Effective:	*08/2001*
Approved:	*12/2016*
Last Revised:	*12/2016*
Expiration:	*12/2019*
Owner:	*DeAnna Read: Dir. Case Management*
Department:	*Case Management*
References:	
Applicability:	*Columbia St. Mary's Hospital Milwaukee* *Columbia St. Mary's Hospital Ozaukee* *Sacred Heart Rehabilitation Institute*

Outpatient Observation - Bedded Outpatient - BDO

POLICY STATEMENT

In keeping with the Core Value of Excellence, CSM ensures safe patient care through short term monitoring by designating Observation Status (OBS) or Bedded Outpatient Status (BDO).

SCOPE

This policy is consistent across CSM.

PURPOSE

1. *To provide a process to evaluate and monitor a patient's condition to determine the need for inpatient admission and/or further treatment.*
2. *To initiate a method for consistent short term patient monitoring throughout all CSM campuses, by assigning the appropriate patient status, either Outpatient Observation, or Bedded Outpatient.*
3. *To ensure compliance with the Centers for Medicaid and Medicare Systems or CMS, (formerly HCFA) and other third party payer's rules and regulations for appropriate billing and documentation.*

DEFINITIONS

1. **OBSERVATION and OUTPATIENT**:
   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. Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. These services typically do not exceed one day (24

hours), but must be a minimum of 8 hours. Some patients may require a second day of outpatient observation (48 hours) or monitoring in order to make a decision concerning their admission or discharge.

A. Examples of appropriate Observation/Outpatient placement:
    1. Used to determine if an inpatient admission is necessary
    2. Must be patient specific
    3. Appropriate for symptomatic or rule out cases
    4. Used when additional evaluation is indicated yet the patient does not meet inpatient criteria
    5. Indicated when close monitoring is required due to medical instability

B. The following is a list of services that are not considered appropriate for observation room services (this list is not all inclusive):
    1. Patient clearly meets delineated Inpatient clinical criteria (i.e., Milliman, InterQual criteria sets)
    2. Patient presents for a routine clinical procedure
    3. Services that are not reasonable or necessary for the diagnosis or treatment of the patient
    4. Outpatient hydration, blood, or chemotherapy administration
    5. Lack of/delay in patient transportation
    6. Provision of a medical exam for patients who do not require skilled support
    7. Routine preparation prior to and recovery after diagnostic testing
    8. Routine recovery and post-operative care after ambulatory surgery
    9. When used as a substitute for inpatient admission
    10. When used for the convenience of the physician, patient or patient's family
    11. While awaiting transfer to another facility
    12. When an overnight stay is planned prior to diagnostic testing

2. **BEDDED OUTPATIENT**:
An out-patient service where a patient is placed in a nursing unit bed for short post-procedure care, extended recovery time, recovery from a weekend/after- hours procedure, assess fetal well- being, prep for a test, etc.

A. Examples of appropriate placement include:
    1. Recovery and aftercare from ambulatory surgery when a patient needs to be assigned a bed
    2. Monitoring for outpatient procedures after the Outpatient Department is closed
    3. Minor post-procedure complications requiring overnight stay
    4. Post-operative recovery for patients following ambulatory surgery when the patient requires monitoring beyond the normal recovery time
    5. Patients requiring a fetal non-stress test (considered an outpatient test)
    6. Patients requiring assistance prior to procedure.

PROCESS

1. As is the same with Observation/Outpatient, during the episode of care, if the patient clearly begins to meet delineated Inpatient clinical criteria, the patient can and should be changed to Inpatient status, after obtaining such order from the patient's attending physician. Physician documentation will reflect the medical criteria for the change in status. See below (Conversion to Inpatient)
2. MEDICAL DECISION-MAKING**:** Observation/Outpatient or BDO (Bedded Outpatient) status is a clinical decision to be made by or in collaboration with the attending physician, irregardless and separate from how reimbursement will be made for the services rendered.
   The choice of Patient Status (Outpatient OBS, or BDO) is a complex, point-in-time, patient-specific medical judgment, which can be made only after the physician has considered a number of factors
   A. The medical record must contain sufficient documentation to support medical decision-making, reason for care, patient's response to care and condition on discharge as well as any discharge conditions.
   B. The documentation by physicians and nurses is essential to substantiate appropriate level of care
   C. Columbia St. Mary's Patient Status/Admission Orders patient status/admission orders were updated in CPOE to assist with compliance with Social Security Act §1814(a). There are four patient status orders.
      It is required that all patient status/admission orders be signed by a physician. If a resident or mid-level provider enters the order, it must be sent for co-signature by the supervising physician. Supervising physician co-signature and nurse VORB/TORB physician signatures are required within 48 hours.
   D. The four patient status order: Admission for Inpatient Service, place in Observation Status, Bedded Outpatient Status, Outpatient Status
3. PHYSICAL REQUIREMENTS:
   A. OBSERVATION/OUTPATIENT STATUS: Order by attending physician
      1. History and physical with pertinent clinical findings and rationale for observation/outpatient status
      2. Date, time and reason for observation/outpatient status placement
      3. Symptoms to observe and discharge criteria (if appropriate)
      4. Ongoing progress notes specifying patient's response to care
      5. Disposition order noting date and time
      6. Discharge summary
   B. BEDDED OUTPATIENT STATUS: Order by attending physician
      1. Discharge order
4. NURSING REQUIREMENTS:
   A. OBSERVATION/OUTPATIENT NOTICE: HUC to provide Observation/Outpatient Status notice on admission, as appropriate. Case Manager to support process as needed to ensure patient is aware of their admission status.

