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INPATIENT-ONLY (IPO) LIST PHASE-OUT

A Clinical Decision Guide For Physicians & Staff

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2026

What's Changing

CMS Phase-Out

CMS is phasing out the Inpatient-Only (IPO) list over 3 years (2026–2028)

CY 2026 Removals

285 procedures removed (mostly musculoskeletal)

Not "Outpatient-Only"

It means service status flexibility

Inpatient Still Appropriate

Inpatient remains appropriate when risk and post-op needs support it

Goal

1

Why adopt to change
Outperform the competition

2

What is changing
IPO list phase out

3

How to do it
People, process & Technology

Prepare for Success



Operating Principle

Default to Outpatient ... but when appropriate we can convert to Inpatient.

But...

We must document why!

Decision Pathway



Risk Scoring Tool

Based on reputable organizations clinical predictors

Outpatient default mindset

Inpatient supported procedure

Assign Risk Points

Based on documented comorbidities

Quick to Use

Takes few minutes to complete

Circulation

CLINICAL PRACTICE GUIDELINES

2024 AHA/ACC/ACS/ASNC/HRS/SCA/ SCCT/SCMR/SVM
Guideline for Perioperative Cardiovascular Management
for Noncardiac Surgery:

A Report of the American College of Cardiology/American
Heart Association Joint Committee on Clinical Practice
Guidelines



American College of Surgeons, American Society of Nuclear Cardiology, Heart Rhythm Society, Society of Cardiovascular Anesthesiologists,
Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance, and the Society for Vascular Medicine

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Major Risk Triggers



- Expected Stay ≥ 2 Midnights
- Significant Arrhythmias & AV blocks



- Unstable Coronary Syndrome or Unstable Angina
- Significant/Severe Valvular Heart Disease



- Recent MI (<3 months)
- Recent CVA or TIA (<3 months)



- Decompensated Heart Failure
- Severe CHF or LVEF <30%

Intermediate Risk

- Prior MI (>3 months & Q waves)

- CAD with Stents (<3 months)
- Diabetes, Poorly Controlled

- Mild Angina Pectoris

- Implanted Pacemaker

- Compensated Heart Failure
- LVEF 30–40%, Moderately Reduced

- Chronic Kidney Disease, Cr > 2 mg/dL
- ESRD on Hemodialysis

Modifiers

- Age ≥ 70 Years

- Low Functional Capacity (< 4 METs)

- Abnormal ECG

- Rhythm Other Than Sinus

- Poorly Controlled COPD, OSA
- Chronic Respiratory Failure (O₂ @ home)

- Ventricular Ectopy Requiring Treatment

Modifiers (Continued)

- HTN with Severe LVH

- Uncontrolled Systolic HTN

- Remote CVA/TIA (>3 months)

- BMI ≥ 40

- Alcohol Abuse or Dependence

- Delirium Risk (DEAR Score >2)

Functional Capacity (<4 METs)

✓ Able to Do

- Self-care (bathe, dress, eat)
- Walk slowly (2 mph)
- Write, vacuum

✗ Unable to Do

- Climb stairs
- Yard work, golf, cycle
- Walk briskly (4 mph)

Document: "Functional capacity <4 METs. Ex: Patient can do self-care but cannot climb 1 flight of stairs."



American Society of
AnesthesiologistsTM

ASA Physical Status Classification

Use ASA class to anchor clinical decision-making and align with scoring tool

ASA I–II

Usually outpatient

ASA III

Higher risk—scrutinize comorbidities

ASA IV–VI

Often inpatient—major risk present

ASA I: Normal Healthy Patient

Definition

Normal healthy patient with no acute or chronic disease

Status Decision

Normal healthy patient with no acute or chronic disease

Examples

- Healthy, non-smoking patient
- No or minimal alcohol use
- No medical conditions

ASA II: Mild Systemic Disease

Definition

Mild systemic disease with no substantive functional limitations

Status Decision

Outpatient appropriate

Examples

- Current smoker, social alcohol use
- Pregnancy, obesity (BMI 30–40)
- Well-controlled DM or HTN
- Mild lung disease

ASA III: Severe Systemic Disease

Definition

Severe systemic disease with substantive functional limitations

Examples

- Poorly controlled DM or HTN
- COPD
- Severe OSA, morbid obesity (BMI ≥ 40)

ESRD on regularly scheduled dialysis

Implanted pacemaker

History (>3 months) of MI/CVA/TIA/CAD stents

Moderately reduced EF (LVEF 30–40%)

