I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Hospital”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to provide guidance to clinical staff and other personnel on the proper procedures and requirements for all patients to receive services for the appropriate patient status, in compliance with third party payer requirements, including those issued by the Centers for Medicare & Medicaid Services (CMS).

III. DEFINITIONS:

A. For the purposes of this policy, “Physician” means a physician or other licensed independent practitioner who has been granted admitting privileges by the Tenet Hospital’s medical staff and is legally accountable for establishing a patient’s diagnosis.

B. “Physician Order” means an order from the Physician admitting the patient to the Tenet Hospital or the Physician responsible for the patient’s general medical management during the admission. The order may be electronic, in writing or be a telephone/verbal order as allowed by the Tenet Hospital’s medical staff bylaws.

C. “Case Management” means a collaborative process of assessment, planning, facilitation, care coordination and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

D. “Inpatient” means any person who has been admitted to a Tenet Hospital for bed occupancy for purposes of receiving hospital services.

E. “Outpatient” means a person who has not been admitted by the Tenet Hospital as an Inpatient but is registered on the Tenet Hospital records as an Outpatient and receives services from the Tenet Hospital. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

F. “Patient Status” means Inpatient or Outpatient.

1The March 19, 2015 revision incorporated and retired COMP-RCC 4.40 Patient Status and Bed Placement.
G. “Level of Care” means the level of Inpatient or Outpatient Services a patient receives. Level of Care may include Observation Services, Telemetry, Acute, Step-Down Unit and other Levels of Care designated by the Tenet Hospital. Observation is not a Patient Status. Observation is a Level of Outpatient Care. See Medicare Claims Processing Manual, Trans. 1760 (June 23, 2009).

H. “Observation Services” or “Observation” means assessment, short-term treatment, reassessment, and stabilization before decision to admit to Inpatient or discharge.

I. “Condition Code 44” means a condition code placed on a Medicare claim indicating that the patient was admitted to inpatient status but subsequently determined to meet outpatient status criteria only. Condition Code 44 is used when an INTERQUAL or other Tenet approved clinical screening criteria review performed after an Inpatient admission subsequently determines that the patient did not meet Inpatient status and that the patient would have been registered as an Outpatient under ordinary circumstances, the Utilization Management Committee concurs, the ordering physician agrees, the patient is still in the hospital, and the claim has not been submitted. See Medicare Claims Processing Manual, Chapter 1, Section 50.3.

J. “INTERQUAL” means the McKesson product housed in Tenet’s case management documentation system. INTERQUAL is utilized to provide objective feedback to physicians and hospitals on the Patient Status and Level of Care that may be appropriate for hospital patients. INTERQUAL is not a government product and serves only as a guideline to prompt feedback and discussion. The physician order determines Patient Status and Level of Care.

K. “Secondary Physician Review” means a clinical review performed by a physician on the Utilization Management Committee other than the ordering physician when INTERQUAL or other Tenet approved clinical screening criteria guidelines suggest a different Patient Status or Level of Care than that ordered.

L. “Admitting or Attending Physician” means, in the context of this policy, a physician or any licensed independent practitioner who is legally accountable for establishing the patient’s diagnosis and has been granted admitting privileges by the Tenet Hospital’s Medical Staff. Emergency Department physicians may be considered Admitting or Attending Physicians when they have been granted admitting privileges by the Medical Staff.

M. “Hospital Case Manager” means, for the purpose of this policy, a Tenet Hospital representative appropriately educated in the accurate application of
INTERQUAL or other Tenet approved clinical screening criteria. The Hospital
Case Manager may be a Tenet Hospital employee or a contractor.

N.  “Federal health care program” means any plan or program that provides health
benefits, whether directly, through insurance, or otherwise, which is funded
directly, in whole or in part, by the United States Government, including, but not
limited to, Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-
Cal, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan,
Indian Health Services, Health Services for Peace Corp Volunteers, Railroad
Retirement Benefits, Black Lung Program, Services Provided to Federal
Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011
Requests.

