



Cigna Medical Coverage Policy

Subject Preoperative Inpatient Admissions

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna companies. Coverage Policies are intended to provide guidance in interpreting certain **standard** Cigna benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supersedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations. Proprietary information of Cigna. Copyright ©2014 Cigna

Coverage Policy

Cigna covers inpatient admission the day prior to elective surgery as medically necessary when an individual's primary or secondary diagnosis requires an inpatient level of care for stabilization or preparation necessary for the planned procedure.

General Background

In general, patients who undergo elective surgery are admitted to the hospital on the day of surgery. This has become a standard of care over the past decade. Preoperative evaluations, preparation and testing are usually performed prior to surgery on an outpatient basis. Clinical issues that are identified through the preoperative evaluation process may require further work-up and management. This screening may also identify unusual circumstances that may necessitate admission to the hospital prior to the surgical procedure.

The preoperative evaluation includes an assessment of risk that may impact the operative outcome. The assessment includes history and physical and various screening tests. The decision regarding which tests to perform is dependent on factors including: patient's age, type of procedure, and the disease or condition of the patient. The testing may include electrocardiogram (ECG), chest radiograph, urinalysis, coagulation studies, creatinine, glucose, electrolytes, hematocrit, and hemoglobin.

While certain procedures carry a higher risk; the necessity of admission on the day prior to surgery is often dependent on concurrent disease or medical condition, and is based on case-specific factors. The plan of care, the services that will be rendered, age of patient, comorbid diagnosis and medical condition, and the surgical procedure that is planned must all be considered.

Hospital Admission Prior to Day of Surgery

Anticoagulation: Patients who receive anticoagulation therapy may require reversal of the anticoagulant effect before surgery. Factors to be considered include: type of surgical procedure, type of anesthesia, patient-specific risk factors, and the anticoagulation agent being used (Pass and Simpson, 2004). Unfractionated heparin or low molecular-weight heparin (LMWH) may be used as a bridge from discontinuation of warfarin to surgery. In patients taking warfarin, the drug is typically held for several days preoperatively to allow the International Normalized Ratio (INR) to fall to a range of 1.5 or less. Patients with an increased risk for recurrent events in the perioperative period (e.g., mechanical heart valves, atrial fibrillation, or recent history of venous thromboembolism or acute arterial embolism) may require hospitalization for administration of intravenous unfractionated heparin during this period (Kearon, 1997). Low molecular-weight heparin may be considered in patients with a lower risk (Douketis, et al., 2012). LMWH can be provided on an outpatient basis and should be held for at least 12 hours before surgery (Pass and Simpson, 2004).

Bowel Preparation: Preparation for colon surgery usually includes purging the colon of feces and administration of antibiotics. Several methods of bowel preparation regimens and antibiotic combinations are currently in use (Neumayer and Vargo, 2008). The bowel preparation is usually performed in the home environment; however, there may be rare cases (e.g., very young age of patient, debilitated patient or risk of fluid electrolyte imbalance) when this should be performed on an inpatient basis.

Diabetes Mellitus: Preoperative assessment may include fasting and postprandial glucose and hemoglobin A1c levels. For some diabetic patients, there may be circumstances where intravenous insulin administration may be the best option to maintain glycemic control. The following principles generally apply to diabetic patients undergoing surgery (Neumayer and Vargo, 2008):

- Substitute shorter-acting insulin for longer-acting insulin.
- Provide reduced doses of insulin on morning of surgery.
- Once a diabetic who is receiving nothing by mouth is given insulin, provide glucose in intravenous fluids.
- In type 2 diabetic patients, long-acting sulfonylurea drugs such as chlorpropamide should be stopped and shorter-acting agents should be substituted.
- Metformin should be stopped due to the slight risk of perioperative drug-induced lactic acidosis.

Perioperative Drug Management: Most medications used in the treatment of chronic disease should be continued in the perioperative period. Patients are usually advised to take medications with a sip of water the morning of surgery. There are circumstances where the medication may require intravenous administration preoperatively. This may occur in a patient who is unstable prior to surgery or is unable to take oral medications the day prior to surgery. Examples may include, but are not limited to, the following:

- Anticonvulsant: Patients with seizure disorder may require anticonvulsants administered intravenously.
- Steroids: Patients may require intravenous administration of steroids.
- Parkinson's disease: Patients undergoing surgery for insertion of a neurostimulator may require inpatient level of care for discontinuance of medication.
- Antiarrhythmic drug therapy: Patients undergoing electrophysiological studies may require inpatient level of care for monitoring while these medications are discontinued.