Scrutinize score & Status Decision: may be outpatient or inpatient depending on number of comorbidities

ASA IV: Constant Threat to Life

Definition

Severe systemic disease that is a constant threat to life

Examples

- Recent (<3 months) MI/CAD stents /CVA/TIA
- Ongoing cardiac ischemia
- Severe valve dysfunction

Shock, sepsis, DIC

Acute respiratory disease

ESRD not on regularly scheduled dialysis

Severely reduced EF (LVEF <30%)

Status Decision: Inpatient typically required

ASA V & VI: Critical Status

ASA V—Moribund Patient

Not expected to survive without operation

- Ruptured aneurysm, massive trauma
- Intracranial hemorrhage with mass effect
- Ischemic bowel with major cardiac pathology
- Multiple organ dysfunction

ASA VI—Brain-Dead

Organs being removed for donation

Status Decision

Inpatient

ASA Emergency Modifier (E)

Definition

Emergency surgery—delay would significantly increase threat to life or body part

Application

- Added to any ASA class (e.g., ASA III-E)
- Indicates urgent/emergent nature of procedure
- Typically supports inpatient status

Integrating ASA with Documentation

Align ASA classification with admitting rationale for stronger documentation

"Severe systemic disease with substantive functional limitations"

"Constant threat to life requiring inpatient monitoring"

Reference specific comorbidities from ASA class in admission note

Documentation Template

"Given the patient's comorbidities and anticipated post-op needs, outpatient management is not clinically appropriate & inpatient hospitalization is required for monitoring/treatment and safe recovery."

Add 1–2 Specifics



Cardiopulmonary Risk



Pain Control Needs



Complex Anticoagulation



Discharge Barriers



Frailty/Functional Limitations

Physicians & Anesthesia Checklist

1

Assess ASA Class

Assess ASA class and key comorbidities with dates/severity

2

Determine Risk

Document drivers and choose inpatient

3

State Expected Post-Op Services

Telemetry, O₂, diuresis, PT/OT

4

Escalate Borderline Cases

Route to UM/Physician Advisor early





Ancillary Staff Checklist

1

Capture Missing Data

EF, ECG, OSA severity, Cr, dialysis schedule

2

Route High-Risk Scores/Flags to UM

Before day of surgery

3

Prevent "Scheduled Surgery Outpatient Autopilot"

Outpatient Procedure are not outpatient-only!

4

Ensure Record Matches Order

Queries inaccuracies early

Critical Pitfalls to Avoid

Don't

- Admit inpatient for procedure without risk drivers or well documented anticipated inpatient services
- Make status decision after the fact due to billing issues
- Use undocumented or clinically invalid comorbidities

