

Thyroidectomy

ORG: S-1090 (ISC)

[Link to Codes](#)

MCG Health

Inpatient & Surgical Care
30th Edition

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Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Procedure

- Procedure is indicated for **1 or more** of the following(1)(2):**NNNNNN**
 - ☐ Toxic multinodular goiter or toxic adenoma and **1 or more** of the following(3):
 - Goiter with compressive symptoms (eg, hoarseness, dysphagia, dyspnea)(3)
 - Goiter with volume of 80 grams or more(3)
 - Substernal or retrosternal extension of thyroid(3)
 - Planned or current pregnancy or lactation(3)(14)
 - Intolerance, inadequate response, or contraindication to antithyroid medications or radioactive iodine therapy(3)

- Hyperparathyroidism requiring surgery(3)
- Concomitant thyroid nodule and **1 or more** of the following:
 - Suspicion for malignancy or indeterminate cytology(4)
 - Nodule 4 cm or more in size(1)(3)
 - Nonfunctioning or hypofunctioning nodule on iodine-123 or technetium-99m scan(3)
- Rapid correction of thyrotoxic state required(3)(15)
- ☐ Graves disease and **1 or more** of the following(16)(17)(18):
 - Goiter with compressive symptoms (eg, hoarseness, dysphagia, dyspnea)(3)(16)
 - Goiter with volume of 80 grams or more(3)(16)
 - Planned or current pregnancy or lactation(16)(19)
 - Child younger than 10 years(20)
 - Intolerance, inadequate response, or contraindication to antithyroid medications or radioactive iodine therapy(7)
 - Thyroid eye disease (Graves orbitopathy)(3)
 - Hyperparathyroidism requiring surgery(3)
 - Concomitant thyroid nodule and **1 or more** of the following(3):
 - Suspicion for malignancy or indeterminate cytology(3)
 - Nodule 4 cm or more in size(3)
 - Nonfunctioning or hypofunctioning nodule on iodine-123 or technetium-99m scan(3)
 - Multiple benign nodules(2)
- Malignancy (primary or secondary) of thyroid(5)(21)
- ☐ High-risk thyroid nodule, as indicated by **1 or more** of the following[A](5)(7):
 - Child age 18 years or younger and **1 or more** of the following(22)(23):
 - Indeterminate cytology(7)
 - Hyperfunctioning nodule(7)
 - Nodule 4 cm or larger(1)
 - Radiation exposure as child or adolescent(1)(7)
 - First-degree relative with thyroid cancer or multiple endocrine neoplasia type 2 (MEN2) syndrome(1)(5)(7)
 - RET proto-oncogene mutation or other high-risk molecular assay (eg, BRAF V600E mutation)(5)(7)
 - PET scan demonstrating FDG avidity(1)(5)
 - Personal history of thyroid malignancy treated with lobectomy(1)
 - Personal history of diagnosis associated with thyroid cancer, including **1 or more** of the following(5):
 - Familial adenomatous polyposis(5)
 - Carney complex(5)
 - Cowden syndrome(5)
 - Other diagnosis associated with increased thyroid cancer risk(5)(22)
 - Growth of nodule within 1 year by 2 mm or more and **1 or more** of the following(4)(22):
 - Nodule volume increased by 50% or more(4)(22)
 - Increase in size by 20% or more on 2 or more dimensions on imaging(4)(22)
 - Thyroid nodule suspicious for malignancy (eg, based on imaging), and biopsy not appropriate or results indeterminate(1)(3)(5)
- High-risk oncogene mutation carrier (eg, RET-PV in MEN2A or MEN2B)(5)(7)
- Thyroid compressing trachea, esophagus, recurrent laryngeal nerve, or great vessels(8)
- Amiodarone-induced thyrotoxicosis that fails to respond to medical therapy(24)

Alternatives to Procedure

- Alternatives include(3)(4)(6)(7)(8)(17)(22):[N](#)
 - Antithyroid medication(3)
 - Radioactive iodine(3)(7)
 - Thyroid hormone suppression(7)(14)(15)
 - Chemotherapy, radioiodine, and external beam radiation for malignancy(5)
 - Percutaneous ethanol or radiofrequency ablation(26)
 - Treatment of thyroid eye disease (eg, orbital radiation, surgical decompression, immunosuppressants, monoclonal antibodies, or insulin-like growth factor I receptor inhibitor)(27)(28)(29)
 - Active surveillance (ie, for very low-risk differentiated thyroid cancer or low-risk differentiated thyroid cancer measuring 1 cm or less)([B](#))(21)(30)

