

Section G – Other Inpatient Surgical Procedures

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

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

Conditions / procedures in this section: 6

Scope: Additional standalone inpatient surgical procedures.

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

EXPLORATORY LAPAROTOMY (TRAUMA / ACUTE ABDOMEN)

ICD-10-CM / ICD-10-PCS / CPT: R10.0 (acute abdomen), K65.0 (generalized peritonitis), K65.1 (peritoneal abscess), S36.x (injury of intra-abdominal organs), T14.8 (other injury of unspecified body region), K63.1 (perforation of intestine) CPT: 49000 (exploratory laparotomy), 49002 (reopening of recent laparotomy), 49010 (exploration of retroperitoneum with drainage)

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

SEVERITY OF ILLNESS (SI) — ALWAYS INPATIENT:

- ≥ 1 : acute abdomen with peritonitis requiring emergent surgical exploration
- penetrating abdominal trauma with hemodynamic instability or peritonitis
- blunt abdominal trauma with positive FAST and hemodynamic instability
- pneumoperitoneum on imaging
- evisceration

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring: hemodynamics, wound/drain management
- Post-operative services not available at outpatient/observation 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

E. EVIDENCE SOURCES

Procedure-specific guidelines (ACS, NCCN, STS, AAOS, ACS NSQIP, ERAS Society). CMS IPO List FY2024.

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

DRG 329-331 (Major Bowel Procedures) if bowel surgery performed; DRG 393-395 (Other Digestive System OR) if no bowel procedure CPT 49000-49010

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-7 days Source: EAST Practice Management 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.

DAMAGE CONTROL SURGERY (ABBREVIATED LAPAROTOMY FOR TRAUMA)

ICD-10-CM / ICD-10-PCS / CPT: T79.4xxA (traumatic shock), T81.19xA (other postprocedural shock), S36.x (intra-abdominal organ injury) CPT: 49000 (exploratory laparotomy), 49002 (reopening), 44602-44604 (bowel repair), 35221-35286 (vascular repair)

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

SEVERITY OF ILLNESS (SI) — ALWAYS INPATIENT / ICU:

- massive trauma with lethal triad (hypothermia <35°C
- acidosis pH <7.2
- coagulopathy INR >1.5)
- damage control surgery philosophy: rapid hemorrhage control
- contamination control
- temporary abdominal closure
- ICU resuscitation
- planned return to OR in 24-72h

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring: hemodynamics, wound/drain management
- Post-operative services not available at outpatient/observation 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

E. EVIDENCE SOURCES

Procedure-specific guidelines (ACS, NCCN, STS, AAOS, ACS NSQIP, ERAS Society). CMS IPO List FY2024.

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

DRG 003-004 (Tracheostomy with MV) if prolonged; DRG 329-331 (Major Bowel) or DRG 957 (Other OR for Multiple Trauma) Multiple CPT codes LOS variable 7-30+ days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-14 days Source: EAST Damage Control Resuscitation

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.

RETROPERITONEAL SARCOMA RESECTION

ICD-10-CM / ICD-10-PCS / CPT: C48.0 (malignant neoplasm of retroperitoneum), C49.4 (connective tissue of abdomen — soft tissue sarcoma), D48.3 (neoplasm of uncertain behavior of retroperitoneum) CPT: 49203-49215 (excision retroperitoneal tumor by size),

plus organ resection codes as needed (nephrectomy, colectomy, splenectomy if en bloc)

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

SEVERITY OF ILLNESS (SI) — ALL:

- biopsy-confirmed retroperitoneal sarcoma (liposarcoma)
- leiomyosarcoma
- MPNST)
- imaging confirms resectable disease (CT/MRI abdomen/pelvis)
- NCCN-recommended surgical resection with goal of R0 margins
- sarcoma multidisciplinary tumor board

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring: hemodynamics, wound/drain management
- Post-operative services not available at outpatient/observation 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

E. EVIDENCE SOURCES

Procedure-specific guidelines (ACS, NCCN, STS, AAOS, ACS NSQIP, ERAS Society). CMS IPO List FY2024.

