Repair of Pelvic Organ Prolapse

ORG: S-1020 (ISC)
Link to Codes

MCG Health
Inpatient & Surgical Care
30th Edition

Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Procedure

- Procedure is indicated for **1 or more** of the following(1)(2):NNN
  - Symptomatic pelvic organ prolapse, as indicated by **ALL** of the following(1)(2):
    - Prolapse is symptomatic,[A] as indicated by **1 or more** of the following:
      - Voiding dysfunction due to prolapse (eg, incomplete emptying, difficulty urinating, recurrent infection)(1)(2)(9)
      - Defecatory dysfunction due to prolapse (eg, incomplete emptying, constipation, incontinence, pain)(1)(2)
      - Sexual dysfunction due to prolapse (eg, dyspareunia)(1)(2)
      - Vaginal bulge or visible prolapse(1)(2)
      - Limitation of physical activity due to prolapse(1)(2)
      - Discomfort due to prolapse (eg, pressure, pain)(1)(2)
    - Nonoperative treatment is not appropriate, as indicated by **1 or more** of the following:
      - Failure of nonoperative care (eg, pessary, pelvic floor muscle training)(1)(2)
      - Patient declines nonoperative care.(1)(2)
  - Concomitant procedure (eg, hysterectomy, urethral suspension) planned and patient judged to be at high risk for postoperative development or worsening of pelvic organ prolapse(4)(10)

Alternatives to Procedure

- Alternatives include(1)(2)(6)(10)(11):N
  - Pessary(9)(12)(14)
  - Pelvic floor muscle training(6)(9)
  - Fiber supplement or osmotic laxative for defecatory dysfunction(9)

Operative Status Criteria

Goal Length of Stay: Ambulatory

Note: The definition of an ambulatory procedure depends on payer-provider contractual agreement or regulatory language (eg, CMS' Two-Midnight Rule). An ambulatory procedure may include one postoperative overnight stay in a facility; therefore, MCG's ambulatory Goal Length of Stay (GLOS) attainment calculation reports the sum of same-day and next-day postoperative discharges. Depending on various patient and procedural factors, some patients undergoing a procedure with an ambulatory GLOS require inpatient care (eg, medical necessity for hospital-based care across 2 or more postoperative midnights). Some of these factors are described in the Extended Stay section of this guideline.

- Ambulatory
- Inpatient (eg, medical necessity for hospital-based care across 2 or more postoperative midnights)
- Inpatient (Medicare patient, and specific procedure is on CMS Inpatient Only List)

Hospitalization

Optimal Recovery Course

Day	Level of Care	Clinical Status	Activity	Routes	Interventions	Medications
1	• Social Determinants of Health Assessment • OR to recovery room to discharge[B] • Discharge planning	• **Hemodynamic stability** • **No evidence of bowel obstruction** • **No evidence of postoperative or surgical site infection** • **Voiding or urine managed with catheter** • **Pain absent or managed** • **Discharge plans and education understood**	• **Ambulatory or acceptable for next level of care**	• **Oral hydration[C]** • **Oral medications or regimen acceptable for next level of care** • **Oral diet or acceptable for next level of care**	• Possible CBC, renal function tests, electrolytes	• Possible oral analgesics • Prophylactic antibiotics

(1)(8)(15)(16)(17)(18)

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: Ambulatory

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Extended Stay

Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Inpatient stay (eg, need for hospital-based care beyond postoperative day 1) may be needed for(1)(19):
  - Failure to meet discharge criteria (recovery milestones in Optimal Recovery Course)
    - Expect brief stay extension.
  - Complications of procedure (eg, vascular, rectal, or urinary tract injury)(18)(20)
    - Complications may require surgical repair.
    - Expect brief to moderate stay extension.
  - Functional abnormalities (eg, inability to ambulate, urinary retention)(20)(21)
    - Abnormalities may require observation and evaluation for possible anatomic injury.
    - Expect brief stay extension.
  - Active comorbidities (eg, renal failure, COPD, heart failure) that require prolonged inpatient care
    - Expect brief stay extension.

See Common Complications and Conditions ISC for further information.