Procedure Performed Prior to Surgery: There may be circumstances when an invasive procedure is preformed the day prior to major surgery. In some of these situations, the patient may be required to be kept after the invasive procedure without oral intake and oral medications until surgery the next day. In these situations, inpatient admission the day prior to surgery may be necessary. Examples of these invasive procedures include, but are not limited to, the following:

- embolization of tumor or vascular malformation
- arteriography in patient with renal failure
- cardiac catheterization

Preoperative Magnetic Resonance Imaging (MRI) with Fiducials: At times a MRI with placement of fiducials, a set of markers, is completed before a planned craniotomy to assist in confirmation of anatomic identity during surgery. It may be difficult to perform this on the same day as surgery, and therefore an admission the day prior to surgery may be needed.

Renal Failure: The patient with end-stage renal disease on hemodialysis may require close attention in the perioperative time period. They may require close observation of fluid and electrolytes balance, as well as intravenous administration of fluid and sodium bicarbonate. Dialysis may also be required prior to surgery to optimize the fluid and potassium level. Blood transfusion may be required before surgery due to low hematocrit.

Unstable Cardiac Status: Patients scheduled for open-heart procedure are generally admitted the day of surgery. They may be admitted the day prior to the surgical procedure in the presence of an unstable cardiac condition including, but not limited to, one of the following conditions:

- unstable angina
- congestive heart failure
- severe hypertension
- significant ventricular arrhythmia

Use Outside of the US

No relevant information

Summary

Patients undergoing surgical procedures in an inpatient setting are generally admitted the day of surgery. The preoperative preparation and evaluation can be performed on an outpatient basis. There may be unusual circumstances due to comorbid conditions that require the patient to be admitted the day prior to surgery for preoperative preparation.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.

- 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

Covered when medically necessary:

Revenue Codes*	Description
0121	Room & Board - SP 2Bd, Med/Surg/Gyn
0131	Room & Board - SP 3 - 4 Bd, Med/Surg/Gyn
0151	Room & Board – Ward, Med/Surg/Gyn

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References

1. American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Practice advisory for preanesthesia evaluation: a report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology*. 2002 Feb;96(2):485-96.
2. DeVita VT, Lawrence TS, Rosenberg SA, editors. DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2011.
3. Douketis JD, Spyropoulos AC, Spencer FA, Mayr M, Jaffer AK, Eckman MH, et al.; American College of Chest Physicians. Perioperative management of antithrombotic therapy: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. *Chest*. 2012 Feb;141(2 Suppl):e326S-50S.

4. Fleisher LA, Beckman JA, Brown KA, Calkins H, Chaikof E, Fleischmann KE, Freeman WK; ACC/AHA Task force members, Smith SC Jr, Jacobs AK, Adams CD, Anderson JL, Antman EM, Buller CE, Creager MA et al. ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Revise the 2002 Guidelines on Perioperative Cardiovascular Evaluation for Noncardiac Surgery): Developed in Collaboration With the American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society of Cardiovascular Anesthesiologists, Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, and Society for Vascular Surgery. *Circulation*. 2007 Oct 23;116(17):1971-96.
5. Halaszynski TM, Juda R, Silverman DG. Optimizing postoperative outcomes with efficient preoperative assessment and management. *Crit Care Med*. 2004 Apr;32(4 Suppl):S76-86.
6. Institute for Clinical Systems Improvement (ICSI). Perioperative Protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2014 Mar. Accessed July 1, 2014. Available at URL address: https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_patient_safetyreliability_guidelines/perioperative/
7. Kearon C, Hirsh J. Management of anticoagulation before and after elective surgery. *N Engl J Med*. 1997 May 22;336(21):1506-11.
8. McAnulty GR, Robertshaw HJ, Hall GM. Anaesthetic management of patients with diabetes mellitus. *Br J Anaesth*. 2000 Jul;85(1):80-90.
9. Miller RD, Eriksson LI, Fleisher LA, Wiener-Kronish JP, Young WL. *Miller's Anesthesia* 7th ed. Philadelphia: Elsevier; 2009.
10. Neumayer L, Vargo D. Principles of Preoperative and Operative Surgery. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. *Sabiston Textbook of Surgery*, 19th edition. Philadelphia: Elsevier Saunders; 2012. ch 11.
11. Pass SE, Simpson RW. Discontinuation and reinstatement of medications during the perioperative period. *Am J Health Syst Pharm*. 2004 May 1;61(9):899-912.
12. Smetana GW, Cohn SL, Lawrence VA. Update in perioperative medicine. *Ann Intern Med*. 2004 Mar 16;140(6):452-61.

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