Elective Inpatient Services (for Idaho Only)

Policy Number: CS182ID.A
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Related Policies

None

Application

This Medical Policy only applies the state of Idaho, including Idaho Medicaid Plus plans.

Coverage Rationale

UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions, when applicable. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Click here to view the InterQual® criteria.

A planned elective inpatient admission for certain surgeries or procedures is considered medically necessary when any of the following criteria are met:

- Medical conditions increasing the risk of major post-operative complications:
  - Advanced liver disease (MELD Score > 8)
  - Cognitive status that warrants inpatient stay
  - Severe renal disease (GFR ≤ 30 mL/min)
  - Severe valvular heart disease
  - Stroke or TIA within last 3 months
  - Symptomatic chronic lung disease (e.g., asthma, COPD)
  - Symptomatic coronary artery disease or heart failure
  - Unstable medical condition (e.g., poorly controlled diabetes)
- Procedure related factors that may increase the risk of complications:
  - Anesthetic risk
    - American Society of Anesthesiologists class III or greater
    - Age 85 years or older
    - High risk for thromboembolism
    - Moderate (AHI 15-30) to severe (AHI > 30) sleep apnea
    - Persistent electrolyte abnormalities unresponsive to treatment (e.g., hyperkalemia, hyponatremia)
    - Risk of post-operative airway compromise (e.g., open neck procedure, airway surgery)
  - Complexity of surgical procedure
    - Complex surgical approach (e.g., unusually extensive dissection needed)
    - Complex post-operative wound care (e.g., complex drain management, open wound, previous local tissue injury resulting from factors such as radiation, previous surgery, impaired circulation, sustained pressure)
    - Difficult approach because of previous operation
    - Extensive or prolonged (longer than the usual time frame) surgery

- The need for pre-operative diagnostic studies that cannot be performed as an outpatient
- Advance surgical planning determines an individual requires inpatient recovery and care following a surgical procedure:
  - Individual's residence is distant to medical facility and there is a potential for urgent complications and no other nearby temporary residence is available and not appropriate for ambulatory or observation level of care
  - Pre- or post-operative inpatient monitoring or treatment related to need to discontinue drugs or other therapies
- Procedural related event that may require an inpatient stay as indicated by any of the following:
  - Acute Kidney Injury
  - Altered mental status that is severe or persistent
  - Ambulatory or appropriate activity level status is not achieved
  - Conversion to open or complex procedure that requires inpatient care
  - Excessive drainage or bleeding from the operative site
  - Hemodynamic Instability
  - Longer post-operative monitoring or treatment is needed due to preoperative use of drugs (e.g., cocaine, amphetamines)
  - Pain, fever, or vomiting not appropriate for ambulatory or observation level of care
  - Severe complications of procedure (e.g., bowel injury, airway compromise, vascular injury)
  - Unstable clinical status

Note: This policy does not apply to an obstetric member during pregnancy, childbirth, or the post-partum period.

Definitions

Acute Kidney Injury: Acute Kidney Injury is defined as any of the following:
- Increase in the serum creatinine value of ≥ 0.3 mg/dL (26.52 micromol/L) in 48 hours
- Increase in serum creatinine of ≥ 1.5 times baseline within the prior 7 days
- Reduction of more than 50% in estimated glomerular filtration rate from baseline
- Urine volume < 0.5 mL/kg/hour for 6 hours (KDIGO, 2012)

Apnea Hypopnea Index (AHI): The number of apneas plus the number of hypopneas during the entire sleeping period, times 60, divided by total sleep time in minutes; unit: event per hour (AASM Scoring Manual, 2020).

ASA Physical Status Classification System Risk Scoring Tool: The American Society of Anesthesiologists (ASA) physical status classification system was developed to offer clinicians a simple categorization of a patient's physiological status that can be helpful in predicting operative risk. The ASA score is a subjective assessment of a patient's overall health that is based on five classes.