Discharge

Discharge Planning

- Discharge planning includes[D]:
  - Assessment of needs and planning for care, including(23)(24):
    - Develop and modify treatment plan (involving multiple providers) as needed.
    - Evaluate and address preadmission functioning as needed.
    - Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment SR for further information.
    - Evaluate and address social determinants of health (eg, housing, food). See Social Determinants of Health Screening Tool SR for further information.
    - Evaluate and address patient or caregiver preferences as indicated.
    - Identify skilled services needed at next level of care, with specific attention to:
      - Gastrointestinal status assessment(25)
      - Genitourinary status assessment(26)
      - Pain management(27)
  - Early identification of anticipated discharge destination; options include(24)(28):
    - Home; considerations include:
      - Home safety assessment. See Home Safety Assessment SR for further information.
      - Patient safe to go home; examples include(29)(30)(31):
        - Medical status stable for patient's condition
        - Functional care can safely be provided with available resources.
        - Mental status stable for patient's condition
        - Medication availability confirmed and reconciliation complete
        - Patient/caregiver education completed with written discharge instructions provided
        - Community resources identified and referrals made, as needed
        - Home care arranged, if indicated
        - Necessary medical equipment delivery arranged or available in home, if indicated
        - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated
      - Access to follow-up care
      - Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment SR for further information.
      - Caregiver need, ability, and availability
    - Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool SR for further information.
  - Transitions of care plan complete, including(24)(28)(32):
    - Patient and caregiver education complete.
      - See Teach-Back Tool SR for further information.
      - See Repair of Pelvic Organ Prolapse: Patient Education for Clinicians SR for further information.
    - Medication reconciliation completion includes(33)(34):
      - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
      - Assess each medication for correlation to disease state or medical condition.
      - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
      - Provide reconciled medication list to all treating providers.
      - Confirm that patient or caregiver can acquire medication.
      - Educate patient and caregiver.
        - Provide complete medication list to patient and caregiver.
        - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
        - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(35)
      - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
      - See Medication Reconciliation Tool SR for further information.
    - Plan communicated to patient, caregiver, and all members of care team, including(36):
      - Inpatient care and service providers
      - Primary care provider
      - All post-discharge care and service providers
    - Appointments planned or scheduled, which may include:
      - Primary care provider(37)
      - Gynecologist(38)

        - Urologist
        - Other
    - Outpatient testing and procedure plans made, which may include:
        - Other
    - Referrals made for assistance or support, which may include:
        - Financial, for follow-up care, medication, and transportation(39)
        - Tobacco use treatment(40)
        - Other
    - Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
        - Wound care equipment and supplies(27)(41)
        - Other

Discharge Destination

- Post-hospital levels of admission may include:
    - Home.
    - Home healthcare. See Home Care Indications for Admission Section HC in Incontinence and Pelvic Support Surgery guideline in Home Care.

Evidence Summary

Background

Pelvic organ prolapse occurs with the loss of connective tissue support, which allows nearby organs (bowel, bladder, uterus) to herniate through the urogenital hiatus into the vaginal space.(1) **(EG 2)** Pelvic organ prolapse may be repaired by using an abdominal, minimally invasive (laparoscopic, robot-assisted), or transvaginal approach.(3)(4) **(EG 2)** A specialty society guideline concludes that, when possible, a minimally invasive approach to apical vaginal prolapse should be performed.(5) **(EG 2)**

Criteria

The evidence for the clinical indications found in this guideline includes 3 published peer reviewed articles, 4 specialty society or other evidence-based guidelines, 2 Cochrane systematic reviews, and 1 book section.

For symptomatic pelvic organ prolapse, a joint specialty society guideline states that surgical repair is reasonable in patients with prolapse-related issues such as vaginal bulge or pressure, urinary symptoms, or defecatory dysfunction.(1) **(EG 2)** Specialty society practice guidelines and a narrative review state that nonoperative and surgical treatment options should be reviewed with patients who have symptomatic pelvic organ prolapse.(1)(2)(6) **(EG 2)**

Approximately 40% of women without stress urinary incontinence develop symptoms of stress urinary incontinence after surgical correction of pelvic organ prolapse.(2) **(EG 2)** A meta-analysis of randomized controlled trials evaluating surgical repair of pelvic organ prolapse in women with or without urinary incontinence (2717 women) found that repair of the prolapse with concomitant midurethral sling in women with stress urinary incontinence reduced subjective complaints of stress urinary incontinence postoperatively.(7) **(EG 1)**

A guideline from 2 specialty societies recommends the following components of Enhanced Recovery After Surgery (ERAS) for urogynecologic surgery: euvolemia, normothermia, adequate surgical site preparation, multimodal analgesia, restrictive use of opiates, the use of chewing gum to reduce ileus, removal of urinary catheter as soon as feasible, avoiding systematic use of drains or vaginal packs, fasting for 6 hours prior to surgery with clear liquids allowed up to 2 hours prior to surgery, and antibiotic, antithrombotic, and antiemetic prophylaxis.(8) **(EG 2)**

