PATIENT STATUS DEFINITIONS 2 MNS 96 HOURS

PURPOSE

It is the policy of Mason General Hospital and Family of Clinics (MGH&FC) that based on the Patient Status Definitions, all placements concerning the use of observation beds, or placements made to the observation unit will meet the criteria for placement. An Advanced Beneficiary Notice (ABN) shall be issued to the patient at the start of care, if the admit is for the convenience of the patient or the physician, it will not be charged to Medicare.

POLICY

INPATIENT

Patient is admitted to a nursing unit and meets both Intensity of Service and Severity of Illness (IS/SI) criteria. Stay expected to be greater than 24 hours. See also Milliman and/or InterQual for admission criteria.

Inpatient is defined by CMS/Medicare as:

A patient is considered an inpatient of a hospital when formally admitted pursuant to a physician order for inpatient admission, <See 42 C.F.R. 412.3(a)>. There is also an expectation that the patient will require hospital care for 2 midnights, <See 42 C.F.R. 412.3(d)>; and a physician certification.

For CAH's, a physician must certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. CAHs must maintain an <u>annual average length of stay (LOS) of 96 hours or less per patient</u> for acute care. <See 42 C.F.R. 424.15(a)>

Effective Date: 11/1/2008
Review Date: 10/8/2020
Revision Date: 9/26/2018
Formulated Date: 10/1/2008

PATIENT STATUS DEFINITIONS 2 MNS 96 HOURS

Timing:

1. For orders written by the Ordering Practitioner prior to when the patient presents to the hospital, (e.g. pre-surgery orders), the time of admission is when the patient is "formally admitted".
2. For orders written by the Ordering Practitioner after the patient has presented to the hospital. The time of admission is the time in the Registration screen.
3. For initial orders written by a proxy provider and countersigned by an Ordering Practitioner prior to the patient's discharge, the time of admission is the time of the initial order.
4. For verbal orders transcribed by appropriate staff and authenticated by an Ordering Practitioner prior to the patient's discharge, the time of admission is the time of the verbal order.
    - If the physician or other practitioner responsible for countersigning an initial order or verbal order does not agree that the inpatient admission was appropriate or valid (including an unauthorized verbal order), the Ordering Practitioner should not countersign the order and the patient is not considered to be an inpatient.

TWO-MIDNIGHT RULE APPLIED:

In General CMS states the following about the Two-Midnight Rule:

- Inpatient admission will generally be payable under Part A if the admitting provider expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.
- As one exception to the above, procedures identified by Medicare as "Inpatient-only" shall be admitted as inpatient, regardless of the anticipated length of stay.

Pursuant to the Two-Midnight presumption, CMS medical review contractors will presume that an inpatient hospital admission is reasonable and necessary (and therefore payable under Part

PATIENT STATUS DEFINITIONS 2 MNS 96 HOURS

A) if it crosses two midnights after the formal admission order. (78 Fed. Reg., 50949). These admissions will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the Two-Midnight presumption.

If patient was admitted as an inpatient for the planned 2 midnights and subsequently stayed less than 2 midnights – therefore the admit may be subject to re-review and possible change to observation status based on medical necessity. Exceptions would be Medicare inpatient only surgical list, deaths and transfers.

Use of Inpatient Utilization Screening Tools (Milliman and InterQual)

1. Commercial utilization screening tools may be considered by the physician in making the inpatient admission decision and determining the anticipated length of stay (78 Fed. Reg., 50948)
2. Utilization screening tools are not dispositive and the physician should order inpatient status when the Two-Midnight Benchmark is met and the outpatient status for identical services when the benchmark is not met. (78 Fed. Reg., 50948; Special Open Door Forum, August 15, 2013, transcript)

OBSERVATION (Formerly Short Stay):

A patient that is put into a bed for a period of time of 23 hours or less, with the expectation of determining if the patient should be discharged or admitted to inpatient status. Patient is classified as "Medical".

Observation is defined by CMS as:

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

PATIENT STATUS DEFINITIONS 2 MNS 96 HOURS

1. Determination of Inpatient or Observation Status may be defined by guidelines of certain insurances and their related contracts. This should be taken into consideration during the decision making process. An Insurance Carrier may declare a circumstance that is special or an exception to this rule for their patient population.

    - For example: An insurance policy may declare that if a stay is under 24 hours, the patient is "observation status" unless they are transferred or expire.

2. To change patient status you need a physician order and a reason "why" the status was changed (i.e. change in clinical treatment or diagnosis).
3. If the status of the patient is always going to be outpatient, then antibiotic infusions, blood transfusions, therapies (PT/OT/ST) and nuclear medicine studies are outpatient services that are not charged Observation during that time.
4. See also, Two-Midnight Rule Section of this policy.

