- joint
- vessel)
- adequate vascular supply for flap confirmed
- infection controlled (negative wound cultures or appropriate antibiotics)
- patient medically optimized for surgery

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

- Microsurgical/complex reconstructive procedure requiring post-operative inpatient monitoring

- Flap perfusion monitoring (clinical/Doppler checks q1h x 72h for free tissue transfer)
- Wound management requiring inpatient nursing (VAC therapy, dressing changes)
- Pain management, mobilization, and rehabilitation beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Flap/graft viable and perfused
- Wound stable with clear wound care plan for outpatient

E. EVIDENCE SOURCES

ASPS Practice Parameters. ABA Burn Guidelines. ACS Trauma Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 573-574 (Skin Graft for Musculoskeletal) or DRG 579-581 (Other Skin Procedures) CPT 15734-15750

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 5-7 days Source: ASPS Microsurgery; ASRM

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

- ICU: Major burns >20% TBSA, inhalation injury, hemodynamic instability, mechanical ventilation, fasciotomies pending or completed, vasoactive requirement, ongoing transfusion.
- Stepdown (Telemetry/PCU): Stable burns with frequent dressing changes, fluid resuscitation per Parkland or modified, post-fasciotomy with limb monitoring, large-volume wound care.
- Med-Surg: Stable fluid balance, transitioning to enteral nutrition, wound care q12-24h, transitioning to PO analgesia.
- Observation: Small burns not meeting ABA inpatient criteria; soft tissue injuries with rapid stabilization.
- Post-Acute (SNF/IRF/LTAC): Burn IRF for ≥ 3 hours/day rehab; LTAC for vent weaning or extensive wound care; SNF for skilled wound management.
- Home (with/without HHA): Wounds healing, pain on PO, ambulating, ADLs achievable, follow-up burn/plastics weekly; HHA for wound care, PT/OT.

LOC Grid Sources: American Burn Association Burn Care Quality Platform; ABA Practice Guidelines.

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.

- Burn-related fluid resuscitation ongoing per Parkland with diuretic phase not reached
- Wound care requiring serial debridements or VAC changes
- Infection (cellulitis, sepsis, fungal) requiring escalation
- Inhalation injury with prolonged ventilator wean
- Compartment syndrome with persistent rhabdomyolysis

- Failure to engage in rehab for IRF placement

Extended Stay Sources: Sources: American Burn Association Burn Care Quality Platform; OTA Compartment Syndrome Consensus.

LIMB REPLANTATION / REVASCULARIZATION (MICROSURGERY)

ICD-10-CM / ICD-10-PCS / CPT: S68.x (traumatic amputation of wrist/hand/fingers), S48.x (traumatic amputation of shoulder/arm), S58.x (traumatic amputation at elbow/forearm), S78.x (traumatic amputation at hip/thigh), S88.x (traumatic amputation at knee/leg), S98.x (traumatic amputation at ankle/foot), T14.7 (traumatic amputation of unspecified body region) CPT: 20802 (replantation arm complete amputation), 20805 (replantation forearm), 20808 (replantation hand), 20816 (replantation digit, single), 20822 (replantation digit, multiple), 35206-35286 (vessel repair)

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

SEVERITY OF ILLNESS (SI) — Must meet ALL:

- viable amputated part (cold ischemia <6h for digits)
- <12h if cooled; <6h warm ischemia for proximal amputations)
- appropriate candidate (non-crush mechanism preferred)
- no severe contamination
- no life-threatening associated injuries taking priority)
- microsurgical team available

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

- Microsurgical/complex reconstructive procedure requiring post-operative inpatient monitoring
- Flap perfusion monitoring (clinical/Doppler checks q1h x 72h for free tissue transfer)
- Wound management requiring inpatient nursing (VAC therapy, dressing changes)
- Pain management, mobilization, and rehabilitation beyond outpatient capability

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Flap/graft viable and perfused
- Wound stable with clear wound care plan for outpatient

E. EVIDENCE SOURCES

ASPS Practice Parameters. ABA Burn Guidelines. ACS Trauma Guidelines.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 907-909 (Other OR Procedures for Injuries, RW 3.10/1.69/1.20) CPT 20802-20822 LOS 5-14 days ICU/monitored bed for flap/replant perfusion checks q1h x 72h

