Admitting night before an elective surgery: indications and contraindications

 In rare instances a patient may need to be hospitalized prior to a scheduled procedure. The Utilization committee at St. Joseph’s Health system has been asked to clearly define and supervise appropriate use criteria for these encounters. The UM committee will consider hospital admission on days prior to scheduled surgery medically necessary when any of the following criteria are met:

* Clear treatment of condition for which pain requires parenteral controlled substances of more than one dose, where documentation supports that pain cannot be controlled in the outpatient setting with oral medications. A patient receiving only oral medications in the hospital is not a reason for hospitalization the day before; or
* Clear treatment of infection related to surgery only if infectious condition has worsened requiring IV antibiotics prior to surgery that cannot be treated with oral antibiotics and are necessary to improve the outcome of the surgical procedure; or
* Vascular/Neurologic deterioration/ concerns requiring IV steroids or strict q4 hour /pulse neurologic monitoring due to acceleration of symptoms; or
* A surgical procedure that is not minor, that is scheduled which requires intravenous fluids to achieve and maintain adequate hydration prior to the procedure without which the patient would be at risk. Documentation needs to support this medical decision in the record prior to hospital care. This does not apply to routine hydration; or
* A planned major surgical procedure which requires an extensive bowel preparation (GoLytely, laxatives, multiple enemas) in a patient with a co-morbidity (e.g., chronic renal failure, elderly individual with muscle wasting and poor nutritional status) whose condition places the individual at high-risk for electrolyte and fluid imbalances;*or*
* A planned surgical procedure on partially obstructed bowel which requires a slow but extensive bowel preparation pre-operatively;*or*
* An invasive diagnostic procedure needed to aid and assist (e.g., aortogram, arteriogram or cardiac catheterization, myelogram) with successful management of major surgery scheduled for the following day; *or*
* Close monitoring of blood sugars is required to provide adequate adjustment of regular insulin coverage in preparation for an operative procedure in a brittle insulin-dependent diabetic (i.e., diabetic individuals who experience large, unpredictable changes in blood glucose, within short periods of time, because of very small deviations from schedule); *or*
* Placement of fiducials (small screws) prior to stereotactic brain surgery; *or*
* The patient has a concurrent/developing medical problem that requires specific inpatient treatment prior to major surgery to reduce the operative risk or assure a more favorable outcome; *or*
* The member is scheduled for an open - heart procedure requiring cardiopulmonary bypass (cardiac valve replacement or repair, coronary artery bypass grafting) *and* has unstable angina, congestive heart failure, severe hypertension, or significant ventricular arrhythmias, or is transferred for surgery awaiting surgical scheduling and is deemed unsafe to send home; *or*
* The member requires conversion from coumadin/DOAC to intravenous heparin (not subcutaneous heparin) for a surgical procedure planned for the next day - examples include individuals with:
1. Atrial fibrillation with one of:
* CHADS2 Score >2
* Rheumatic or mechanical valve
* TIA/Stroke within last 3 months
1. Mechanical heart valve with one of:
	1. TIA/Stroke within last 6 months
	2. Aortic or Mitral Valve
2. VTE with one of:
	1. VTE in last 3 months
	2. VTE with associated protein C/S deficiency or antiphospholipid syndrome or antithrombin disease or any clotting disease needing anticoagulant)

Or any documentation with support as to why bridge therapy is required; or

* The member requires intravenous steroid preparation for protection against a previously documented allergic reaction to dye prior to intravascular administration of dye necessary to perform a diagnostic study or operative procedure; *or*
* The member requires intravenous steroid preparation, intravenous anti-convulsant protection, or osmotic diuresis prior to a craniotomy scheduled for the following day (e.g., intracranial arterio-venous malformations).
* Members awaiting transplants are commonly hospitalized prior to surgery.  Hospitalization of such individuals, however, is only considered medically necessary when the member has needs that justify inpatient confinement.  Assessment of the medical necessity of hospitalization prior to transplant surgery is performed using the same criteria that are considered in assessing the medical necessity of hospitalization for other conditions. However, careful documentation by the transplant surgeon can define the risk to the patient not foreseen by these rules in this high-risk population.

The UM committee will consider hospital admission on days prior to scheduled surgery not medically necessary when any of the following criteria are met:

* Preoperative clearance since this should occur routinely on an outpatient basis prior to surgery. However, if a patient is symptomatic requiring cardiac stabilization prior to an urgent or emergent basis then the admission to the hospital before surgery would be appropriate. Unusual circumstances do exist, but documentation needs to clearly explain circumstance (ex. Nursing home patient with functional quadriplegia without ability to transport to office for cardiac clearance)
* Convenience for the physician or patient is never a reason for hospitalization prior to the day of surgery.
* Bypassing the normal scheduling process and diverting patients to the Emergency Department as an urgent hospitalization will be scrutinized through UM committee. The UM committees’ goal is to deter this practice while supporting clinicians who are struggling with scheduling and block time with the support of the CMO.

Patients who do not meet criteria may be issued an Advanced Beneficiary Notice of Non Coverage/HINN1 or appropriate equivalent commercial insurance notification by the UM committee to shift liability for payment to the patient after discussion with the attending.

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