

# Musculoskeletal Program

# Preoperative Admission

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# Description and Application of the Guidelines

The AIM Clinical Appropriateness Guidelines (hereinafter “AIM Clinical Appropriateness Guidelines” or the “Guidelines”) are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. As used by AIM, the Guidelines establish objective and evidence-based, where possible, criteria for medical necessity determinations. In the process, multiple functions are accomplished:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To advocate for patient safety concerns
- To enhance the quality of healthcare
- To promote the most efficient and cost-effective use of services

AIM guideline development process complies with applicable accreditation standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up to date clinical principles and best practices. Relevant citations are included in the “References” section attached to each Guideline. AIM reviews all of its Guidelines at least annually.

AIM makes its Guidelines publicly available on its website twenty-four hours a day, seven days a week. Copies of the AIM Clinical Appropriateness Guidelines are also available upon oral or written request. Although the Guidelines are publicly-available, AIM considers the Guidelines to be important, proprietary information of AIM, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of AIM.

AIM applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The AIM Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient’s unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient’s condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient’s care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. If requested by a health plan, AIM will review requests based on health plan medical policy/guidelines in lieu of the AIM Guidelines.

The Guidelines may also be used by the health plan or by AIM for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

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# Preoperative Admission Guidelines for Musculoskeletal Surgery and Procedures

## Description and General Requirements

The intent of this guideline is to assist in determining appropriate indications for hospital admission prior to elective surgery. The vast majority of musculoskeletal procedures do not require preoperative day admission. Providers should be prepared to submit the required supporting medical documentation to include but not limited to:

- Provider office notes detailing preoperative medical optimization\*
- List of managed or unmanaged comorbidities and/or other surgical risk factors
- If requested, the specific reason for an inpatient preoperative day
- Copies of medical consultations or clearances
- If available, ASA physical status ([Appendix A](#)), Charlson comorbidity score, or other validated surgical risk score

This guideline does not address the clinical appropriateness of the procedure. The AIM prior authorization process for clinical appropriateness of the surgical procedure is completed separately and precedes the level of care determination.

A preoperative day is an inpatient admission 24 hours prior to the scheduled date of an inpatient surgical procedure. This guideline applies to elective musculoskeletal surgical procedures and does not apply to fractures, infections, tumors or other emergent non-elective cases.

\*All patients are expected to undergo medical optimization on an outpatient basis. Medical optimization is not an indication for preoperative day admission.

## Indications

Preoperative admission is indicated when the admission has been shown or is reasonably expected to reduce surgical risk and improve patient centered outcomes relative to outpatient preoperative preparation. One preoperative day is considered medically necessary for any one of the following indications:

- Ensuring adherence to preoperative preparations
  - Bowel preparations such as Golytely when patients cannot complete the prep at home
  - Prophylaxis against contrast allergy
- Preoperative intravenous medication administration
  - Bridging anticoagulation
- Expedite/perform additional procedures prior to the surgery
  - Interventional radiology

- Nasogastric tube

## Selected References

- 1 deFreitas, DJ, Kasirajan, K, Ricotta, JJ, 2nd, et al. Preoperative inpatient hospitalization and risk of perioperative infection following elective vascular procedures. *Annals of vascular surgery*. 2012;26(1):46-54.
- 2 Fleisher, LA, Pasternak, L, Herbert, R, et al. Inpatient hospital admission and death after outpatient surgery in elderly patients: Importance of patient and system characteristics and location of care. *Archives of Surgery*. 2004;139(1):67-72.
- 3 Fleisher, LA, Pasternak, LR, Lyles, A. A novel index of elevated risk of inpatient hospital admission immediately following outpatient surgery. *Archives of surgery (Chicago, Ill : 1960)*. 2007;142(3):263-8.
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- 5 Kulasegarah, J, Lang, EE, Carolan, E, et al. Day of surgery admission—is this safe practise? *Irish medical journal*. 2008;101(7):218-9.
- 6 Martin, CT, Pugely, AJ, Gao, Y, et al. Thirty-Day Morbidity After Single-Level Anterior Cervical Discectomy and Fusion: Identification of Risk Factors and Emphasis on the Safety of Outpatient Procedures. *J Bone Joint Surg Am*. 2014;96(15):1288-94.
- 7 Mathis, MR, Naughton, NN, Shanks, AM, et al. Patient selection for day case-eligible surgery: identifying those at high risk for major complications. *Anesthesiology*. 2013;119(6):1310-21.
- 8 Santaguida, PL, Hawker, GA, Hudak, PL, et al. Patient characteristics affecting the prognosis of total hip and knee joint arthroplasty: a systematic review. *Canadian journal of surgery Journal canadien de chirurgie*. 2008;51(6):428-36.
- 9 Soohoo, NF, Farnig, E, Lieberman, JR, et al. Factors that predict short-term complication rates after total hip arthroplasty. *Clinical orthopaedics and related research*. 2010;468(9):2363-71.
- 10 Tamames, S, Perez Rubio, A, Castrodeza Sanz, J, et al. Factors associated with the appropriate use of preoperative hospital stays: historical cohort study. *BMC health services research*. 2007;7:187.

## Appendix A. ASA Physical Status Classification System

ASA PS Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

\*The addition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

Source: 2014 [ASA Physical Status Classification System](#) available at the American Society of Anesthesiologists website; Accessed November 21, 2017.

## History

Status	Date	Action
Reviewed	12/12/2017	Independent Multispecialty Physician Panel review.
Created	03/01/2018	-