Alternatives

Specialty society practice guidelines conclude that pessary use is effective and that pessaries can be fitted in most women with prolapse (regardless of stage or site).(1)(2)(12) **(EG 2)** These guidelines recommend that patients be offered a pessary for symptomatic pelvic organ prolapse before considering surgery.(1)(2) **(EG 2)** A noninferiority randomized clinical trial conducted in 21 hospitals in the Netherlands of patients with stage 2 or greater pelvic organ prolapse randomized to either pessary use or surgery (440 patients, mean age 65 years) was unable to conclude noninferiority of pessary use compared with surgical correction, although the authors concluded that interpretation was limited due to significant loss to follow-up as well as large crossover of participants from the pessary group to the surgical group.(13) **(EG 1)** In the same trial, by 1-year follow-up, 52% of women randomized to pessary use had discontinued use, with most then opting for surgery.(13) **(EG 1)** Obliterative surgery, such as colpocleisis or colpectomy, may be associated with a reduction in perioperative morbidity but significantly shortens and narrows the vagina, so patients must be certain that they will not desire vaginal intercourse in the future.(2)(4)(11) **(EG 2)**

Length of Stay

A study of 2 national databases spanning 3 years and including 422,287 patients (median age 62 years) undergoing surgery for pelvic organ prolapse found that 91% were discharged the day of or the day after surgery.(16) **(EG 2)** A retrospective review of a single institution's performance of robotic and abdominal sacrocolpopexy for the treatment of pelvic organ prolapse (494 cases: 203 robotic, 291 abdominal) found a mean length of stay of 16 hours for robotic surgery and 26 hours for abdominal surgery.(15) **(EG 2)** A retrospective review of a multicenter randomized trial of women with stage II or greater pelvic organ prolapse and stress urinary incontinence who underwent native tissue vaginal repair and placement of a urethral sling (255 women) found that 98% had a length of stay of 1 day or less.(18) **(EG 2)** Analysis of procedure data for a commercially insured population shows 99% of patients undergoing pelvic organ prolapse repair were discharged the day of or the day after surgery.(17) **(EG 3)** Analysis of procedure data for a Medicare-insured population shows 98% of patients undergoing pelvic organ prolapse repair were discharged the day of or the day after surgery.(17) **(EG 3)**

Rationale

Use of this MCG care guideline helps the clinician identify, for a given procedure, which patient-specific factors and clinical conditions are appropriate for that procedure. The evidence-based clinical criteria assist the clinician in the decision to appropriately perform a procedure, evaluating whether the potential benefits of a procedure outweigh the potential risks. For Medicare enrollees, surgical MCG care guidelines also identify which procedures CMS has designated as inpatient only.

Use of these evidence-based clinical criteria to support decision making around the need for a given procedure is of benefit to the patient, as all procedures come with inherent risk that must be balanced by anticipated clinical benefit. Utilizing evidence-based clinical criteria enables a more accurate and patient-specific decision-making process. In addition, the use of evidence-based guidelines can help reduce unwarranted variation in care, such as divergent clinical thresholds to perform a procedure for clinically similar patients that vary across geographic regions, between facilities, and among individual clinicians.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 412.3(42); 42 CFR 419.22(43); 42 CFR 422.101(44)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(45); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B(46); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services(47); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment(48)

Medicare Coverage Determinations: Medicare Coverage Database(49)