O.  “Authorization” means a process by which the hospital contacts the payer to seek
preauthorization/precertification/authorization for the patient status and treatment
ordered by the Admitting Physician.

IV.  POLICY:

All Tenet Hospitals must establish a process to ensure that patients are admitted and maintained
in the appropriate patient status. The patient status for payers with an Authorization process must
be reflected in the medical record and on all billing documentation to ensure proper billing to all
payers.

V.  PROCEDURE:

A.  Physician Orders

It is the joint responsibility of Case Management, Patient Access, Nursing and
the Emergency Department to ensure that appropriate electronic, written, or
verbal orders are obtained. All Physician Orders must be patient-specific and
tailored to the clinical needs of each patient. For example, standing or routine
orders for Observation Status following Outpatient procedures are prohibited.
While standing or routine orders for outpatient observation following a
procedure are prohibited, it is acceptable for a Physician to order outpatient
observation if a patient develops symptoms requiring observation beyond normal
recovery time following a procedure and the Physician has provided the clinical
rationale for such order.

This process must include who, in all Departments of the Tenet Hospital, is
responsible for ensuring that an appropriate order has been obtained before a
patient is registered. All Tenet Hospital employees are responsible for and
empowered to “stop the line” before registering a patient and assigning a hospital
bed if orders complying with this policy have not been received.
B. Discussion with Admitting or Attending Physician

All Tenet employees are prohibited from leading the Physician to a certain Patient Status or Level of Care or attempting to influence the Physician’s Order. Examples of inappropriate “leading” discussions would include, but are not limited to, informing the Physician what is needed to meet Inpatient Status or discussing the financial impact of the Physician’s Order of Inpatient or Outpatient Status or Observation Level of Care. The Hospital Case Manager may educate the Physician on the differences between Inpatient and Outpatient Status and an Outpatient Observation Level of Care when the results of the INTERQUAL or other Tenet approved clinical screening criteria review or authorization process do not match the status ordered. If a clear Physician Order has not already been provided, the Hospital Case Manager must request a Physician Order that clearly states Patient Status by use of the words “Inpatient” or “Outpatient” and the appropriate Level of Care and services to be provided. See Attachment C for examples of proper admission orders.

C. Outpatient Observation

1. Outpatient observation is commonly assigned to patients who present to the Emergency Department (ED) and then require a period of treatment or monitoring before a decision is made whether to admit the patient as an inpatient to the Tenet Hospital or discharge.

2. Patients may also be placed in outpatient observation from labor and delivery, short-procedure units after 4-6 hours of recovery time, other outpatient units, or a Physician’s office.

3. A patient must not be placed in outpatient observation following an outpatient procedure based on (a) a standing order, (b) an order given prior to the procedure, or (c) an order that does not articulate patient-specific physician findings indicating the need for outpatient observation services. Notwithstanding the foregoing, if a payer with an Authorization process preauthorizes outpatient observation pursuant to a standing order, an order given prior to the procedure or without patient-specific findings, the Tenet Hospital may provide observation care to the patient as authorized.

4. The criteria for outpatient observation are:

   a. The outpatient observation services must be specifically ordered by a Physician (e.g., the Physician Order states “place into outpatient observation status” or “initiate outpatient observation services”);
b. Those hospital stays in which the Physician cannot reliably predict the beneficiary to require a hospital stay greater than 2 midnights;

c. The outpatient observation “start” and “stop” times must be documented in the medical record;

d. The patient must be under the care of a Physician during the time of outpatient observation, documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the Physician according to the Tenet Hospital’s Medical Staff bylaws; and

e. The medical record must include documentation that the Physician explicitly assessed patient risk to determine that the patient would benefit from outpatient observation care.

1. Upon the determination a patient needs outpatient observation, the severity of the condition and the specific monitoring or therapeutic interventions required must be documented.

