Inpatient Recommendation Following Procedures

Physician Advisor Decision Support Tool

Purpose

This decision support tool is designed to assist Physician Advisors in evaluating whether an **inpatient admission recommendation** is clinically appropriate following surgical or procedural interventions, particularly in the context of the **Inpatient-Only (IPO) list phase-out**.

In addition to PA decision support, this tool may be used as a **physician-facing educational aid** to:

- Facilitate informed discussions regarding anticipated patient status
- Align expectations around inpatient versus outpatient care
- Support shared understanding of clinical risk, intensity, and expected course

This tool supports **clinical judgment**.
It does **not** replace physician decision-making, CMS policy, or case-specific analysis.

Guiding Principles

- There is **no longer a procedural shortcut** for inpatient status
- Removal of a procedure from the IPO list does **not** mandate outpatient status
- Inpatient appropriateness is determined by **patient-specific risk, intensity, and expected care needs**
- The Two-Midnight framework remains relevant but is **not absolute**
- No single factor is determinative

This tool is intended to promote **consistent, defensible clinical reasoning**, not rigid rules.

Procedure-Related Considerations

When reviewing a procedural case, consider:

- Expected physiologic stress of the procedure
- Anticipated complexity of post-procedure recovery
- Expected post-procedure pain management requirements
- Risk of procedure-related complications
- Need for close post-procedure monitoring or frequent reassessment

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Patient-Specific Risk Factors

Evaluate individual patient characteristics that may affect recovery:

- Significant medical comorbidities
- Frailty, advanced age, or limited physiologic reserve
- History of complications with similar procedures
- Cognitive, functional, or mobility limitations
- Baseline respiratory, cardiac, or renal vulnerability

Patient-specific factors may independently justify inpatient care.

Post-Procedure Care Requirements

Assess anticipated care needs following the procedure:

- Need for hospital-level nursing care
- Requirement for IV medications, fluids, or blood products
- Need for invasive monitoring
- Planned diagnostics or interventions requiring inpatient resources
- Anticipated escalation risk during early recovery

These needs often drive inpatient necessity more than procedural complexity alone.

Expected Clinical Course

Consider the anticipated post-procedure trajectory:

- Expected duration of medically necessary hospital care
- Risk of early clinical deterioration or instability
- Degree of uncertainty in early recovery
- Likelihood that discharge readiness cannot be safely determined within a short outpatient timeframe

Clinical uncertainty and risk are valid considerations.

Two-Midnight Consideration (Decision Support)

As part of the expected clinical course assessment, determine whether the patient is **reasonably expected** to require **medically necessary hospital care spanning two midnights** (the Two-Midnight benchmark).

Consider:

- The **cumulative time** the patient is expected to require hospital-level care, including medically necessary ED or outpatient time prior to admission when applicable
- Whether anticipated post-procedure monitoring, treatment intensity, and risk profile reasonably support care spanning **two or more midnights**
- Whether any recognized **exceptions** apply (e.g., high-risk clinical scenario, unforeseen circumstance preventing a second midnight)

Key reminder:
Crossing (or not crossing) two midnights is **supporting evidence**, not the sole determinant. Clinical risk and intensity remain central.

Disposition and Support Considerations

Evaluate whether safe outpatient recovery is realistic:

- Adequacy of home support
- Ability to manage pain, mobility, or wound care outside the hospital
- Need for inpatient therapy or rehabilitation assessment
- Barriers to safe or timely outpatient follow-up

Disposition limitations may support inpatient admission when combined with clinical risk.

Documentation Expectations

When an inpatient recommendation is made, documentation should clearly reflect:

- Clinical rationale for inpatient-level care
- Identified risks, uncertainties, or intensity of services
- Expected post-procedure care needs

- Anticipated clinical course
- Whether care is expected to span **two midnights** and **why**, using clinical reasoning rather than time alone

Documentation should emphasize **clinical judgment**, not policy language.

Key Reminders for Physician Advisors

- There is **no default status** once a procedure is removed from the IPO list
- Short stays can still represent appropriate inpatient admissions
- Time thresholds do **not** replace clinical judgment
- This tool supports decision-making; it does not dictate outcomes

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Use for Physician Education

This tool may be shared with physicians to:

- Frame pre-procedure discussions regarding anticipated patient status
- Clarify factors that support inpatient-level care
- Reinforce that inpatient decisions are based on **clinical risk and expected care needs**, not procedure labels or time alone

When used for physician education, this tool should be presented as:

- A **clinical reasoning framework**
- A support for shared decision-making
- Not a utilization or billing rule

How to Use This Tool

This decision support tool is intended for use:

- During pre-procedure case review
- When advising surgeons on anticipated patient status
- In utilization review discussions
- When evaluating short-stay procedural admissions

It is **not** a billing or coding checklist and should not be used as an audit scoring tool.

Bottom Line

As the IPO list is phased out, **Physician Advisors play a critical role** in ensuring that inpatient admission decisions for procedural cases remain:

- Clinically appropriate
- Patient-specific
- Well-reasoned
- Defensible

This decision support tool is designed to support both **PA decision-making** and **physician education** during that transition.

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