

Hospitalization Criteria for Pacemaker and ICD Placement and EP/Ablations

The purpose of this document is to outline the position of the Heart Rhythm Society regarding the appropriate classification of patient status (inpatient vs outpatient) for the implantation of permanent pacemakers, implantable cardioverter defibrillators and EP/ ablations.

First and foremost, it must be recognized and acknowledged that this determination is a clinical decision best made by the patient's attending physician after a careful consideration of multiple clinical factors including, but not limited to, the specific procedure planned, the urgency of the procedure, the hemodynamic stability of the patient, patient comorbidities and the likelihood and consequences of complications arising from the procedure.

In general, patients who are medically stable and who present for elective pacemaker and ablation procedures can often undergo their procedure in an accredited outpatient environment. Appropriate monitoring and observation of these patients should be performed.

In-patient status is warranted for patients who require more intensive monitoring, intravenous hydration, medication titration and extended nursing or physician care. Patients with post procedure complications are often best managed as an inpatient status. The list below identifies some of the situations that HRS believes are appropriate for inpatient admission. This list is not inclusive of all situations. It must be emphasized that the determination of appropriate medical necessity for inpatient admissions is a clinical decision only made by the attending physician.

Conditions that warrant inpatient admission status:

1. Urgent implantation of any device. Hospitalization is triggered by onset of symptoms or detection of a potentially serious condition, i.e. syncope, heart block, ventricular tachycardia
2. Any resynchronization therapy device implant.
3. Patients who have their device implanted during hospitalization for another problem.
4. Patients who require lead extraction as part of the implantation or re-implant procedure.
5. Patients with complex anticoagulation needs who require admission for the peri-surgical management of these anticoagulation issues.
6. Pacemaker/ICD implants or EP/ ablation in patients with uncontrolled co-morbidities including, but not limited to, renal insufficiency, angina, congestive heart failure, severe COPD, and electrolyte disturbances in whom in the attending physician's best judgment requires inpatient admission for optimal medical management. The physician must clearly document in the medical record the comorbidities, whether they are uncontrolled or of recent onset, and the treatment plan to address these issues.
7. New ICD implants or patients undergoing ICD generator replacement with concomitant lead replacement who are NYHA class II, III or IV; and who receive DFT testing. If DFT testing is not performed, documentation and treatment plan of the reason to not perform DFT testing must be present to support admission status.
8. Patients undergoing an AVJ ablation and acute device implant due to the need for extended monitoring for potentially lethal arrhythmias.

In general, otherwise stable patients, except as noted above, who are admitted for a device and stay over one night in the hospital, should be considered as "overnight outpatients" unless a complication develops during or following device implantation that requires a prolonged hospital stay.