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

DRG 820-822 (Other OR Procedures) or DRG 329-331 if bowel resected CPT 49203-49215 LOS 5-10 days

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 7-10 days Source: MSTS/SSO Soft Tissue Sarcoma; 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.

PHEOCHROMOCYTOMA RESECTION

ICD-10-CM / ICD-10-PCS / CPT: E27.5 (adrenomedullary hyperfunction), D35.00 (benign neoplasm of unspecified adrenal gland), D35.01 (right), D35.02 (left), C74.10 (malignant neoplasm of medulla of adrenal gland) 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) — ALL:

- biochemically confirmed pheochromocytoma (elevated plasma/urine metanephrines/catecholamines)
- imaging-confirmed adrenal mass on CT/MRI
- adequate alpha-blockade pre-operatively (≥ 14 days of phenoxybenzamine or doxazosin followed by beta-blockade
- volume expansion)
- anesthesia team experienced in pheochromocytoma management

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring: hemodynamics, wound/drain management
- Post-operative services not available at outpatient/observation 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

E. EVIDENCE SOURCES

Procedure-specific guidelines (ACS, NCCN, STS, AAOs, ACS NSQIP, ERAS Society). CMS IPO List FY2024.

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

DRG 628-630 (Other Endocrine/Nutritional Procedures, RW 3.33/1.92/1.32) CPT 60540-60650 CRITICAL: Intraoperative hemodynamic lability common — ICU post-op for BP monitoring, glucose monitoring (rebound hypoglycemia)

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 3-5 days Source: Endocrine Society Pheochromocytoma Guideline 2014; AAES

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

- ICU: Hemodynamic instability post-pheochromocytoma resection (catecholamine crisis or hypotension), severe hypocalcemia post-parathyroidectomy/thyroidectomy with tetany, airway concerns from neck hematoma.
- Stepdown (Telemetry/PCU): Calcium titration with q4-6h labs, vasoactive wean post-pheo, airway monitoring.
- Med-Surg: Calcium stable on PO, tolerating diet, ambulating, drains intact.
- Observation: Uncomplicated parathyroidectomy may discharge same day per AAES; thyroidectomy frequently 23-hour stay.
- Post-Acute: Rarely needed.
- Home (with/without HHA): Calcium stable, voice intact, dressing clean, follow-up endocrine surgery in 1-2 weeks.

LOC Grid Sources: AAES Parathyroid Guidelines; Endocrine Society Pheochromocytoma 2014; AAES/ATA Thyroid Surgery.

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.

- Neck hematoma requiring evacuation
- Persistent hypocalcemia requiring IV calcium with frequent labs
- Recurrent laryngeal nerve injury with airway concerns
- Pheochromocytoma post-op hemodynamic instability beyond 48 h

Extended Stay Sources: Sources: AAES Parathyroid/Adrenal Guidelines; Endocrine Society Pheochromocytoma 2014.

PARATHYROIDECTOMY (INPATIENT — FOR HYPERCALCEMIC CRISIS)

ICD-10-CM / ICD-10-PCS / CPT: E21.0 (primary hyperparathyroidism), E21.1 (secondary hyperparathyroidism), E21.2 (other hyperparathyroidism), E21.3 (hyperparathyroidism unspecified), E83.52 (hypercalcemia) CPT: 60500 (parathyroidectomy or exploration of parathyroid), 60502 (re-exploration of parathyroid), 60505 (parathyroidectomy with mediastinal exploration)

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

SEVERITY OF ILLNESS (SI) — NOTE:

- Routine parathyroidectomy is OUTPATIENT. INPATIENT only if: hypercalcemic crisis (Ca >14 mg/dL with AMS
- cardiac arrhythmia
- dehydration)
- requiring IV fluid resuscitation + calcitonin + bisphosphonate + surgical planning
- concurrent medical comorbidities requiring inpatient monitoring
- mediastinal exploration required

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring: hemodynamics, wound/drain management
- Post-operative services not available at outpatient/observation 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

E. EVIDENCE SOURCES

Procedure-specific guidelines (ACS, NCCN, STS, AAOS, ACS NSQIP, ERAS Society). CMS IPO List FY2024.