OUTPATIENT:

Outpatient is a generic term for patients that receive care for a specific diagnosis or test. They can present to many different areas of the hospital or clinic; they may be scheduled in Diagnostic Imaging and Day Surgery; or unscheduled as in the Laboratory and the Emergency Department. There is also an outpatient service that is provided by a series of appointments – we call this service "recurring". The types of patients typically in this category are Rehab Therapies (PT/OT/ST), Wound Care, Diabetic Education and Injection/Infusion therapy. See below for additional information on some of these types of services.

1. Emergency Department Patients are outpatients, but they do have their own service code designation (ED) in the computer system. These patients are treated and released, treated then admitted, or treated and transferred to another facility. When a patient is treated and admitted to MGH, the patient status changes on admit to inpatient or placed in observation or outpatient status. For example(s):

- An ED patient is sent to outpatient surgery for an ORIF, and then is subsequently discharged from the outpatient surgery. This patient has a change in status from ED to Outpatient Surgery. The ED physician hands-off to the Surgeon.
- An ED patient is sent to the procedure room for an EGD and returns to the ED for recovery and definitive treatment. ED physician oversees care and surgeon is procedure specific. The patient's status remains ED. With Cerner you will have to place in SDC then back to ER, otherwise surgery will not have access to the patient's information.

2. Ambulatory Surgery patients stay may or may not be contained within the Ambulatory Surgery area. There are occasions where the patient is still recovering from the surgical encounter, nothing unexpected medically is happening, but they may need to be moved to another area, i.e. MSP to complete the stay. Regulations clearly state: **these patients are to remain OPS** status. If however, something unexpected happens (for example, vomiting, blood pressure issues, or reaction to medications) then the patient will need to be admitted to Inpatient Status or placed in Observation Status. This can only be done under the direction of the physician along with appropriate medical necessity documentation.

   - The patient could be registered as an outpatient surgery patient, the infusion/transfusion given, then proceeds to surgery. The services are pre-determined and all part of the surgery plan of care.
   - In the case of the patient leaving the ED and waiting for surgery, but needing pain control, Observation may be justified until the patient has reached the medical status to go to surgery. This last case could fall into the "short term treatment, assessment, and reassessment" because the patient could potentially worsen and need something more than the planned outpatient surgery. However, at the time they go to surgery, observation time would stop.
   - There are also situations whereby the intent is outpatient surgery and there is an intentional delay until morning. If nothing more is being done, then the patient status remains outpatient surgery for the time period prior to the scheduled surgery. Intent on admission is key in this and all status assignments.

3. In the outpatient category there are a couple of category designations such as:
   - Recurring Series
   - Outpatient Surgery
   - Outpatient Procedure Room

- Emergency Department
- Reference Lab (reserved for nursing home visits)

PATIENT STATUS DEFINITIONS 2 MNS 96 HOURS

Example

Scenario #4: Uncertain Length of Stay

80 year-old patient presents from home to the ED on a Saturday with clinical presentation consistent with an acute exacerbation of chronic congestive heart failure. She is short of breath and hypoxic with ambulation. The physician determines that she will require hospital care for diuresis and monitoring, however it is unclear at presentation whether she will require 1 or 2 midnights of hospital care.

12/7/2013

- 9:00 pm – Patient begins receiving medically necessary services in the ED. She shows evidence of fluid overload, requiring intravenous diuresis and supplemental oxygen and continuous monitoring.
- 11:00 pm – Intravenous diuretics are provided and an order for observation services is written with a plan to re-evaluate her within 24 hours for the need for continued hospital care or discharge to home.

12/8/2013

- 9:00 am - She remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis and supplemental oxygen.
- 5:00 pm – She continues to respond to diuretics but remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis for another 12 to 24 hours. Inpatient admission order is written based on the expectation that the patient will require at least 1 more midnight in the hospital for medically necessary hospital care.

12/9/2013

- 10:00 am - The patient's acute CHF exacerbation is resolved and she is discharged home.

Hospital may bill this claim for inpatient Part A payment. Providers should treat patients as outpatients until the expectation develops that the patient will require a second midnight of hospital care. When the expectation develops, an inpatient admission order should be written by the physician.

MLN Connects™ www.cms.gov/NPC 21

Referenced Documents

UR HINN, ABN, Detailed Notice of Discharge and Important Message Policy
Critical Access Bed Utilization Guidelines and Procedure

CMS Transmittal 138 April 2015
78 Fed. Reg., 412
78 Fed. Reg., 50949
78 Fed. Reg., 50948

Effective Date: 11/1/2008
Review Date: 10/8/2020
Revision Date: 9/26/2018
Formulated Date: 10/1/2008

PATIENT STATUS DEFINITIONS 2 MNS 96 HOURS

Special Open Door Forum, August 15, 2013, transcript

****This procedure will be posted to the main hospital Internet page.**