2. The Physician Order must include the clinical reason or medical necessity for placement in outpatient observation.

5. Clinical findings must justify the need for outpatient observation services and must be documented. For patients whose payers do not have an authorization process, outpatient observation must be documented consistent with INTERQUAL or other Tenet approved clinical screening criteria.

6. The decision to discharge the patient from outpatient observation services or to admit the patient as an inpatient should usually be made within 24 hours after admission to outpatient observation services, and outpatient observation services should not typically exceed 48 hours.\(^2\)

7. Services Not Covered as Outpatient Observation Services

The following services are not considered outpatient observation services:

a. Services not reasonable and necessary for the diagnosis or treatment of the patient;

\(^2\)While in very rare cases outpatient services extending beyond 48 hours might be reasonable and necessary, payers usually deny claims for outpatient observation beyond that time as not reasonable and necessary.
b. Services provided for the convenience of the patient, the patient’s family or the Physician (e.g., Physician is unavailable when the patient is physically ready for discharge or the patient is awaiting placement in a long-term care facility) or due to staffing, scheduling or transportation issues unless a payer with an authorization process preauthorizes observation care for these reasons;

c. Medically appropriate inpatient admission(s);

d. For patients whose payers do not have an authorization process, services included in the payment for another service, such as:

(1) Routine preparation services furnished prior to diagnostic testing and/or therapeutic services in a hospital outpatient department and routine recovery afterwards.

(a) Scheduled therapeutic services such as blood transfusions, chemotherapy, allergy injections, respiratory treatments, parenteral medications, or dialysis, do not qualify for outpatient observation status even if the patient otherwise meets outpatient observation criteria in INTERQUAL or other Tenet approved clinical screening criteria (for patients whose payer does not have an Authorization process) or as specified by the payer’s Authorization process. The scheduled therapeutic services should be billed to Federal health care program patients as outpatient services or, for non-Federal health care program patients, in accordance with the terms of the managed care agreement.

(2) Routine postoperative or post procedure monitoring during a standard recovery period (which are to be billed as recovery room services).

(a) Outpatient observation services following an outpatient procedure are appropriate for patients whose payers do not have an Authorization process only if:

(i) The patient has complications that are not resolved after a standard recovery period of 4 to 6 hours;
(ii) The Physician determines that the patient has developed symptoms requiring outpatient observation beyond normal recovery time following a procedure,

(iii) The Physician has provided the clinical rationale for the outpatient observation order;³ and

(iv) The patient’s condition and the specific monitoring or therapeutic interventions required and furnished are documented and meet INTERQUAL criteria.

(3) Extended Recovery Time – For patients whose payers do not have an Authorization process

(a) Absent a specific Physician’s Order for outpatient observation services following an outpatient procedure, time the patient remains at the Tenet Hospital following release from the post-anesthesia care unit (PACU) must not be billed as an observation service (i.e., no observation time must be billed).⁴

(b) The Tenet Hospital’s Medical Staff may adopt policies authorizing extended recovery time beyond normal recovery in the PACU for specific particular outpatient procedures.⁵

(c) Patients remaining at the Tenet Hospital for extended recovery time authorized by a Medical Staff policy must be assigned to the appropriate bed occupancy code which indicates that the patient is registered as outpatient in a bed. Separately billable services furnished during extended recovery

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³ A Physician’s order for observation services must be based on an evaluation of the patient post-surgery and a specific finding that the Outpatient Observation is required.

⁴To avoid confusion regarding these services, the term “extended recovery” should be used in place of “extended observation.”

⁵This decision will usually be made based on the nature of the procedure and the experience of local Physicians performing it on an outpatient basis, generally or for a specific patient population.
time must be billed pursuant to the usual procedures for outpatient services.\(^6\)

When the time for extended recovery specified in the Medical Staff policy has elapsed, the patient must be processed for discharge in accordance with the Physician’s Order and normal outpatient surgery discharge procedures.\(^7\)

If a patient expresses a desire to remain in the Tenet Hospital beyond the extended recovery time authorized by Medical Staff policy for an outpatient procedure, the patient must be informed that Medicare will not pay for the additional time, but the Tenet Hospital will provide the service if the patient agrees to sign an ABN and to pay for the additional services. See Regulatory Compliance policy COMP-RCC 5.00 Medical Necessity and Advance Beneficiary Notice of Non-Coverage of Outpatient Services (ABN).