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

DRG 625-627 (Thyroid/Parathyroid Procedures, RW 2.33/1.33/0.87) CPT 60500-60505 DENY INPATIENT for routine primary hyperparathyroidism without hypercalcemic crisis

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.

LYMPH NODE DISSECTION (AXILLARY / INGUINAL / PELVIC — STANDALONE ONCOLOGIC)

ICD-10-CM / ICD-10-PCS / CPT: C77.0 (secondary malignant neoplasm lymph nodes head/face/neck), C77.1 (intrathoracic), C77.2 (intra-abdominal), C77.3 (axilla/upper limb), C77.4 (inguinal/lower limb), C77.5 (intrapelvic) CPT: 38740 (axillary lymphadenectomy complete), 38745 (axillary lymphadenectomy radical including pectoral muscles), 38760 (inguinal lymphadenectomy superficial), 38765 (inguinal lymphadenectomy superficial and deep), 38770 (pelvic lymphadenectomy), 38780 (retroperitoneal lymphadenectomy)

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

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

- clinically positive lymph nodes confirmed by biopsy (FNA or core) in melanoma
- SCC
- breast cancer
- GU cancer

- or gynecologic cancer; completion lymph node dissection after positive sentinel lymph node biopsy (when indicated per NCCN);

therapeutic lymphadenectomy for node-positive disease

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

- Surgical procedure requiring post-operative inpatient recovery
- Post-operative monitoring: hemodynamics, wound/drain management
- Post-operative services not available at outpatient/observation 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

E. EVIDENCE SOURCES

Procedure-specific guidelines (ACS, NCCN, STS, AAOS, ACS NSQIP, ERAS Society). CMS IPO List FY2024.

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

DRG varies by primary site: DRG 582-583 (Breast), DRG 740-742 (GYN), DRG 656-658 (GU), DRG 129-130 (H&N) CPT 38740-38780

Note: sentinel node biopsy alone is outpatient; full dissection may be outpatient or inpatient depending on extent/location

G. GOAL LENGTH OF STAY (UNCOMPLICATED CASE)

Goal LOS: 1-3 days standalone Source: ASBrS/SSO Lymph Node 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.

APPENDIX D — ADDITIONAL PUBLIC SOURCES USED FOR GOAL LOS, LOC GRIDS, AND EXTENDED STAY CRITERIA

The following public-source guidelines, registries, and federal regulatory materials were used to derive the Goal Length of Stay benchmarks, the standardized Level of Care (LOC) grids, and the Extended Stay criteria added to each condition in this version of the policy. All content was paraphrased and synthesized from publicly available sources. No proprietary criteria sets (MCG, InterQual, etc.) were referenced or reproduced.

- CMS 2-Midnight Rule — 42 CFR §412.3 (Federal Register 2013, updated 2023).
- CMS Inpatient Prospective Payment System (IPPS) Final Rule — FY 2024 (89 FR 35934).
- CMS FY2024 MS-DRG v41 with Geometric Mean Length of Stay (GMLoS) values.
- CMS Inpatient-Only (IPO) List and procedure removal policy (CY 2024 OPPTS Final Rule).
- Medicare Benefit Policy Manual — Chapters 1 (Inpatient Hospital Services), 6 (Hospital Services Covered Under Part B), 8 (Coverage of Extended Care Services), and 9 (Coverage of Hospice Services).
- Medicare Program Integrity Manual (CMS Pub 100-08), Chapter 6.
- Medicare Coverage Database — National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
- SCCM Guidelines for ICU Admission, Discharge, and Triage — Nates JL, et al. Crit Care Med. 2016;44(8):1553-1602.
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End of Appendix D.