# Cohere Medical Policy -
# Level of Care Criteria for Inpatient vs. Outpatient Services

***Clinical Policy for Medical Necessity Review***

**Version:** 2
**Cohere Health UMC Approval Date: August 28, 2025**
Last Annual Review: August 28, 2025
Revision: Not Applicable
Next Annual Review: August 28, 2026

# Important Notices

## Notices & Disclaimers:

**GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.**

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## Other Notices:



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## Policy Information:

**Specialty Area:** All Specialities
**Policy Name:** Level of Care Criteria
**Type:** [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

**Table of Contents**

# Medical Necessity Criteria

***Service: Level of Care Criteria***

## Description

This policy is intended to aid in determining the appropriate level of care (inpatient vs outpatient) for elective scheduled surgical or interventional procedures. In the absence of explicit indications in the Cohere Health medical policy, medical necessity will be determined using established clinical best practices as supported by peer-reviewed evidence, professional society guidelines, and state or national recommendations, unless directed by the health plan, and with additional consideration of patient-specific factors, including age, comorbidities, and social support, as well as procedural complexity and anticipated complications.

## Medical Necessity Criteria

### Indications

**Inpatient care** is considered appropriate if **ANY** of the following is **TRUE**:

- The surgical or interventional procedure involves **ANY** of the following:
  - The procedure is on the medicare inpatient only (IPO) list; **OR**
  - The procedure is being done in conjunction with a procedure on the medicare IPO list; **OR**
  - The procedure is not low risk, with sufficient complexity or duration indicating the need for close postoperative monitoring(e.g., tikosyn-loading)[1]; **OR**
  - Surgical blood loss that is expected to require a transfusion[2];
  - Post-operative wound care is expected to be extraordinarily complex (e.g., complex drain management, pre-existing tissue damage due to injury, radiation, previous surgery, impaired circulation, sustained pressure, etc), with documentation of necessity and complexity[4]; **OR**
- The patient is considered pediatric and **ANY** of the following[5-7]:
  - The patient is medically complex as reflected in the medical record; **OR**
  - The surgery is considered high risk as defined by **ANY** of the following:

        - Expected blood loss that could require a transfusion; **OR**
        - Duration of anesthesia longer than 2 hours; **OR**
- American Society of Anesthesiologists (ASA) Physical Status Classification System ASA IV or higher in adult patients[8,9]; **OR**
- Clinical comorbidities, including **ANY** of the following:
    - Cardiovascular disease, including **ANY** of the following[10,11]:
        - History of myocardial infarction (MI) within 90 days of the planned surgical procedure; **OR**
        - Coronary artery disease (CAD) with ongoing cardiac ischemia requiring medical management and poor functional capacity (less than 4 METS or Canadian Cardiovascular Society (CCS) Class III or IV angina; **OR**
        - Uncompensated chronic heart failure NYHA Class III or higher; **OR**
        - Severe symptomatic valvular heart disease (VHD)[12]; **OR**
    - Hepatic or renal compromise, including **ANY** of the following[13]:
        - Advanced liver disease with model for end-stage liver disease (MELD) score greater than 8; **OR**
        - End-stage renal disease with hyperkalemia, defined as a serum potassium level greater than 5; **OR**
        - The patient is on scheduled peritoneal dialysis or hemodialysis; **OR**
    - The patient has poorly controlled diabetes mellitus (hemoglobin A1C greater than 8 in the 3 months prior to the planned surgical procedure) and **ANY** of the following[14-16]:
        - The patient has a documented history of frequent large fluctuations in blood glucose concentration (brittle diabetes) with clear documentation in the medical record of the need for inpatient management[17]; **OR**
        - The patient receives enteral or parenteral nutrition; **OR**
    - Respiratory conditions, including **ANY** of the following:
        - Poorly controlled asthma (FEV1 less than 80%) despite appropriate medical management[18]; **OR**
        - Severe chronic obstructive pulmonary disease (COPD) symptomatic despite management or FEV1 less than 50%[19,20]; **OR**
    - Hematologic conditions, including **ANY** of the following:
        - Thrombocytopenia with recent platelet count less than 100,000/microL[21]; **OR**