TRANSPLANT-RELATED SURGICAL PROCEDURES

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: ASSH/ASRM Replantation Consensus

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

- ICU: Major burns >20% TBSA, inhalation injury, hemodynamic instability, mechanical ventilation, fasciotomies pending or completed, vasoactive requirement, ongoing transfusion.
- Stepdown (Telemetry/PCU): Stable burns with frequent dressing changes, fluid resuscitation per Parkland or modified, post-fasciotomy with limb monitoring, large-volume wound care.
- Med-Surg: Stable fluid balance, transitioning to enteral nutrition, wound care q12-24h, transitioning to PO analgesia.
- Observation: Small burns not meeting ABA inpatient criteria; soft tissue injuries with rapid stabilization.
- Post-Acute (SNF/IRF/LTAC): Burn IRF for ≥ 3 hours/day rehab; LTAC for vent weaning or extensive wound care; SNF for skilled wound management.
- Home (with/without HHA): Wounds healing, pain on PO, ambulating, ADLs achievable, follow-up burn/plastics weekly; HHA for wound care, PT/OT.

LOC Grid Sources: American Burn Association Burn Care Quality Platform; ABA Practice Guidelines.

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.

- Burn-related fluid resuscitation ongoing per Parkland with diuretic phase not reached
- Wound care requiring serial debridements or VAC changes
- Infection (cellulitis, sepsis, fungal) requiring escalation
- Inhalation injury with prolonged ventilator wean
- Compartment syndrome with persistent rhabdomyolysis
- Failure to engage in rehab for IRF placement

Extended Stay Sources: Sources: American Burn Association Burn Care Quality Platform; OTA Compartment Syndrome Consensus.

SMALL BOWEL TRANSPLANT / MULTIVISCERAL TRANSPLANT

ICD-10-CM / ICD-10-PCS / CPT: Z94.82 (intestine transplant status), T86.850 (unspecified complication of intestine transplant), T86.851 (intestine transplant failure), T86.852 (intestine transplant infection), T86.858 (other complications) ICD-10-PCS: ODY80Zx (transplantation of small intestine) CPT: 44135 (intestinal allotransplantation from cadaver donor), 44136 (intestinal allotransplantation from living donor)

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

SEVERITY OF ILLNESS (SI) — ALL:

- irreversible intestinal failure on TPN with life-threatening TPN complications (liver failure)
- recurrent line sepsis
- loss of central venous access
- dehydration despite IV fluids)
- evaluated and listed at intestinal/multivisceral transplant center

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

- Transplant/donor surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring specific to organ/procedure type
- Immunosuppression management (recipient) or donor safety monitoring

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Donor surgery at facility not designated as transplant center

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Organ function labs trending appropriately
- Immunosuppression at therapeutic levels (recipient)

E. EVIDENCE SOURCES

UNOS Policies. AST Guidelines. ASTS Practice Guidelines. CMS Conditions of Participation for Transplant Centers.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 005 (Liver Transplant/Intestinal Transplant, RW ~11.39) CPT 44135-44136 LOS 30-60+ days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 30-60 days Source: OPTN/UNOS Policy 12; ITS Standards

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

- ICU: Immediate post-op (≥ 24 -48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4-6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1-2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1-2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6-14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

LIVING DONOR NEPHRECTOMY

ICD-10-CM / ICD-10-PCS / CPT: Z52.4 (kidney donor) ICD-10-PCS: 0TT10ZZ (resection of left kidney, open), 0TT14ZZ (laparoscopic) CPT: 50300 (donor nephrectomy open), 50547 (laparoscopic donor nephrectomy)

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

SEVERITY OF ILLNESS (SI) — ALL:

- healthy living kidney donor who has completed full donor evaluation (medical
- psychosocial

- imaging
- GFR confirmation)
- cleared by independent donor advocate
- no medical contraindications
- informed consent documented

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

- Transplant/donor surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring specific to organ/procedure type
- Immunosuppression management (recipient) or donor safety monitoring