8. Placement of Outpatient Observation Patients

a. All requests for outpatient observation beds must be reviewed through the Case Management (CM) Department or by designated nursing personnel. Patients must be placed in an outpatient observation bed, when appropriate, without regard to their ability to pay or insurance status, based on Physician Orders. For patients whose payers do not have a preauthorization process, the outpatient observation status must meet INTERQUAL or other Tenet approved clinical screening criteria. For patients whose payers do have an Authorization process, the outpatient observation status must meet the criteria set forth by the payer. However, if outpatient observation status ordered is not authorized by the payer or if the clinical presentation of the patient indicates that outpatient observation status is not clinically appropriate for the patient, the case manager must complete an INTERQUAL or other Tenet approved clinical screening criteria review for the patient for purposes of discussing the appropriate clinical status.

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\(^6\)When the Medical Staff has adopted such a policy for a procedure, a Physician’s Order is not necessary for the extended recovery period authorized by the Medical Staff policy for that procedure. Physician Orders are required for any specific diagnostic of therapeutic services other than nursing monitoring and assessment.

\(^7\)The patient can safely prepare to leave the Tenet Hospital when the patient has met discharge criteria, all medical/nursing interventions have been completed, and the patient (or family member) has received discharge instructions.
b. In the absence of a designated outpatient observation unit, outpatient observation patients may be placed in an available acute care bed.\(^8\)

c. A patient’s status can change from outpatient observation to inpatient without actually changing beds, unless the Tenet Hospital has distinct outpatient observation beds.

9. Clinical Review for Outpatient Observation Patients and Calculating Outpatient Observation Time Periods for Patients Whose Payers do Not Have an Authorization Process

a. The Tenet Hospital must be able to identify and track the status of all patients who are in the Tenet Hospital to receive outpatient observation services. Because of the relatively short duration of outpatient observation services and the need for periodic nursing and medical staff documentation of testing and/or clinical intervention, patients in the Tenet Hospital to receive outpatient observation services must be evaluated immediately and then must be clinically reviewed at least every four hours.

b. Clinical reviews shall be performed by a Physician or the nurse responsible for making regular assessments of the patient. The results of all clinical reviews shall be noted in the patient’s medical record. The person conducting this review must immediately notify the Physician, nursing supervisor, and/or CM staff of any change in the condition of the patient that may change the patient status or require continued hospital stay over 2 midnights, including any indication that outpatient observation services are no longer clinically necessary or appropriate. If a patient’s clinical condition changes, the Physician must be notified and offered assistance in transitioning the patient to inpatient status or discharging the

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\(^8\)Only in a rare circumstance (e.g., lack of an available acute care bed) and following the approval of the DCM or Administrator on call may beds from other specialty units, such as licensed skilled nursing facility (SNF), be used for outpatient observation patients. Prior to placing a patient in a specialty unit for outpatient observation services, the CM staff or designated personnel must confirm that the patient does not meet INTERQUAL/ other Tenet approved clinical screening criteria or the payer’s inpatient admission criteria. Each Tenet Hospital must consult with its Regional Counsel to discuss state licensure and PPS-exemption requirements that may be impacted by placing patients in specialty area beds. Each Tenet Hospital must develop its own written process regarding the approvals needed to place an outpatient observation patient in a specialty unit bed if the Tenet Hospital desires to utilize specialty units for such purposes.
patient. If the Physician declines to admit as an inpatient or discharge the patient as appropriate, the appropriate supervisor (e.g., Physician Advisor (PA), Director of Case Management (DCM), and nursing supervisor, as defined in the Tenet Hospital’s policies) must be notified.

c. For Federal health care program patients, CM or hospital designated staff must ensure effective tracking of outpatient observation time periods.

