HARDIN COUNTY GENERAL HOSPITAL
UTILIZATION REVIEW/RISK MANAGEMENT POLICY

Title: OBSERVATION BED **Effective Date: 6/06**
Policy Number: 145 **Med Staff:**
Regulation: Medicare Hospital Manual (230.6, 455 A, B, & E) **Admin:**

I. POLICY

1. Observation services at the hospital outpatient level of care are appropriate for patients, adult or pediatric, presenting with conditions that require urgent evaluation and treatment in a setting with availability of ancillary resources for diagnosis and/or treatment under medical and skilled nursing observation. (CIMRO, 5/93)
2. It is expected that prompt initiation of diagnostic evaluation and/or short term treatment in the observation setting, will resolve or stabilize the patient's presenting acute problems usually within, but not limited to, 24 hours.
3. Patients may be admitted for observation either through the emergency room or direct.
4. Patients receiving observation services will receive the same standard of quality of care, confidentiality, privacy, infection control measures and safety practices as the inpatient.
5. All necessary diagnostic and/or therapeutic services routinely available to inpatients will be available to the observation patient.
6. The patient cannot be discharged from an inpatient status to observation status.

II. DEFINITIONS

Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient.

III. RESPONSIBILITY

Medical Staff, Health Information Management, Nursing Services, Patient Accounts, Utilization Review, Social Services, and Insurance verification.

IV. EQUIPMENT

N/A

V. PROCEDURES

INFECTION CONTROL: N/A

<u>PHYSICIAN RESPONSIBILITIES</u>:

1. **Physician order** to place patient in observation bed. **Be sure to write "admit to observation"**. Include what the patient will be observed for. This will help facilitate documentation from all disciplines to focus on the primary condition.
2. An **H&P or Short Stay Record** must be documented.

3. Documentation of diagnostic and therapeutic orders on the **Physician Orders Sheet**.
4. Documentation of patient progress on the **Progress Notes** form.
5. Orders for discharge, admission or transfer of patient within the approved observation time frame.

TIME LIMITS:

1. HCFA expects most observation patients to be in the facility for less than 24 hours and will not pay for a stay that exceeds 48 hours. **For Medicare patients who stay in observation for more than 48 hours,** a formal request for an exception is required to be submitted by the attending physician documenting the medical necessity for observation services in excess of 48 hours. Claims submitted for observation services in excess of 48 hours lacking any of the above items of medical record documentation may be denied for lack of sufficient information upon which to make payment under sec. 1833(e) of the Social Security Act. (10/98)
2. **Illinois DPA** may stay up to 99 hours in observation.
3. The majority of **Private Insurance's** recognize observation as less than 24 hours. If the patient must stay longer, a daily review/report to them is required for approval of the extended time.
4. **Private Pay** patients will be at the discretion of the physician, but is expected to be less than 48 hours.

PATIENT SELECTION CRITERIA:

MUST MEET ONE OF THE FOLLOWING: (CIMRO 5/93)

1. Patient's presentation requires continuing or extended evaluation for determination of admission necessity.
2. Patients who require access to diagnostic services to identify a disorder or define the extent of an illness or injury.
3. Patients who undergo a minor procedure/treatment or outpatient surgery requiring an observation period to regain stability. **Medicare patients requiring monitoring beyond the usual 4-6 hour recovery period in Ambulatory Surgery (ASC) can be admitted for observation up to 5 hours but may not stay over night in OBR. Medicare Patients that require an over night stay after surgery are expected to be admitted as inpatients. (MEDICARE 10/98)**
4. Patients whose physicians have ordered other noninvasive treatment not expected to produce complications but require extended monitoring or surveillance.
5. Patients whose physical or mental/emotional disorders or injuries require immediate attention or treatment, yet are less severe than to require acute level inpatient admission.
6. Patients whose condition requires the utilization of multi-departmental services and supplies not accessible in a lesser setting such as an office, clinic or skilled nursing facility.
7. Patients with physical or mental/emotional conditions who require evaluation to

determine if they can return to their original environment without jeopardizing their well-being and safety.