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 to discharge[C] - Discharge planning	Hemodynamic stability No evidence of hematoma No evidence of neck swelling[D] No evidence of respiratory compromise No evidence of dysphagia	Ambulatory post procedure or acceptable for next level of care	Oral hydration as tolerated[E] Oral medications as tolerated or regimen acceptable for next level of care Oral diet as tolerated or acceptable for next level of care - IV fluids, medications for procedure	- General or local anesthesia - Intraoperative nerve monitoring - Possible perioperative PTH levels - Elevate head of bed 30 degrees - Check for airway compression and clinical signs of hypocalcemia	- Calcium with or without vitamin D - Multimodal analgesia

- **No evidence of dysphonia**
- **No evidence of symptomatic hypocalcemia**
- **Pain absent or managed**
- **Discharge plans and education understood**

- Postoperative PTH, serum calcium

(1)(31)(32)(33)(34)(35)(36)N

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)(22)(33)(37)(38)(39):
 - Failure to meet discharge criteria (recovery milestones in Optimal Recovery Course)
 - Expect brief stay extension.
 - Selected patient factors, which include:
 - Large substernal extension of goiter
 - Graves disease with large goiter and marked elevation of thyroid hormone(16)(33)
 - Active comorbidities (eg, heart failure, COPD) requiring prolonged postoperative care(33)
 - Expect brief stay extension.
 - Thyroidectomy with neck dissection(33)
 - Expect brief stay extension.
 - Complications of procedure(16)(39)(40):
 - Postoperative hematoma or neck swelling requiring close observation(39)
 - Recurrent laryngeal nerve injury or edema sufficient to cause respiratory compromise or bilateral vocal cord palsy(39)(41)(42)(43)
 - Postoperative hypocalcemia not easily stabilized with oral calcium supplementation(39)(42)(44)
 - Thyroid storm[F](15)
 - Expect brief stay extension.

See Common Complications and Conditions  ISC for further information.

Discharge

Discharge Planning

- Discharge planning includes[G]:
 - Assessment of needs and planning for care, including(46)(47):
 - 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.(48)
 - Evaluate and address patient or caregiver preferences as indicated.
 - Identify skilled services needed at next level of care, with specific attention to:
 - Electrolyte management(49)
 - Medication management, adherence instruction, and side effects assessment(50)(51)
 - Wound or dressing management(52)
 - Early identification of anticipated discharge destination; options include(47)(53):
 - Home; considerations include:
 - Home safety assessment. See Home Safety Assessment [SR](#) for further information.
 - ☐ Patient safe to go home; examples include(54)(55)(56):
 - 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.(57)
 - 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(47)(53)(58):
 - Patient and caregiver education complete.
 - See Teach-Back Tool [SR](#) for further information.
 - See Thyroidectomy: Patient Education for Clinicians [SR](#) for further information.
- ☐ Medication reconciliation completion includes(51)(59):
 - 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)(60)
- 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(61):
 - Inpatient care and service providers
 - Primary care provider
 - All post-discharge care and service providers
- Appointments planned or scheduled, which may include(62):
 - Primary care provider(63)
 - Endocrinologist
 - General surgeon
 - Oncologist(64)
 - Rehabilitation therapy services(57)
 - Other
- Outpatient testing and procedure plans made, which may include:
 - Laboratory testing(64)
 - Other
- Referrals made for assistance or support, which may include:
 - Financial, for follow-up care, medication, and transportation(65)
 - Tobacco use treatment(66)(67)
 - Other
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
 - Wound care equipment and supplies(68)
 - Other

Discharge Destination

- Post-hospital levels of admission may include:
 - Home.
 - Home healthcare. See Home Care Indications for Admission Section [↗](#) HC in Thyroidectomy guideline in Home Care.

Evidence Summary

Background

This guideline is appropriate for both total thyroidectomy (removal of the entire gland) as well as thyroid lobectomy or partial removal of the gland.

Criteria

The evidence for the clinical indications found in this guideline includes 15 published peer reviewed articles, 6 specialty society or other evidence-based guidelines, and 2 book sections.

For Graves disease, a surgical textbook and a specialty society guideline state that thyroidectomy is the preferred treatment in the following clinical situations: severe eye disease, failure or contraindications to alternative treatments, need for rapid control of hyperthyroidism, presence of suspicious thyroid nodules, goiter with compressive symptoms, and patients who are planning pregnancy, are pregnant, or are breast-feeding.(1)(3) **(EG 2)**

For thyroid cancer (eg, papillary, follicular, medullary, and anaplastic), a specialty society guideline and an expert consensus guideline recommend thyroidectomy as part of the treatment plan.(4)(5) **(EG 2)**

For a high-risk thyroid nodule (eg, indeterminate cytology, extrathyroidal extension, genetic finding), an expert consensus guideline and a review article state that thyroidectomy is appropriate.(5)(6) **(EG 2)** An expert consensus guideline and a review article note that prophylactic thyroidectomy is appropriate in the setting of a confirmed high-risk oncogene mutation associated with thyroid malignancy.(5)(7) **(EG 2)**