(1) Beginning of Observation

(a) Outpatient observation begins at the clock time documented in the patient’s medical record, which must coincide with the initiation of outpatient observation care or with the time the patient is placed in a bed whether in the Emergency Department or on a nursing unit for the purpose of initiating outpatient observation care in accordance with a Physician’s Order rounded to the nearest hour.\(^9\) Outpatient observation time cannot begin before the time of the Physician’s Order for observation services.

(i) For patients placed in outpatient observation via the Emergency Department, the time starts with the Physician’s Order for outpatient observation services.

(ii) For patients directly placed in outpatient observation from other outpatient settings such as the Physician office, the time starts with patient registration.

(b) Outpatient observation services must not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).

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\(^9\)For example, a patient who was placed in an observation bed at 3:03 pm according to the nurses’ notes and discharged to home at 9:45 pm should have a “7” placed in the units field of the reported observation HCPCS code.
(i) If such a procedure interrupts ongoing outpatient observation services, Tenet Hospitals must record the beginning and ending times for each period of outpatient observation services and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour).

(ii) Tenet Hospitals must use the Tenet Healthcare Monitored Procedure Carve Out List (Attachment A) to determine what procedures are deemed to be “monitored procedures” and the time to be excluded from the calculation of hourly observation services.

(2) End of Observation

(a) Outpatient observation time ends when all medically necessary services related to observation care are completed.

(b) Specifically outpatient observation time ends with the Physician’s order to change the patient status from outpatient observation to inpatient admission or when the patient status changes from outpatient observation to discharged.

(c) Reported outpatient observation time must not include time a patient remains in the Tenet Hospital after treatment is finished for reasons such as completing discharge paperwork, waiting for transportation home or other patient or family convenience. The DCM must ensure that the correct number of outpatient observation hours is communicated to the appropriate billing personnel so that the claim can be submitted accurately.

d. Any patient receiving outpatient observation services who has been discharged by the Physician, but wishes to remain in the Tenet
Hospital for an additional time for his/her own comfort or convenience, must be notified the Tenet Hospital will no longer be able to provide care.

e. The CM staff or the PA must review all outpatient observation services for medical appropriateness. The CM staff must review and closely monitor the entire outpatient observation census at the beginning of, and prior to the end of, each business day. Each Tenet Hospital must have processes to address patients approaching 48 hours in outpatient observation. A summary report of outpatient observation services must be presented to the Tenet Hospital’s Utilization Management (UM) Committee at regular intervals as determined by the Tenet Hospital’s UM Plan.

D. Inpatient Status

1. Inpatient services must be specifically ordered by a Physician with admitting privileges. All orders for inpatient services must use the word “inpatient.”

2. Physicians should admit a patient as an inpatient if:

   a. they expect the patient will remain in the hospital for greater than (>1) one Medicare utilization day, which CMS defines as an admission that crosses two midnights; or

   b. the patient requires a procedure that is specified as inpatient-only on the CMS Inpatient Only List for the current year.

3. The Attending Physician must complete a Physician Certification, which must be included in the electronic health record (medical record). The Physician Certification must include the following elements:

   a. Authentication of the Physician’s Order

   b. Reason for inpatient services

   c. Estimated time the patient requires or required hospitalization

   d. Plans for post-hospital care, if appropriate

4. Tenet Case Managers must verify that the certification elements are present in the record prior to billing.
5. All Acute inpatients whose payers do not have an Authorization process must have a documented INTERQUAL or other Tenet approved clinical screening criteria review according to the following requirements:

a. As soon as possible after the Tenet Hospital receives an electronic, verbal, or written Physician Order for hospital care, the Hospital Case Management reviewer must conduct an initial review on the day of admission as soon as adequate clinical information is available to complete an accurate review, but within 24 hours of admission.

b. When Inpatient Acute, Intermediate or Critical INTERQUAL or other Tenet approved clinical screening criteria level of care for the condition is “Met” then inpatient status is “Met.”

c. Follow up or Continued Stay reviews must be completed on hospital day 3, then no less frequently than every third day, as appropriate for the patient’s condition and timely progression of care.