B. OBSERVATION/OUTPATIENT: Verify patient Status order, Nursing Admission History and Assessment Form, Documentation of patient's progress and response to treatment, Documentation of patient education and/or follow up care, Discharge note, dated, timed.

C. BEDDED OUTPATIENT: Verify Patient Status order, Nursing Admission History and Assessment Form, Discharge Note, dated, timed

5. DISCHARGE: The physician makes the determination to discharge the patient, and writes the order, the patient is provided with discharge instructions, the physician completes a discharge progress note/ summary, the exact time of discharge must be documented

6. CASE MANAGEMENT

   A. Screen the available information against admission criteria that Observation Status meets Medical Necessity

      1. If observation meets Medical Necessity or continued testing and treatment - document accordingly and admit to inpatient schedule for follow up of necessary

      2. If observation status does not meet medical Guidelines contact admitting physician for additional information or clarification on treatments and to allow opportunity for physician to present their view.

   B. Re-Screen against admission criteria

   C. If observation status now meets Medical Necessity - document accordingly-schedule for follow-up if necessary

   D. If Observation Status does not meet Medical Necessity:

      1. Consider discharge if Physician agrees

   E. Request peer review if physician disagrees, outcome of peer review is the status of the patient

   F. Two-Midnight rule:

      1. Inpatient admissions will generally be payable under Part A if the admitting practitioner 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

      2. Inpatient admissions are considered reasonable and necessary for Medicare beneficiaries who require more than a one-day stay in a hospital or who need treatment specified as inpatient only

      3. Documentation in the medical record must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights.

7. CONVERSION TO INPATIENT (if applicable per clinical criteria) The attending physician makes the determination to admit to inpatient. The order also requires documentation of a "reason for inpatient status." Admitting physicians clearly document the medical necessity relevant to the admitting diagnosis. The documentation should contain specific words and phrases, such as "admit as an inpatient" and clinical reasons why they expect a patient will need hospital care that crosses two midnights. Furthermore, admitting physicians must use "objective medical information" to support the decision that it is "reasonable and necessary" to keep a patient at the hospital for the care provided. This includes such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. See attachment with specific requirements for Inpatient

admissions and CMS Two Midnight Benchmark. Patient type code is changed by HUC and the Medicare IM notice is given to the patient by the HUC.

Attachments:

Pocket Cards

Approval Signatures

Step Description	Approver	Date
	Gloria Rawski: Policy/Clinical Database Coordinator	12/2016
	Gerri Staffileno: VP Hospital Operations & CNO	12/2016
	Richard Shimp, MD: Chief Medical Officer	12/2016
	DeAnna Read: Dir. Case Management	12/2016

Pocket Cards

Physician certification – required for all **inpatient** admissions starting Oct 1, 2013 • Authentication of inpatient order – must be done before discharge • The reason for inpatient services – the medical reasons that inpatient care is needed as documented in the H&P and progress notes • Estimated time the patient required in the hospital – based on the two midnight expectation. • The plans for post hospital care, if appropriate. The physician certification must be completed before discharge, but the first three points should be completed at the time of admission.	Two midnight benchmark • The decision to admit as **inpatient** must be based on an expectation that the stay will span two midnights. • If the patient has spent one night as an outpatient in observation and you document a medical reason that they need to stay another midnight, it is appropriate to admit them before the second midnight • The first midnight in observation counts toward the two midnight benchmark, but it is still an outpatient day and does not count toward the three inpatient midnights needed to qualify for skilled benefits. • Surgeries on the Medicare inpatient only list are exempted from the two midnight benchmark and should be inpatients regardless of their length of stay. • Stays for social or scheduling issues alone do not show a medical reason to be in the hospital. • Without a reasonable expectation of two midnight stay, even ICU admissions should be observation