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Donor surgery at facility not designated as transplant center

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Organ function labs trending appropriately
- Immunosuppression at therapeutic levels (recipient)

E. EVIDENCE SOURCES

UNOS Policies. AST Guidelines. ASTS Practice Guidelines. CMS Conditions of Participation for Transplant Centers.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 652 (Kidney Transplant, RW ~3.42) — donor side CPT 50300, 50547 LOS 2-4 days (laparoscopic) to 4-6 (open)

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: Immediate post-op (≥ 24 -48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4-6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1-2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1-2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6-14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

LIVING DONOR HEPATECTOMY

ICD-10-CM / ICD-10-PCS / CPT: Z52.6 (liver donor) ICD-10-PCS: 0FT10ZZ (resection of liver right lobe, open), 0FT20ZZ (resection of liver left lobe, open) CPT: 47140 (donor hepatectomy from living donor, left lateral segment), 47141 (donor hepatectomy, total left lobectomy), 47142 (donor hepatectomy, total right lobectomy)

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

SEVERITY OF ILLNESS (SI) — ALL:

- healthy living liver donor cleared by transplant center evaluation
- adequate future liver remnant confirmed ($\geq 30\text{-}35\%$ by volumetric CT)
- no medical/surgical contraindications
- independent donor advocate evaluation complete

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

- Transplant/donor surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring specific to organ/procedure type
- Immunosuppression management (recipient) or donor safety monitoring

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Donor surgery at facility not designated as transplant center

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile $\geq 24\text{h}$
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Organ function labs trending appropriately
- Immunosuppression at therapeutic levels (recipient)

E. EVIDENCE SOURCES

UNOS Policies. AST Guidelines. ASTS Practice Guidelines. CMS Conditions of Participation for Transplant Centers.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 005-006 (Liver Transplant, RW 11.39/5.80) — donor side CPT 47140-47142 LOS 5-7 days Higher complexity than nephrectomy; closely monitored for bile leak, hemorrhage, liver insufficiency

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 4-7 days Source: AHPBA/IHPBA

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

- ICU: Immediate post-op (≥ 24 –48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4–6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1–2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1–2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6–14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

ISLET CELL TRANSPLANT

ICD-10-CM / ICD-10-PCS / CPT: E10.10 (type 1 DM with DKA), E10.65 (type 1 DM with hyperglycemia), Z94.89 (other transplanted organ/tissue status) CPT: 0584T (islet cell transplantation via portal vein percutaneous)

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

SEVERITY OF ILLNESS (SI) — ALL:

- type 1 diabetes with severe hypoglycemia unawareness despite optimized insulin therapy (Clarke score ≥ 4)
- Gold score ≥ 4)
- hypoglycemic episodes requiring third-party assistance ≥ 1 /year
- evaluated at islet transplant center
- listed per CIT/CITR criteria

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

- Transplant/donor surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring specific to organ/procedure type
- Immunosuppression management (recipient) or donor safety monitoring

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
- Diagnostic procedure alone 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 (Section D) met
- Continued stay solely awaiting facility placement when medically ready (activate case management)
- Post-operative stay extending beyond expected LOS without documented medical justification
- Donor surgery at facility not designated as transplant center

C. CONTINUED STAY / CONCURRENT REVIEW

DAILY surgical team review. Post-op complication (wound infection, hemorrhage, anastomotic leak, ileus, DVT/PE, AKI, arrhythmia), unable to meet functional milestones, medical co-management of unstable comorbidities.

D. DISCHARGE CRITERIA

- Vital signs stable, afebrile ≥ 24 h
- Pain controlled on oral analgesics
- Tolerating adequate oral diet (or nutrition plan in place)
- Wound clean, dry, intact; drains removed or output minimal with plan
- Ambulatory at expected post-procedure level
- DVT prophylaxis plan documented for post-discharge
- Surgeon follow-up scheduled within 1-2 weeks
- Discharge education completed: wound care, activity restrictions, medications, return-to-ED criteria
- Organ function labs trending appropriately
- Immunosuppression at therapeutic levels (recipient)