(1) When Tenet/Tenet Hospital policy dictates a more frequent schedule.

(2) Delivering mothers and newborns’ stays must be reviewed if they develop complications or if they exceed the federally mandated timeframe for vaginal or C-section deliveries.

For patients whose payers have an Authorization process, the Case Managers must follow the payer’s Authorization process but will complete an INTERQUAL or other Tenet approved clinical screening criteria review when the payer authorization does not agree with the Physician order and/or if the payer’s patient status is not clinically appropriate for the patient.

6. INTERQUAL or other Tenet approved clinical screening criteria review, if applicable, must be documented and used in the various stages of the medical necessity denials and appeals process.

7. Discharge criteria must be assessed whenever a patient does not meet Episode Day criteria and/or meets “Responder” criteria, or has a discharge order.
8. Patients who do not meet INTERQUAL/other Tenet approved clinical screening or the payer’s criteria for either admission or continued stay but meet INTERQUAL Discharge Screens/other Tenet approved clinical screening or the payer’s discharge criteria and do not have discharge orders must be discussed with the Physician and other caregivers to obtain additional information. If no additional information exists to support the proposed or ordered services, alternate levels of care must be discussed with the Physician and transfer of the patient to an appropriate alternate level of care, or discharge, must be facilitated. If the Physician does not agree to discharge the patient or to transfer the patient to an alternate level of care, and the patient’s payer does not have a utilization review process, the case must be referred for secondary review by the PA or other designated UM committee Physician for review and determination.

9. Medicare patients shall be notified of discharge and coverage determination pursuant to Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients (Including Important Message From Medicare). Medicaid patients must be notified regarding their discharge and/or continued stay cases determined to be medically unnecessary in accordance with each state’s specific guidelines.

E. Assignment of and/or Changes in Patient Status - Federal Health Care Program and Self-Pay Patients

The Patient Access/Admitting staff is responsible for assigning, updating and/or correcting and/or updating the patient status as stated in the Physician’s Order, regardless of the reason for the change (e.g., Physician admission order or change in Physician patient status order, clerical error, Condition Code 44, etc.). Each Tenet Hospital must have processes to ensure timely and accurate notification of all census designation changes.

1. Change of Medicare Patient Status from Inpatient to Outpatient Observation (CMS Condition Code 44).

    a. In some instances, a Physician may order a Medicare patient to be admitted to Inpatient Status, but upon subsequent review, the Tenet Hospital’s UM Committee determines that an admission does not meet the Tenet Hospital’s inpatient admission criteria. In such cases, the Tenet Hospital may change a Medicare patient’s status from inpatient to outpatient observation or outpatient provided all of the following conditions are met:
(1) The Tenet Hospital’s UM Committee determines that the inpatient admission does not meet the Tenet Hospital’s inpatient admission criteria;

(a) The UM Committee may delegate responsibility for internal utilization review and application of Condition Code 44 to the following individuals acting in concert, provided that the UM Committee reflects in its minutes that it has delegated this function.

(b) Pursuant to UM Committee delegation, CM personnel must screen inpatient admissions for satisfaction of admission criteria.

(c) CM staff must discuss patients that do not meet admission criteria with the Physician to determine if additional information is available to support the need for inpatient admission.

(d) If no further documentation is provided to support the inpatient admission, the case must be referred directly to a PA or other UM Physician.

(e) If the PA or UM Physician agrees that a patient does not meet inpatient admission criteria, CM staff and/or the PA must contact the Physician as soon as practicable in order to discuss the patient, and if possible, obtain the Physician’s concurrence that the patient’s status should be changed to outpatient observation or outpatient.