References

1. Pelvic organ prolapse: ACOG Practice Bulletin, Number 214. Obstetrics & Gynecology 2019 (ACOG reaffirmed 2024);134(5):e126-e142. DOI: 10.1097/AOG.0000000000003519. (Reaffirmed 2025 May) [Context Link 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18] View abstract...
2. American Urogynecologic Society (AUGS) Guidelines and Statements Committee with assistance of Cassan, et al. American Urogynecologic Society best practice statement: evaluation and counseling of patients with pelvic organ prolapse. Female Pelvic Medicine and Reconstructive Surgery 2017 Sep/Oct;23(5):281-287. DOI: 10.1097/SPV.0000000000000424. (Reaffirmed 2025 Jun) [Context Link 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17] View abstract...
3. Maher C, et al. Surgery for women with apical vaginal prolapse. Cochrane Database of Systematic Reviews 2023, Issue 7. Art. No.: CD012376. DOI: 10.1002/14651858.CD012376.pub2. [Context Link 1] View abstract...
4. Krlin R, Hallner B, Rourke E, Winters JC. Vaginal and abdominal reconstructive surgery for pelvic organ prolapse. In: Dmochowski RR, et al., editors. Campbell Walsh Wein Urology. 13th ed. Elsevier; 2026:2426-2459.e8. [Context Link 1, 2, 3]
5. Geoffrion R, Larouche M. Surgical management of apical pelvic organ prolapse in women. Guideline no. 413:. Journal of Obstetrics and Gynaecology Canada 2021;43(4):511-523.e1. DOI: 10.1016/j.jogc.2021.02.001. (Reaffirmed 2025 Jul) [Context Link 1] View abstract...
6. Brown OE, Mou TP, Ackenbom MF. Uterine prolapse. Journal of the American Medical Association 2023;330(15):1486-1487. DOI: 10.1001/jama.2023.16277. [Context Link 1, 2, 3] View abstract...
7. Baessler K, Christmann-Schmid C, Maher C, Haya N, Crawford TJ, Brown J. Surgery for women with pelvic organ prolapse with or without stress urinary incontinence. Cochrane Database of Systematic Reviews 2018, Issue 8. Art. No.: CD013108. DOI: 10.1002/14651858.CD013108. [Context Link 1] View abstract...
8. Latthe P, et al. AUGS-IUGA Joint Clinical Consensus statement on enhanced recovery after urogynecologic surgery: developed by the Joint Writing Group of the International Urogynecological Association and the American Urogynecologic Society. Individual writing group members are noted in the Acknowledgements section. Urogynecology (Hagerstown, Md.) 2022;28(11):716-734. DOI: 10.1097/SPV.0000000000001252. [Context Link 1, 2] View abstract...
9. Cameron AP, et al. The AUA/SUFU guideline on the diagnosis and treatment of idiopathic overactive bladder. Journal of Urology 2024;212(1):11-20. DOI: 10.1097/JU.0000000000003985. (Reaffirmed 2025 Jul) [Context Link 1, 2, 3, 4] View abstract...

