

## GUIDELINES

### Medicare Decisions: Observation or Inpatient?

#### **Does Medicare Observation still exist? YES!**

Ambulatory Payment Classification (APC) changed the way Medicare pays hospitals, but the rules for observation admission remain unchanged for physicians and hospitals.

#### **What is Observation?**

The Medicare definition: *Observation Services are those services furnished by a hospital on its premises, including the use of a bed, periodic monitoring by nursing and other staff, and any other services that are reasonable and necessary to evaluate a patient's condition or to determine the need for a possible (inpatient) admission to the hospital.*

**HINT:** If the admission is based on a symptom (suggesting a diagnosis that must be ruled out, e.g., chest pain, abdominal pain, TIA symptoms) or if there is an unusually prolonged recovery period after an outpatient procedure (e.g., pain management issues, cardiopulmonary concerns, urinary retention), admit to *Observation*.

**If the admitting diagnosis is "Rule Out (R/O)," then "Remember Observation." (R/O = R/O)**

#### **What is my responsibility as the attending and/or admitting physician?**

- Knowledge of the definition and appropriate use of Observation and Inpatient status.
- Determination and documentation of admission status by a signed and dated physician order: *Admit to Observation* or *Admit to Inpatient*.
- Documentation of clinical rationale for hospitalization status decision(s).

#### **Can resident physicians care for patients in Observation status? YES!**

Teaching institutions are encouraged to include patients admitted under Observation status as a routine resident responsibility and learning opportunity.

#### **How long can Observation last?**

Medicare permits up to 48 hours for Medicare fee-for-service patients. This differs from some private insurance company and Managed Care Organization definitions that often terminate Observation at 24 hours.

#### **Can Observation Admission be changed to Inpatient Admission? YES!**

Admission status may be changed anytime within 48 hours if the following conditions are met:

1. The patient requires continuing services and monitoring beyond 48 hours, and
2. The patient's condition is severe enough to require inpatient treatment.

*InterQual Criteria* are used by HSAG/CMS to determine the appropriate level of care. Contact your hospital's quality/utilization/case management staff for patient-specific questions.

#### **Can I convert an Inpatient Admission to an Observation Admission? YES!**

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit a CODE 44 claim for medically necessary Medicare Part-B services that were furnished to the beneficiary, provided all of the following conditions are met:

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- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital.
- The hospital has not submitted a claim to Medicare for the inpatient admission.
- A physician concurs with the utilization committee’s decision.
- The physician’s concurrence with the utilization review committee’s decision is documented in the patient’s medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

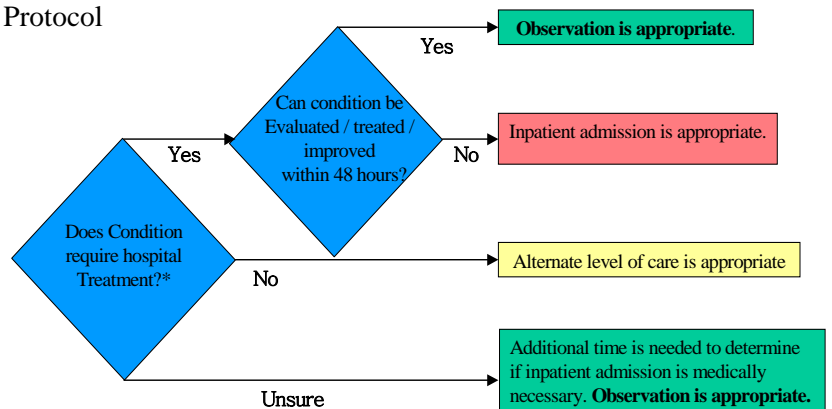
**Why is the admission status such an important decision?**

The quality of care and treatment of the patient should be the same whether a Medicare admission is Inpatient or Observation status. The difference is cost—an important consideration for patients, hospitals and Medicare. When admitted under Observation the patient becomes financially responsible for the co-pay(s) under the Ambulatory Payment Classification system. The exact amount varies with the service provided. Patients may be responsible for more than one co-payment. If the patient’s needs are best served by care administered in the acute inpatient setting, the patient is then responsible for a \$992 Part A deductible (2007) (per benefit period)—as well as all non-covered charges. However, if upon review, the admission is deemed inappropriate, the hospital could be responsible for the cost of services.

**Is there a protocol for Observation vs. Inpatient Admission? YES!**

A case management protocol has been successfully piloted in Florida. The following elements were found to be essential to successful decision-making:

- Support from the hospital staff
- Physician admits / assigns patient to the Protocol
- Case Manager/Utilization Manager assessment
- Assign patient to the appropriate status (Inpatient vs. Outpatient)
- Decision is binding with the physician who wrote the order
- The same protocol for all patients, regardless of payer
- 2–12 hours to assess patient and determine status
- Observation status is the default status if > 12 hours



The decision to admit a patient as an inpatient requires complex medical judgment including consideration of the patient’s medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.

**Where can I get more information?**

[www.hsag.com/hpmp/tools.asp](http://www.hsag.com/hpmp/tools.asp)

[www.cms.hhs.gov](http://www.cms.hhs.gov)

[www.cms.hhs.gov/medlearn](http://www.cms.hhs.gov/medlearn)

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