    - Neurological or neuromuscular conditions, including ANY of the following[22,23]:
        - History of cerebrovascular accident (CVA) within 6 months of planned surgical procedure; **OR**
        - Recent stroke or transient ischemic attack (TIA) within 90 days of planned surgical procedure; **OR**
        - Multiple sclerosis (MS) with acute symptom worsening or documented increased perioperative risk[24]; **OR**
        - Amyotrophic lateral sclerosis (ALS); **OR**
        - Muscular dystrophy; **OR**
    - Chronic, prescription high-dose opioid use[25,26]; **OR**
    - Body mass index (BMI) greater than 40 with documentation of additional medical complexities necessitating inpatient care[27-29]; **OR**
- The patient has documented evidence, including objective screening, of severe dementia[30-32]; **OR**
- The patient is pregnant or within 6 weeks post-partum and has a documented pregnancy-related risk factor necessitating inpatient care (e.g., increased risk of aspiration, thromboembolism, or need for maternal or fetal monitoring).[33,34]

# Medical Evidence

Determination of the appropriate level of care for elective surgical services involves consideration of several patient- and procedure-specific factors. The American Society of Anesthesiologists (ASA) Physical Status Classification System is a widely used preoperative evaluation tool, and has been successfully used in adult patients for over 60 years.[8] A patient's physical status may be determined at several time points prior to the procedure, with the final assessment occurring on the day of surgery. Ferrari et al. (2021) identified that this system is not reliable for use in pediatric patients, notably in the presence of acute illness, and in determining how well a chronic condition was controlled; therefore, the ASA criteria should be reserved for adults.[5]

Bhat et al. (2024) reviewed perioperative management in patients with neuromuscular disorders. The authors note that these patients may be particularly vulnerable to postoperative complications, including aspiration and respiratory compromise, pneumonia, sepsis, and bleeding.[23] Recommendations for postoperative care included postural positioning to mitigate potential respiratory complications, consideration of specific metabolic factors that may be further exacerbated by blood loss and fluid replacement therapy, secretion management in patients unable to self-manage secretions, mitigation of extubation failure risks, and consideration of complications and adverse effects from pain and nausea control medications. These and other potentially serious postoperative complications led the authors to conclude that specific and detailed postoperative plans should be developed and implemented for all patients with neuromuscular disorders.

Hedge et al. (2017) reviewed ischemic heart disease and associated risk factors in elective surgery patients. They found that these patients are prone to myocardial infarction and arrhythmias during surgery; therefore, a thorough preoperative evaluation is needed, and any modifiable risk factors should be corrected prior to surgery.[11]

Sethuraman et al. (2022) provided a narrative review of studies of Hemoglobin A1c (HgbA1c) levels within 8-12 weeks of surgery. While there is no consensus, they suggested HgbA1c levels should be checked prior to elective surgery and recommend a cut-off level of HgbA1c less than 8, with consideration of a lower cut-off of less than 7 for spine and joint replacement surgeries and cardiac surgeries.[14]

Madsen et al. (2023) discuss the additional risks associated with surgery in obese patients. These include longer operative times with higher adjusted odds of developing infection, venous thromboembolism, and renal complications.[28]

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# Policy Revision History/Information

| Original Date: July 30, 2024 | | |
|---|---|---|
| **Review History** | | |
| Version 2 | 08/28/2025 | Annual review.<br><br>Policy title changed. Formerly “Site of Service Criteria for Inpatient vs. Outpatient Services”.<br><br>Added indications for procedures on the Medicare IPO list, done in conjunction with such a procedure, and procedures not considered low risk.<br><br>Added indications for procedures or patients with high probability of complex wound care, advanced dementia, pregnancy, and post-partum.<br><br>Refined and clarified criteria for ASA physical classification, diabetes, MS, addiction, high BMI.<br><br>Removed criteria for cardiac arrhythmia, hypertension, obstructive sleep apnea, bleeding disorders, sickle cell disease, oxygen dependence.<br><br>Reorganized criteria for clarity and ease-of-use.<br><br>Added description section.<br><br>References added and updated throughout.<br><br>Literature review - Medical Evidence section updated (Bhat et al., 2024). |