For nontoxic goiter, a surgical textbook and a specialty society guideline state that thyroidectomy is appropriate for local compressive symptoms (eg, dyspnea, dysphagia).(1)(8) **(EG 2)**

For amiodarone-induced hyperthyroidism, a surgical textbook and a specialty society guideline state that thyroidectomy is appropriate for patients who do not respond sufficiently to medical therapy.(1)(3) **(EG 2)**

Thyroidectomy can be performed through a standard cervicotomy incision or via minimally invasive endoscopic and video-assisted techniques.(9)(10) **(EG 2)** A database analysis of thyroidectomy in 77,863 patients found, after multivariate adjustment, that surgery by a low-volume surgeon (1 to 3 thyroidectomies per year) was independently associated with a higher risk of postoperative complications (eg, hypocalcemia, hematoma) when compared with a high-volume surgeon performing 30 or more thyroidectomies per year.(11) **(EG 2)** A multivariate analysis of 6327 thyroidectomies found that surgeries performed by low-volume surgeons (fewer than 40 cases per year) were independently associated with a higher risk of postoperative complications when compared with cases done by a high-volume surgeon performing 40 or more thyroidectomies per year.(12) **(EG 2)** Adjusted analysis of 16,954 patients undergoing total thyroidectomy found that the likelihood of experiencing a complication decreased with increasing surgeon volume up to 26 procedures per year.(13) **(EG 2)** A specialty society guideline concludes that, when possible, thyroidectomy should be performed by a high-volume thyroid surgeon.(2) **(EG 2)**

Alternatives

Most cases of hyperthyroidism and some nodules and goiters can be treated nonsurgically.(3)(4)(6)(8)(25) **(EG 2)**

Length of Stay

A retrospective review of multiple state databases including inpatient and ambulatory databases of adult patients who underwent total thyroidectomy over a 6-year period (86,187 patients, mean age 51 years) found that 89% were discharged the day of or the day after surgery.(33) **(EG 2)** A retrospective review of 6 state databases of pediatric thyroidectomies (1241 thyroidectomies; 37% for carcinoma, 28% for thyroid nodule, 20% for Graves disease, 18% for goiter, and 15% for thyroiditis) found that 83% were discharged the day of or the day after surgery.(34) **(EG 2)** A retrospective review of a national database including 24,820 adult patients (mean age 52 years) who underwent thyroidectomy found that the average postoperative length of stay was 16.4 hours.(35) **(EG 2)** Analysis of procedure data for a commercially insured pediatric population shows 88% of patients undergoing thyroidectomy were discharged the day of or the day after surgery.(36) **(EG 2)**

3) Analysis of procedure data for a commercially insured adult population shows 97% of patients undergoing thyroidectomy were discharged the day of or the day after surgery.(36) **(EG 3)** Analysis of procedure data for a Medicare-insured population shows 93% of patients undergoing thyroidectomy were discharged the day of or the day after surgery.(36) **(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(69); 42 CFR 419.22(70); 42 CFR 422.101(71)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(72); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B(73); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services(74); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment(75)

Medicare Coverage Determinations: Medicare Coverage Database(76)

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Footnotes

[A] A national guideline notes that, depending on the type of malignancy suspected, repeat fine needle aspiration, molecular diagnostics, or a second opinion may be appropriate.(5) [A in Context Link 1]

[B] A national guideline notes that patient preference for surgery over active surveillance is an appropriate indication to proceed with surgery in the setting of low-risk differentiated thyroid cancer.(5) [B in Context Link 1]

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

[D] Some patients may be sent home with a neck drain in place.(31) [D in Context Link 1]

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

[F] Thyroid storm is manifested by severe tachycardia, fever, confusion, vomiting, and adrenergic overstimulation.(1) [F in Context Link 1]

[G] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(45) [G 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)

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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)

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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.

Multimodal analgesia

- Multimodal analgesia involves the utilization of 2 or more analgesic agents with different mechanisms of action in order to provide additive or synergistic pain control, while minimizing side effects and reliance on opioids.(1)(2)(3)

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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

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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.

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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)

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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: C73, C79.89, D09.3, D34, D44.0, D49.7, E01.0, E01.1, E01.2, E04.0, E04.2, E04.8, E04.9, E05.00, E05.10, E05.20, E05.40, E05.80, E05.90 [Hide]

ICD-10 Procedure: 0B110Z4, 0GBG0ZZ, 0GBG3ZZ, 0GBG4ZZ, 0GBH0ZZ, 0GBH3ZZ, 0GBH4ZZ, 0GBJ0ZZ, 0GBJ3ZZ, 0GBJ4ZZ, 0GTG0ZZ, 0GTG4ZZ, 0GTH0ZZ, 0GTH4ZZ, 0GTJ0ZZ, 0GTJ4ZZ, 0GTK0ZZ, 0GTK4ZZ [Hide]

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