Children's Surgery Verification
American College of Surgeons

Optimal Resources for Children's Surgical Care, 2021 Standards
Standards Manual Change Log

Standard	Level	Date Change Made	Edit Made	Reason
Standard 3.1: Neonatal Intensive Care Unit (NICU)	Level II	September 13, 2021	A Level II center may prospectively define its scope of practice to exclude neonatal patients. These centers would not be associated with a birthing center or take neonates in transfer. Typically, these centers would be part of a system with a Level I center that is admitting neonates born within or transferred to the system. If the Level II center does not care for neonates, a NICU is not required but the center must have a PICU and all relevant medical and surgical specialties.	Guidance change
Standard 4.1: Surgeons	All Levels change to Level III	October 14, 2022	The following criteria apply to General Surgeons at Level III centers: A surgeon with pediatric expertise is defined as a surgeon either in the examination process or with current certifications from the American Board of Surgery or similar ABMS Board or equivalent. The surgeon will demonstrate continuous experience with children as defined by caring for at least 25 patients ≤ 18 years of age per year and completing 12 or more pediatric AMA PRA Category 1 Credits™ credit hours annually All surgeons with pediatric expertise will demonstrate ongoing clinical engagement in children's surgery, as	Clarification of standard

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			evidenced by the performance of 25 or more procedures annually on patients 18 years or younger. In summary, a Level III children's surgical center must have continuous 24/7 availability within 60 minutes of general surgeons with pediatric expertise; one of these individuals should serve as the primary surgeon for children 5 years or younger with general surgical needs. A general surgeon with pediatric expertise is defined as a surgeon either eligible for certification or certified by the American Board of Surgery or an equivalent body in general surgery. In addition, this individual will demonstrate ongoing clinical engagement and expertise in children's surgery as evidenced by the performance of 25 or more procedures annually in patients younger than 18 years, as well as completion of 12 or more pediatric AMA PRA Category 1 Credits™ credit hours annually.	
Standard 4.3: Medical Specialists	Level I Specialty Musculoskeletal	February 6, 2024	Specialty musculoskeletal hospitals must have all the pediatric medical specialties listed available for preoperative evaluation as a part of the Perioperative Anesthesia Risk Assessment Program. These specialists are important to assure appropriate risk stratification and risk reduction. Given that the overwhelming majority of operations at musculoskeletal centers are non-emergent, thorough risk assessment allows appropriate patient selection to meet the center's resources and personnel.	Guidance change

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			Musculoskeletal centers are not required to have the medical specialties available at bedside within 60 minutes 24/7. Centers must prospectively define which specialties must be immediately available at bedside within 60 minutes 24/7 based on the center's scope of service. The center must have transfer agreements for these specialties not immediately available. The PIPS process must monitor all transfers for medical specialty consultation and situations in which specialty consultation would have improved care. If the review identifies the need for a particular specialty to be available immediately, it must create a plan to provide this coverage.	
Standard 4.3: Medical Specialists	All Levels	January 14, 2026	The Children's Surgery Verification Program recognizes the national shortage of Pediatric Rheumatologists, as well as the rare situation where a surgical patient may require an urgent consultation with this type of specialist. If a surgical patient requires an urgent or emergent pediatric rheumatology consult, the center may instead have a transfer agreement with a hospital that has a Pediatric Rheumatologist on staff. The center must submit a transfer agreement and track any transfers required for surgical patients requiring this care. An alternative would be a consultation visit by telehealth to assess if a transfer is warranted or if the patient could be cared for as an outpatient	Guidance Change

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			after discharge. The formal arrangement for coverage must be described at the site visit.	
Standard 4.23: Child Maltreatment Services	Level I Specialty Oncology	October 5, 2021	Level IS Oncology centers are not required to have a dedicated child protective or child maltreatment team available 24/7/365 for consultation. While a child maltreatment team is recommended, transfer agreements are acceptable to provide those services when not available. A process and policy must be in place to screen for abuse or suspected abuse of a child. The process and policy must follow state guidelines for reporting suspected child abuse.	Clarification of standard
Standard 4.26: Transport Services	Level I Specialty Centers	7/26/2023	The following criteria do not apply to Level I Specialty Centers: • A transport team for neonatal and pediatric patients within the scope of service is essential. Personnel must have specific training in advanced airway management skills and a skills maintenance program as outlined in 11th Edition Accreditation Standards as published by the Commission on Accreditation of Medical Transport Systems (CAMTS) (https://www.camts.org/standards/). • A back-up plan is required when all the available teams are already deployed and there is a patient transfer need.	Guidance Change

Standard	Level	Date Change Made	Edit Made	Reason
			• A medical director of the transport team must be a physician with acute care experience who has working knowledge of transport medicine including infants and children and who assumes overarching responsibility of the program. • Transport team members must have onboarding education at a minimum in the following: pediatric critical care pathophysiology, physiological effects of transport on the pediatric patient, technical skills for emergency management, and adaptation to the physical environment of the transport vehicle as outlined in the Commission on Accreditation of Medical Transport Systems (CAMTS) standards (https://www.camts.org/ standards/). Level I Specialty Hospitals must meet the below requirements: • The ability to stabilize and transfer critically ill children must be demonstrated. • The receiving hospital must have a written policy regarding hospital-to-hospital communication that includes pre-transfer workup information, determination of best method of transport (in other words, air versus ground), and patient stabilization requirements.	

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			• Well defined evidence-based protocols dealing with specific clinical situations must be developed and utilized. This includes transports for imaging in Musculoskeletal hospitals. Level I Specialty Hospitals must have a relationship with and deploy a pediatric-specific transport team when transferring appropriate infants and children to and from their centers.	