10. Kobashi KC, et al. Updates to surgical treatment of female stress urinary incontinence (SUI): AUA/SUFU guideline (2023). Journal of Urology 2023;209(6):1091-1098. DOI: 10.1097/JU.0000000000003435. [Context Link 1, 2] View abstract...
11. Raju R, Linder BJ. Evaluation and management of pelvic organ prolapse. Mayo Clinic Proceedings 2021;96(12):3122-3129. DOI: 10.1016/j.mayocp.2021.09.005. [Context Link 1, 2] View abstract...
12. Harvey MA, Lemieux MC, Robert M, Schulz JA. Vaginal pessary use. Guideline no. 411. Journal of Obstetrics and Gynaecology Canada 2021;43(2):255-266.e1. DOI: 10.1016/j.jogc.2020.11.013. (Reaffirmed 2025 Jul) [Context Link 1, 2] View abstract...
13. van der Vaart LR, et al. Effect of pessary vs surgery on patient-reported improvement in patients with symptomatic pelvic organ prolapse: a randomized clinical trial. Journal of the American Medical Association 2022;328(23):2312-2323. DOI: 10.1001/jama.2022.22385. [Context Link 1, 2] View abstract...
14. Strohbehn K, et al. Effectiveness and safety of a novel, collapsible pessary for management of pelvic organ prolapse. American Journal of Obstetrics and Gynecology 2024;231(2):271e1-271 e10. DOI: 10.1016/j.ajog.2024.05.009. [Context Link 1] View abstract...
15. Korn E, Welton C, Garely A, Govindarajulu U, Rahimi S. A cohort study comparing cost-efficiency of abdominal and robotic sacrocolpopexy. Urology 2025;196:110-114. DOI: 10.1016/j.urology.2024.10.073. [Context Link 1, 2] View abstract...
16. St Martin B, Markowitz MA, Myers ER, Lundsberg LS, Ringel N. Estimated national cost of pelvic organ prolapse surgery in the United States. Obstetrics & Gynecology 2024;143(3):419-427. DOI: 10.1097/AOG.0000000000005485. [Context Link 1, 2] View abstract...
17. Proprietary health insurance data sources (2023-2024); and Medicare 5% Standard Analytical File (2022-2023). [Context Link 1, 2, 3]
18. Matthews CA, et al. A randomized trial of retropubic vs single-incision sling among patients undergoing vaginal prolapse repair. American Journal of Obstetrics and Gynecology 2024;231(2):261.e1-261.e10. DOI: 10.1016/j.ajog.2024.04.036. [Context Link 1, 2, 3] View abstract...
19. Premier PINC AI™ Healthcare Database (PHD), 01/01/2023-12/31/2024. Premier, Inc. [Context Link 1]
20. Urinary Incontinence and Pelvic Organ Prolapse in Women: Management. NICE Guideline NG123 [Internet] National Institute for Health and Care Excellence. 2019 Jun (NICE reviewed in 2021) Accessed at: https://www.nice.org.uk/guidance. [accessed 2025 Apr 04] [Context Link 1, 2] View abstract...
21. McDermott CD, et al. Postoperative urinary retention. Urogynecology (Philadelphia, Pa.) 2023;29(4):381-396. DOI: 10.1097/SPV.0000000000001344. [Context Link 1] View abstract...
22. Hudson T. The role of social determinates of health in discharge practices. Nursing Clinics of North America 2021;56(3):369-378. DOI: 10.1016/j.cnur.2021.04.004. [Context Link 1] View abstract...
23. Chovanec KA, Arsene C, Beck A, Zachrich K, Liedel B, Wolff-Elliott J. Association of discharge disposition with outcomes. Population Health Management 2021;24(1):116-121. DOI: 10.1089/pop.2019.0176. [Context Link 1] View abstract...
24. Centers for Medicare and Medicaid Services. "Condition of participation: Discharge planning." 42 CFR Pt. 482.43 Washington, DC 2025 Jan 01 [accessed 2025 Jul 22] Accessed at: https://www.ecfr.gov/. [Context Link 1, 2, 3]
25. Schafer R. Female reproductive problems. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:1412-1433. [Context Link 1]
26. Turnbull T. Assessment: urinary system. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:1177-1194. [Context Link 1]
27. Rudolphi DM. Postoperative care. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:365-384. [Context Link 1, 2]
28. Targeted care planning and care transitions. In: Perez R, editor. CMSA's Integrated Case Management. 2nd ed. Springer Publishing Company LLC; 2023:178-189. [Context Link 1, 2]
29. Elements of Excellence in Transitions of Care (TOC). TOC Checklist [Internet] National Transitions of Care Coalition. 2006 Accessed at: https://www.ntocc.org. [accessed 2025 Sep 16] [Context Link 1]
30. Medical-surgical nursing. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:33-55. [Context Link 1]
31. Transition of care. In: Gillingham DC, editor. Foundations of Case Management. Blue Bayou Press; 2021:137-144. [Context Link 1]
32. Becker C, et al. Interventions to improve communication at hospital discharge and rates of readmission: a systematic review and meta-analysis. JAMA Network Open 2021;4(8):e2119346. DOI: 10.1001/jamanetworkopen.2021.19346. [Context Link 1] View abstract...
33. The nursing process in drug therapy and patient safety. In: Tucker RG, editor. Karch's Focus on Nursing Pharmacology. 9th ed. Wolters Kluwer; 2023:47-57. [Context Link 1]
34. Adverse drug reactions and medication errors. In: Burchum JR, Rosenthal LD, editors. Lehne's Pharmacology for Nursing Care. 12th ed. Elsevier; 2025:64-75. [Context Link 1]
35. Safe medication preparation. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. Clinical Nursing Skills and Techniques. 11th ed. Elsevier; 2025:586-607. [Context Link 1]
36. The case manager's roles, functions, and activities. In: Gillingham DC, editor. Foundations of Case Management. Blue Bayou Press; 2021:9-14. [Context Link 1]
37. Anderson TS, Ayanian JZ, Herzig SJ, Souza J, Landon BE. Gaps in primary care follow-up after hospital discharge among Medicare beneficiaries. Journal of the American Geriatrics Society 2025;DOI: 10.1111/jgs.19496. [Context Link 1] View abstract...
38. Management of patients with female reproductive disorders. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:1676-1707. [Context Link 1]
39. Bragg-Underwood T. Family health. In: Nies MA, editor. Community/Public Health Nursing. 8th ed. Elsevier; 2024:404-427. [Context Link 1]