(f) If the Physician concurs with the PA or UM Physician that the inpatient order should be changed to outpatient observation or outpatient services, and the Physician’s concurrence and clinical rationale is documented in the patient’s medical record.

(2) The Physician’s order to change a patient’s status from inpatient to outpatient observation or outpatient is made prior to discharge or release, and while the patient is still a patient in the Tenet Hospital.
(3) The Tenet Hospital has not submitted a claim to Medicare for the inpatient admission.

(4) The Physician gives an order for the change in status to outpatient and an order for outpatient observation services if indicated.

2. Outpatient Observation to Inpatient
   a. CM staff or designated nursing personnel must only change the status of a patient receiving outpatient services to inpatient upon the order of a Physician. Each Tenet Hospital must ensure Patient Access coordination to complete valid patient status and level of care changes.
   b. When a patient who is receiving outpatient observation or outpatient services is subsequently admitted as an inpatient, the inpatient admission date is the date/time of the Physician Order to admit as an inpatient.
   c. The charges for medically necessary outpatient observation services must be billed on the inpatient claim. Outpatient observation charges must not be “backed out” of a Medicare inpatient DRG claim in the event a patient in outpatient observation status is subsequently admitted as an inpatient.

F. Long Term Acute Care (LTAC)
   1. Patients are admitted to a LTAC for complex inpatient care that is required for an extended period of time. For patients whose payers have an authorization process, the payer’s process is followed for pre-admission, admission, continued stay and discharge readiness.
   2. For patients whose payers do not have an authorization process, INTERQUAL or other Tenet approved clinical screening criteria is used to document medical necessity for pre-admission, admission, continued stay and discharge readiness.
   3. Preadmission reviews are required during the intake process. Admission reviews must be done within 48 hours of admission.
   4. Continued Stay reviews must be done every 7 days,
5. Discharge criteria must be assessed whenever a patient does not meet Episode Day criteria, meets “Responder” criteria, or has a discharge order.

6. Refer to PMICMT.101 INTERQUAL Application and Training.

G. Determining Inpatient Appropriateness for Admission to Behavioral Health Unit

1. General Requirements

The physician will determine medical necessity for admission to the Inpatient Behavioral Health Unit and document the patient’s symptoms or conditions meeting the diagnostic criteria for a DSM Axis I or ICD-10 Substance Dependence diagnosis and the patient can be reasonably expected to respond to therapeutic intervention.

Case Management reviewers must conduct an initial clinical review within 24 hours of admission. Follow up or Continued Stay reviews must be completed no less frequently than every third day, as appropriate for the patient’s condition and timely progression of care. The review must assure documentation of behaviors meeting physician certification requirements and therapeutic interventions planned to diagnose and treat those behaviors in an inpatient setting as well as the anticipated transition plan.

2. Physician Certification – Fee-For-Service Medicare and Medicaid/Medi-Cal for Non-Exempt Units

a. The Physician must certify and recertify the medical necessity for inpatient psychiatric services.

   (1) The initial physician certification statement is required at the time of admission or as soon thereafter as is reasonable and practicable.

   (a) The physician’s initial certification statement should state the medical necessity for inpatient psychiatric hospital services for either:

      (i) Treatment which could reasonably be expected to improve the patient’s condition; or

      (ii) Diagnostic Study
(2) The first physician recertification is required as of the 12th day of hospitalization.

(3) Subsequent recertification will be required at intervals no less frequently than every 30 days.

(4) The physician’s recertification should state:

(a) That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either;

(i) Treatment which could reasonably be expected to improve the patient’s condition; or

(ii) Diagnostic study;

(b) The hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services, and the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

H. Determining Appropriateness for Admission to a Medicare Certified Skilled Nursing Facility (SNF)

1. General Requirements

The physician will determine medical necessity for admission to the Medicare Certified SNF and document the patient requires skilled nursing or skilled rehabilitation care for a condition that was treated during the qualifying hospital stay or for a condition that arose while in the SNF for treatment of a condition which was being treated while in the hospital.