E. EVIDENCE SOURCES

UNOS Policies. AST Guidelines. ASTS Practice Guidelines. CMS Conditions of Participation for Transplant Centers.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

Investigational at many payers — check plan-specific coverage. If covered: DRG 628-630 (Other Endocrine Procedures) CPT 0584T

Note: not yet universally covered by commercial payers; CMS covers under limited circumstances

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: OPTN/UNOS; CITR

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

- ICU: Immediate post-op (≥ 24 -48h standard for heart/lung; 24h for liver/SBT/multivisceral), induction immunosuppression, ventilator support, vasopressor requirement, primary graft dysfunction, rejection with hemodynamic compromise.
- Stepdown (Telemetry/PCU): Telemetry post-heart/lung tx, immunosuppression titration, drain monitoring, infection surveillance, frequent labs (q4-6h then q12h).
- Med-Surg: Hemodynamically stable, tolerating diet, drains low, immunosuppression therapeutic levels, transplant education completed, ambulating.
- Observation: Generally not applicable for solid organ transplant; living donor nephrectomy may have POD 1-2 discharge per AST/OPTN.
- Post-Acute (SNF/IRF/LTAC): Heart/lung tx patients commonly require IRF; SNF for deconditioned patients; LTAC for vent weaning.
- Home (with/without HHA): Hemodynamically stable, immunosuppression levels therapeutic, no rejection, infection surveillance plan in place, follow-up transplant clinic 1-2 times/week initially; HHA for IV antibiotics and home labs.

LOC Grid Sources: OPTN/UNOS Policies (Policies 6-14); ISHLT Heart and Lung Transplant Guidelines; AASLD Liver Transplant Practice Guideline; AST Kidney Transplant Recipient Care Guidelines.

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.

- Primary graft dysfunction or non-function requiring continued support
- Acute rejection (biopsy-proven) requiring high-dose steroids or T-cell-depleting therapy
- Infection (CMV, BK, fungal, line sepsis) requiring continued IV therapy
- Surgical complication (anastomotic stricture, bile/urine leak, hepatic artery thrombosis)
- Failure of induction immunosuppression to reach therapeutic levels

Extended Stay Sources: Sources: OPTN/UNOS Policies; ISHLT, AST, AASLD Transplant Practice Guidelines.

CORNEAL TRANSPLANT (WHEN INPATIENT)

ICD-10-CM / ICD-10-PCS / CPT: H18.601 (keratoconus unspecified, right eye), H18.602 (left), H18.611 (keratoconus stable, right), H18.621 (keratoconus unstable, right), H18.10 (bullous keratopathy), H18.42 (band keratopathy), T86.840 (corneal transplant rejection), T86.841 (corneal transplant failure) CPT: 65710 (keratoplasty lamellar), 65730 (keratoplasty penetrating), 65750 (keratoplasty penetrating, aphakic eye), 65755 (keratoplasty penetrating, in pseudophakic eye), 65756 (endothelial keratoplasty DSEK/DMEK)

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

SEVERITY OF ILLNESS (SI) — NOTE:

- Corneal transplant is nearly always OUTPATIENT. Inpatient only if: combined with other inpatient eye surgery
- post-operative complication requiring monitoring (rejection)
- primary graft failure
- elevated IOP)
- medically complex patient requiring inpatient setting

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

- Transplant/donor surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring specific to organ/procedure type
- Immunosuppression management (recipient) or donor safety monitoring

B. DOES NOT MEET CRITERIA / NOT MEDICALLY NECESSARY

- Procedure safely performed in ambulatory surgery center with same-day discharge
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C. CONTINUED STAY / CONCURRENT REVIEW

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E. EVIDENCE SOURCES

UNOS Policies. AST Guidelines. ASTS Practice Guidelines. CMS Conditions of Participation for Transplant Centers.

F. MS-DRG CROSSWALK, PROCEDURE CODES & REVENUE CODES

DRG 116-117 (Intraocular Procedures, RW 1.28/0.82) CPT 65710-65756 DENY INPATIENT if no documented medical justification beyond the corneal transplant itself

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: Outpatient or 1-2 days when inpatient Source: EBAA Medical Standards; AAO PPP

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

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