40. Harding MM. Substance use disorders in acute care. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:162-178. [Context Link 1]
41. Management of patients with dermatologic disorders. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:1815-1864. [Context Link 1]
42. Centers for Medicare and Medicaid Services. "Admissions." 42 CFR 412.3 Washington, DC 2025 Jul [accessed 2025 Jul 22] Accessed at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412. [Context Link 1]
43. Centers for Medicare and Medicaid Services. "Hospital services excluded from payment under the hospital outpatient prospective payment system." 42 CFR 419.22 Washington, DC 2023 Jul [accessed 2025 Jul 22] Accessed at: https://www.ecfr.gov/. [Context Link 1]
44. Centers for Medicare and Medicaid Services. "Requirements relating to basic benefits." 42 CFR 422.101 Washington, DC 2025 Jun 03 [accessed 2025 Jul 23] Accessed at: https://www.ecfr.gov/. [Context Link 1]
45. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A Rev. 10892 [Internet] Centers for Medicare and Medicaid Services. 2021 Aug Accessed at: https://www.cms.gov/manuals/. [accessed 2025 Sep 09] [Context Link 1]
46. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 6 - Hospital Services Covered Under Part B Rev. 12425 [Internet] Centers for Medicare and Medicaid Services. 2023 Dec Accessed at: http://www.cms.gov/manuals/. [accessed 2025 Sep 09] [Context Link 1]
47. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 15 - Covered Medical and Other Health Services Rev. 13108 [Internet] Centers for Medicare and Medicaid Services. 2025 Apr 11 Accessed at: https://www.cms.gov/manuals/. [accessed 2025 Sep 09] [Context Link 1]
48. Centers for Medicare and Medicaid Services. Medicare Program Integrity Manual. Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment Rev. 10365 [Internet] Centers for Medicare and Medicaid Services. 2020 Oct 02 Accessed at: https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms. [accessed 2025 Sep 09] [Context Link 1]
49. Medicare Coverage Database. [Internet] Centers for Medicare and Medicaid Services. Accessed at: https://www.cms.gov/medicare-coverage-database/search.aspx? Updated 2025 [accessed 2025 Oct 23] [Context Link 1]

Footnotes

[A] Validated questionnaires to assess symptoms due to pelvic organ prolapse include the Pelvic Floor Distress Inventory (PFDI), Pelvic Floor Impact Questionnaire (PFIQ), Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-IR), and the International Consultation on Incontinence Questionnaire - Vaginal Symptoms (ICIQ-VS).(2) [A in Context Link 1, 2]

[B] See Ambulatory Surgery Discharge and Complications: Common Complications and Conditions ISC for further information. [B in Context Link 1]

[C] Some patients may have their hydration needs met via alternative means (eg, percutaneous endoscopic gastrostomy tube). [C in Context Link 1]

[D] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(22) [D in Context Link 1]

Definitions

Hemodynamic stability

- Hemodynamic stability, as indicated by **1 or more** of the following:
  - Hemodynamic abnormalities at baseline or acceptable for next level of care
  - Patient hemodynamically stable, as indicated by **ALL** of the following(1)(2):
    - Tachycardia absent
    - Hypotension absent
    - No evidence of inadequate perfusion (eg, no myocardial ischemia)
    - No other hemodynamic abnormalities (eg, no Orthostatic hypotension)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Ramgopal S, Sepanski RJ, Martin-Gill C. Empirically derived age-based vital signs for children in the out-of-hospital setting. Annals of Emergency Medicine 2023;81(4):402-412. DOI: 10.1016/j.annemergmed.2022.09.019.

Hypotension absent

- Hypotension absent,[A] as indicated by **1 or more** of the following:
  - Hypotension absent in adult patient, as indicated by **1 or more** of the following:

- Systolic blood pressure greater than or equal to 90 mm Hg[A](1)
- Mean arterial pressure[B] greater than or equal to 70 mm Hg MAP Calculator[A](1)(2)
- Blood pressure at patient's baseline (eg, healthy adult with low systolic blood pressure), at intentional therapeutic goal (eg, patient with heart failure), or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)

- Hypotension absent in pediatric patient, as indicated by **1 or more** of the following:
  - Systolic blood pressure greater than or equal to 110 mm Hg in child 13 to 17 years of age[A](3)
  - Systolic blood pressure greater than or equal to 100 mm Hg in child 6 to 12 years of age[A](3)
  - Systolic blood pressure greater than or equal to 95 mm Hg in child 3 to 5 years of age[A](3)
  - Systolic blood pressure greater than or equal to 90 mm Hg in child 1 or 2 years of age[A](3)
  - Systolic blood pressure greater than or equal to 80 mm Hg in infant 6 to 11 months of age[A](3)
  - Systolic blood pressure greater than or equal to 70 mm Hg in infant 3 to 5 months of age[A](3)
  - Systolic blood pressure greater than or equal to 65 mm Hg in infant 1 or 2 months of age[A](3)
  - Blood pressure at patient's baseline (eg, healthy child with low systolic blood pressure), at intentional therapeutic goal, or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Puskarich MA, Jones AE. Shock. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:34-41.e1.
3. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

B. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.