Do

- Decide prospectively and document clearly

Scoring Example 1: Inpatient

84-year-old with T1DM, BMI 42, and CHF, LVEF 25%

Risk Factor	Risk Degree
Age ≥ 70	Minor
T1DM	Minor
BMI ≥ 40	Minor
LVEF 25%	Severe

Inpatient supported

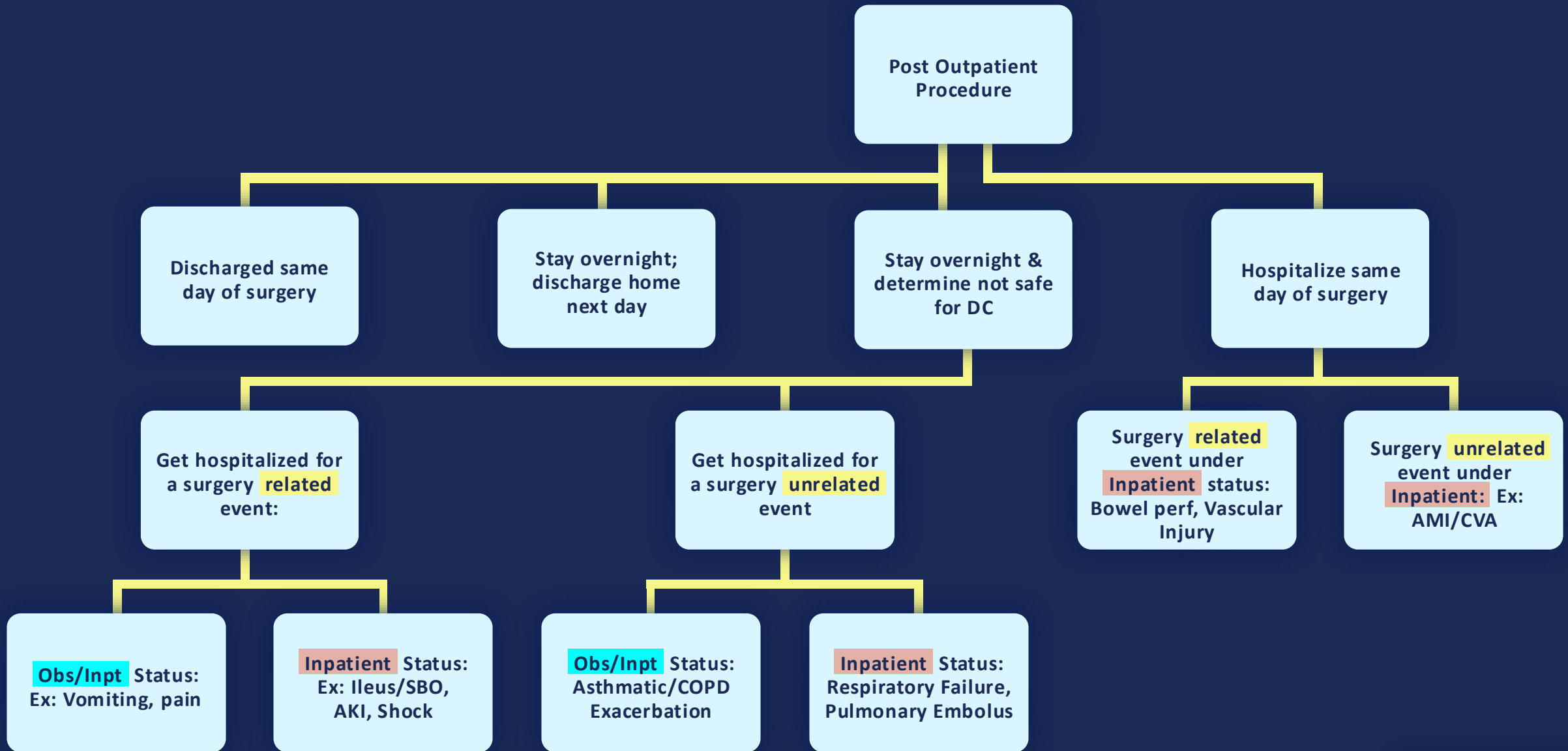
Example 2: Outpatient

62-year-old with well-controlled HTN, BMI 32

Assessment	Risk Degree
Major risk triggers	None
Intermediate risk factors documented	None
Functional capacity >4 METs	None
Expected discharge - Same-day	None

Outpatient default



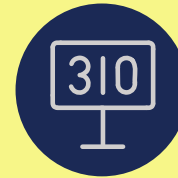


Key Takeaways



IPO List Is Fading

Our clinical judgment is not



Use the Scoring Tool

Support inpatient decisions



Document Prospectively

Clear rationale and expected services



Escalate Borderline Cases

Route to UM Managers / Physician Advisor



ACS / AMERICAN COLLEGE
OF SURGEONS

ACS Risk Calculator - Patient Information

Enter Patient and Surgical Information

i Procedure

Clear

Begin by entering the procedure name or CPT code. One or more procedures will appear below the procedure box. You will need to click on the desired procedure to properly select it. You may also search using two words (or two partial words) by placing a '+' in between, for example: "cholecystectomy + cholangiography"

Reset All Selections

i Are there other potential appropriate treatment options? ☐ Other Surgical Options ☐ Other Non-operative options ☐ None

Please enter as much of the following information as you can to receive the best risk estimates.
A rough estimate will still be generated if you cannot provide all of the information below.

Age (between 18 and 112): **i**

50

Sex

Female

Functional Status **i**

Independent

Emergency Case **i**

No

ASA Class **i**

Healthy patient

Immunosuppressive Therapy **i**

No

Ascites within 30 days prior to surgery **i**

No

Systemic Sepsis within 48 hours prior to surgery **i**

None

Ventilator Dependent **i**

No

Diabetes **i**

No

Hypertension requiring medication **i**

No

Congestive Heart Failure in 30 days prior to surgery **i**

No

Oxygen Support **i**

No

Current Smoker within 1 Year **i**

No

History of Severe COPD **i**

No

Dialysis **i**

No

Stage 2/3 Acute Kidney Injury **i**

No

BMI Calculation: **i**

Height: in / cm

COMMENTS, CONCERNS OR QUESTIONS?



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