SERVICE PROVISION CRITERIA: (Stay in Observation)

MUST MEET BOTH CRITERIA: (CIMRO 5/93)

1. Nursing/other staff assessment of patient's condition is frequently monitored and documented as appropriate for service/therapy provided (e.g. regular vital signs).
2. Appropriate and timely recognition, physician notification and medical/nursing interventions to a patient's status, significant change and/or response to a service/therapy.

OBSERVATION RELEASE CRITERIA: (Discharge from Observation status)

MUST MEET ONE OF THE FOLLOWING: (CIMRO 5/93)

1. Documentation by a physician of patient's stability for discharge and specified disposition.

OR

2. Documentation by a physician of patient's appropriate transfer to another setting (e.g. acute care, extended care, etc.) with documentation of needed orders for ensuring continued care.

SERVICES WHICH ARE NOT COVERED AS OBSERVATION BY MEDICARE: 10/98

1. Observation services which exceed 48 hours unless the fiscal intermediary grants an exception.
2. Services provided for the convenience of the patient, family, or patient's physician, and are not reasonable and necessary for diagnosis or treatment. (e.g. Following uncomplicated treatment or procedure, waiting for a physician visit when the patient is physically ready for discharge, or holding while awaiting placement in a long-term care Facility).
3. Services which are covered under Part A, such as a medically appropriate inpatient Admission. Observation services to a Medicare beneficiary which are deemed to represent a medically appropriate inpatient admission will be denied by the fiscal intermediary (FI).
4. Postoperative monitoring during a standard recovery period (e.g., 4-6 hours) which should be billed as recovery room services.
5. Routine preparation and recovery services furnished in association with diagnostic testing which are included in the payment for those diagnostic services.
6. Observation services billed concurrently with therapeutic services such as chemotherapy or transfusion.
7. Standing orders for observation following outpatient surgery. Note that the availability of outpatient observation does not mean that procedures for which an overnight stay is anticipated, such as cardiac catheterization, may be performed on an outpatient basis. **Procedures that anticipate an overnight stay in the hospital should be performed on patients who have been admitted as inpatients.**

8. Services which were ordered as inpatient services by the admitting physician, but billed as outpatient by the hospital billing office.

9. Claims for inpatient care such as complex surgery clearly requiring an overnight stay and billed as outpatient.

STAFFING:

Observation patients will be cared for by the Nursing Staff from the Med/Surg area and will be assigned according to the patient's needs.

NURSING RESPONSIBILITIES:

1. Patients will be admitted to a regular patient bed, but they will be considered outpatients.
2. The **General Admission Assessment** will be initiated by the nursing staff member Assigned. The RN assessment will be documented in the **Graphic Chart/Nurses Notes** form and focus specifically on what the patient is to be observed for.
3. The patient's Advance Directive status is to be assessed by the RN using the **Advanced Directive Acknowledgment** form.
4. The patient chart and Kardex is to be marked with a **"purple dot"** for easy identification of patient admission status.
5. Documentation of vital signs, reassessments, treatments, medications, etc. by nursing and other services will be done on the **appropriate forms as applicable** (e.g., Graphic Chart/Nurses Notes, Patient Medication Orders, Parenteral Fluid Flow Sheet, Medication Records, etc.).
6. If patient has medications ordered, a **Patient Medication Profile** must be filled out and sent to Pharmacy.
7. If the patient is discharged from OBR the **Patient Discharge Instructions** form will be used to give instructions to the patient on medications, activity, diet, etc.
8. If the patient is transferred from OBR the chart is closed the same as for an inpatient to include, if applicable, **Ambulance Transfer Record**.
9. If the patient is admitted as an inpatient, the OBR chart is closed and a new chart is started to include all inpatient forms. **The following forms may be copied and placed on the inpatient chart from the OBR chart:**

Graphic Chart	**Any applicable Consents**
Most recent Lab results	**General Admission Assessment**

10. If patient is admitted as an inpatient, the RN must do the **RN Admission Assessment (**which includes the Advanced Directive status), **Patient Care Plan,** and the **Patient and Family Education Assessment**.

VI. DOCUMENTATION

N/A