Orthostatic hypotension

- Orthostatic hypotension,[A][B] as indicated by **1 or more** of the following(1)(2)(3):
  - Fall in SBP of 20 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position
  - Fall in DBP of 10 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position

References

1. Shibao C, Lipsitz LA, Biaggioni I, American Society of Hypertension Writing Group. Evaluation and treatment of orthostatic hypotension. Journal of the American Society of Hypertension 2013 Jul-Aug;7(4):317-324. DOI: 10.1016/j.jash.2013.04.006.
2. Dalal AS, Van Hare GF. Syncope. In: Kliegman RM, et al., editors. Nelson Textbook of Pediatrics. 22nd ed. Elsevier; 2025:592-599.
3. Fang JC, O'Gara PT. History and physical examination: an evidence-based approach. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:123-140.

Footnotes

A. Concomitant measurements of the heart rate are important to measure to help diagnose subtypes of orthostatic hypotension (eg, the lack of a compensatory increase in heart rate is typical of autonomic failure and an exaggerated tachycardia may be reflective of volume depletion). However, the heart rate is not a component of the definition of orthostatic hypotension, which relies upon blood pressure alone.(1)(2)(3)

B. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

Social Determinants of Health Assessment

- Risk of poor health outcomes may be increased by the presence of **1 or more** of the following social determinants of health(1)(2)(3):
  - Housing insecurity, as indicated by **1 or more** of the following:
    - Individual or caregiver's current living situation is **1 or more** of the following(4):
      - Does not have own housing (eg, staying in a hotel, shelter, or with others)
      - Has own housing (eg, house, apartment), but at risk of losing it in the future (ie, behind on rent or mortgage)
      - Has own housing (eg, house, apartment), but has lived in 3 or more places in past year
    - Current housing has **1 or more** of the following:
      - Electrical appliances (eg, stove, refrigerator) not working or unavailable
      - Insufficient heating or cooling
      - Insufficient ventilation
      - Lead paint or pipes
      - Mold
      - Pests (eg, bugs) or rodents
      - Smoke detectors not working or unavailable
  - Food insecurity, as indicated by **1 or more** of the following(5):
    - In the past year, individual or caregiver ran out of food and did not have money to buy more food.
    - In the past year, individual or caregiver worried that they would run out of food before they received money to buy more food.
  - Insufficient transportation, as indicated by **1 or more** of the following(6):
    - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of transportation.
    - In the past year, individual or caregiver missed nonmedical activities, work, or could not get things needed for daily living due to lack of transportation.
  - Insufficient utilities, as indicated by **1 or more** of the following(7):
    - Utilities (eg, electricity, water, gas, or oil) are currently shut off or unavailable.
    - In the past year, electric, water, gas, or oil company threatened to shut off services.
  - Personal safety risk, as indicated by **2 or more** of the following(5):
    - Individual is sometimes or frequently physically hurt by another person (including family member).
    - Individual is sometimes or frequently insulted or talked down to by another person (including family member).
    - Individual is sometimes or frequently threatened with physical harm by another person (including family member).
    - Individual is sometimes or frequently screamed or cursed at by another person (including family member).
  - Insufficient dependent care, as indicated by **1 or more** of the following:
    - In the past year, individual or caregiver was unable to work due to lack of dependent care.
    - In the past year, individual or caregiver was unable to work more (additional) hours due to lack of dependent care.
    - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of dependent care.
    - In the past year, individual or caregiver missed nonmedical activities (eg, school, church, social activity) due to lack of dependent care.
  - Depression risk, as indicated by **ALL** of the following(8):
    - In the past 2 weeks, individual had little interest or pleasure in normal activities on at least several days.
    - In the past 2 weeks, individual felt down, depressed, or hopeless on at least several days.

References

1. Scanlon A, Reinisch C. Social determinants of health. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:18-20.
2. Billioux A, Verlander K, Anthony S, Alley D. Standardized Screening for Health-Related Social Needs in Clinical Settings: the Accountable Health Communities Screening Tool. [Internet] National Academy of Sciences. 2017 May Accessed at: https://nam.edu/. [accessed 2025 Sep 12]
3. Addressing social determinants of health. In: Perez R, editor. CMSA's Integrated Case Management. 2nd ed. Springer Publishing Company LLC; 2023:62-75.
4. Sandel M, et al. Unstable housing and caregiver and child health in renter families. Pediatrics 2018;14(2):e20172199. DOI: 10.1542/peds.2017-2199.
5. Children's HealthWatch Survey. Screening Instrument [Internet] Children's HealthWatch. 2024 Feb 13 Accessed at: https://childrenshealthwatch.org/. [accessed 2025 Mar 31]
6. PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Screening Tool. 2.0 [Internet] Association of Asian Pacific Community Health Organizations (AAPCHO) and National Association of Community Health Centers (NACHC). 2025 Accessed at: https://prapare.org/the-prapare-screening-tool/. [accessed 2025 Sep 08]
7. Cook JT, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. Pediatrics 2008;122(4):e867-75. DOI: 10.1542/peds.2008-0286.
8. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care 2003;41(11):1284-92. DOI: 10.1097/01.MLR.0000093487.78664.3C.