Hemodynamic Instability: Vital sign abnormality not readily corrected by appropriate treatment as indicated by 1 or more of the following:
- A systolic blood pressure < 90 mm hg or decrease in systolic blood pressure > 40 mm hg
- Oliguria treatment goal of 0.5 ml/kg/hour urine output
- Mean arterial pressure (MAP) is < 65 mm hg
- New abnormal capillary refill (greater than 3 seconds)
- Altered level of consciousness
- Shortness of breath
- Persistent tachycardia (Sevransky, 2009)

Clinical Evidence

American Academy of Sleep Medicine (AASM)

The AASM defines obstructive sleep apnea as a sleep related breathing disorder that involves a decrease or complete halt in airflow despite an ongoing effort to breathe.
OSA severity is defined as:
- Mild for AHI or RDI ≥ 5 and < 15
- Moderate for AHI or RDI ≥ 15 and ≤ 30
- Severe for AHI or RDI > 30/hour (AASM, 2008)

American College of Cardiology (ACC) and American Heart Association (AHA)

The ACC and AHA Task Force states in the 2014 guideline on perioperative cardiovascular evaluation and management of patients undergoing noncardiac surgery, evaluation of patients should include assessment of perioperative risk, determination of the need for changes in management, and identification of cardiovascular conditions or risk factors requiring longer-term management. Changes in management can include the decision to change medical therapies, the decision to perform further cardiovascular interventions, or recommendations about postoperative monitoring. This may lead to recommendations and discussions with the perioperative team about the optimal location and timing of surgery (e.g., ambulatory surgery center versus outpatient hospital, or inpatient admission) or alternative strategies (Fleisher et al., 2014).

American Heart Association (AHA)

In collaboration with the American College of Cardiology, the AHA has identified four stages of heart failure.

Stage A: At risk for heart failure. People who are at risk for heart failure but do not yet have symptoms or structural or functional heart disease. Risk factors for people in this stage include hypertension, coronary vascular disease, diabetes, obesity, exposure to cardiotoxic agents, genetic variants for cardiomyopathy and family history of cardiomyopathy.

Stage B: Pre-heart failure. People without current or previous symptoms of heart failure but with either structural heart disease, increased filling pressures in the heart or other risk factors.

Stage C: Symptomatic heart failure. People with current or previous symptoms of heart failure.

Stage D: Advanced heart failure. People with heart failure symptoms that interfere with daily life functions or lead to repeated hospitalizations.

American Society of Anesthesiologists (ASA)

The ASA Physical Status Classification System's purpose is to assess and communicate a patient's pre-anesthesia medical co-morbidities.
Physical Status Classification:

- ASA I - A normal healthy patient
- ASA II - A patient with mild systemic disease
- ASA III - A patient with severe systemic disease
- ASA IV - A patient with severe systemic disease that is a constant threat to life
- ASA V - A moribund patient who is not expected to survive without the operation
- ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes (ASA, 2020)

The 2014 ASA Task Force on Perioperative Management of Patients with Obstructive Sleep Apnea states that a determination should be made regarding whether a surgical procedure is most appropriately performed on an inpatient or outpatient basis.
Factors to be considered in determining whether outpatient care is appropriate include:

- Sleep apnea status
- Anatomical and physiologic abnormalities
- Status of coexisting diseases
- Nature of surgery
- Type of anesthesia
- Need for postoperative opioids
- Patient age
- Adequacy of post discharge observation
- Capabilities of the outpatient facility (ASA, 2014)

Global Initiative for Asthma (GINA)

The 2023 GINA report on Global Strategy for Asthma Management and Prevention found no evidence of increased peri-operative risk for the general asthma population. There is an increased risk for individuals with COPD and in asthma patients with reduced FEV. For elective surgery, attention should be paid pre-operatively to achieving good asthma control especially in individuals with severe asthma, uncontrolled symptoms, exacerbation history, or persistent airflow limitation (GINA, 2023).

References

American Academy of Sleep Medicine (AASM). Obstructive Sleep Apnea. 2008.

American Heart Association (AHA). Stages of Heart Failure. Available at: Classes of Heart Failure | American Heart Association.

American Society of Anesthesiologists (ASA). Statement on ASA Physical Status Classification System (asahq.org). December 13, 2020.

American Society of Anesthesiologists Task Force on Perioperative Management of patients with obstructive sleep apnea. Practice guidelines for the perioperative management of patients with obstructive sleep apnea: an updated report by the American Society of Anesthesiologists Task Force on Perioperative Management of patients with obstructive sleep apnea. Anesthesiology. 2014 Feb;120(2):268-86.

Fleisher LA, Fleischmann KE, Auerbach AD, et al. 2014 ACC/AHA guideline on perioperative cardiovascular evaluation and management of patients undergoing noncardiac surgery: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014 Dec 9;130(24):e278-333.

Global Initiative for Asthma (GINA) Report. Global Strategy for Asthma Management and Prevention. 2023.

Policy History/Revision Information

Date	Summary of Changes
06/01/2025	• New Medical Policy

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.