Tachycardia absent

- Tachycardia[A][B] absent, as indicated by **1 or more** of the following:
  - Heart rate less than or equal to 100 beats per minute in adult[A][B](1)
  - Heart rate less than or equal to 85 beats per minute in child 13 to 17 years of age[A][B](2)
  - Heart rate less than or equal to 95 beats per minute in child 6 to 12 years of age[A][B](2)
  - Heart rate less than or equal to 110 beats per minute in child 1 to 5 years of age[A][B](2)
  - Heart rate less than or equal to 120 beats per minute in infant 3 to 11 months of age[A][B](2)
  - Heart rate less than or equal to 150 beats per minute in infant 1 or 2 months of age[A][B](2)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

A. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

B. Interpretation of heart rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline heart rate, medications, and clinical impact. For example, an elderly patient on a beta-blocker medication with a baseline resting heart rate of 60 beats per minute may be clinically tachycardic at a heart rate of 94 beats per minute. Likewise, a patient who is upset, in pain, or nervous in the emergency department with a heart rate of 106 beats per minute may meet the technical definition of tachycardia, but this tachycardia (absent associated findings such as chest pain or hypotension) may not be clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachycardia. Whether a heart rate above or below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Codes

ICD-10 Diagnosis: N39.3, N39.491, N39.492, N39.498, N81.0, N81.10, N81.11, N81.12, N81.2, N81.3, N81.4, N81.5, N81.6, N81.81, N81.82, N81.83, N81.84, N81.85, N81.89, N81.9, N99.3 [Hide]

ICD-10 Procedure: 0DSP0ZZ, 0DSP4ZZ, 0DSP7ZZ, 0DSP8ZZ, 0JQC0ZZ, 0TSB0ZZ, 0TSB4ZZ, 0TSC0ZZ, 0TSC4ZZ, 0UBF0ZZ, 0UBF4ZZ, 0UBF7ZZ, 0UBF8ZZ, 0ULF7DZ, 0ULF7ZZ, 0ULF8DZ, 0ULF8ZZ, 0ULG7DZ, 0ULG7ZZ, 0ULG8DZ, 0ULG8ZZ, 0UQF0ZZ, 0UQF4ZZ, 0UQF7ZZ, 0UQF8ZZ, 0UQG0ZZ, 0UQG4ZZ, 0UQG7ZZ, 0UQG8ZZ, 0US40ZZ, 0US44ZZ, 0US48ZZ, 0US90ZZ, 0US94ZZ, 0US97ZZ, 0US98ZZ, 0USF0ZZ, 0USF4ZZ, 0USF8ZZ, 0USG0ZZ, 0USG4ZZ, 0USG7ZZ, 0USG8ZZ, 0USGXZZ, 0UTF0ZZ, 0UTF4ZZ, 0UTF7ZZ, 0UTF8ZZ, 0UU407Z, 0UU40JZ, 0UU40KZ, 0UU447Z, 0UU44JZ, 0UU44KZ, 0UUF07Z, 0UUF0JZ, 0UUF0KZ, 0UUF47Z, 0UUF4JZ, 0UUF4KZ, 0UUF77Z, 0UUF7JZ, 0UUF7KZ, 0UUF87Z, 0UUF8JZ, 0UUF8KZ, 0UUG07Z, 0UUG0JZ, 0UUG0KZ, 0UUG47Z, 0UUG4JZ, 0UUG4KZ, 0UUG77Z, 0UUG7JZ, 0UUG7KZ, 0UUG87Z, 0UUG8JZ, 0UUG8KZ, 0WQN0ZZ, 0WQN4ZZ [Hide]

CPT®: 45560, 57240, 57250, 57260, 57265, 57268, 57270, 57280, 57282, 57283, 57284, 57285, 57423, 57425

DSM-5: N39.498

MCG Health
Inpatient & Surgical Care 30th Edition

Last Update: 1/25/2026 6:09:54 AM
Build Number: 30.0.2026012500524.025256