Case Management reviewers must conduct an initial clinical review within 48 hours of admission. Follow up or Continued Stay reviews must be completed no less frequently than every seven days, as appropriate for the patient’s condition and timely progression of care.
The review must assure documentation of behaviors meeting physician certification requirements and therapeutic interventions planned to diagnose and treat those behaviors in an inpatient setting as well as the anticipated transition plan.

2. Physician Certification

Physician certification must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable but no later than the 14th day following admission. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program. There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.

Subsequent recertification must be obtained at intervals not exceeding 30 days.

I. Medicare Coverage Analysis

Unlike commercial payers, the Medicare program does not have a pre-certification or pre-authorization process to inform hospitals whether services and procedures are covered by the Medicare program. Instead, the Medicare program adopts Local Coverage Determinations and National Coverage Decisions that determine whether the Medicare program will cover the services ordered for the patient. Each Tenet Hospital and non-Hospital entity shall develop a process to ensure that, preferably prior to the performance of a service or procedure but in any event prior to billing a claim as a covered service to Medicare, all requirements of the Local Coverage Determination (LCD) and National Coverage Decision (NCD) have been met and are documented in the medical record. Please refer to Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients for instructions on how to proceed when a Physician desires to order an inpatient service or procedure and it does not appear from a review of the LCD and/or NCD that it will be covered by Medicare. Tenet Hospitals must use Order Checker to screen outpatient services, including outpatient observation services, against the NCDs and LCDs and ensure that services and procedures that do not meet Medicare coverage requirements are not billed to the Medicare program as covered services or without appropriate modifiers (e.g., GA, GZ or GY). See Regulatory Compliance policy COMP-RCC 5.00 Medical Necessity and Advance Beneficiary Notice of Non-Coverage of Outpatient Services (ABN).
J. Auditing and Monitoring

The Audit Services and Quality Management departments will audit compliance with this policy.

K. Responsible Person

The DCM is responsible for ensuring that all individuals adhere to the requirements of this policy, that the policy and its procedures are implemented and followed at the Tenet Hospital, and that instances of policy noncompliance are reported to the Compliance Officer.

L. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will result in performance management, up to and including termination. Such performance management may also include modification of compensation, including merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- **Regulatory Compliance policy COMP-RCC 4.11 Inpatient Rehabilitation Facility Admission, Continued Stay, and Discharge Criteria**

- **Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients (Including Important Notice from Medicare)**

- **Regulatory Compliance policy COMP-RCC 5.00 Medical Necessity and Advance Beneficiary Notice of Non-Coverage of Outpatient Services (ABN)**

- Conifer Policy & Procedure Manual policy 04.07.01A PBAR – Payer Request to Change Patient Type Designation Policy

- **Case Management policy PMI.CMT.101 INTERQUAL Application and Training**

- **Case Management policy PMI.CMT.104 Hospital Case Management Utilization Review Process**


- Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 6, section 20.5
VII. ATTACHMENTS:

- Attachment A: Tenet Healthcare Monitored Procedure Carve Out List
- Attachment B: Condition Code 44 Tool
- Attachment C: Examples of Proper Admission Orders
### TENET HEALTHCARE MONITORED PROCEDURE CARVE OUT LIST

The basis for determining a “monitored procedure” on this carve out list is when clinical assessment or monitoring is required to assess the effects of the therapy or procedure including vital signs, pulse oximetry, cardiac rhythm, and/or skin color.

<table>
<thead>
<tr>
<th>Description</th>
<th>Time* (in minutes)</th>
<th>Monitored Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ablation</td>
<td>360</td>
<td>Yes</td>
</tr>
<tr>
<td>Angioplasty</td>
<td>120</td>
<td>Yes</td>
</tr>
<tr>
<td>Barium Swallow</td>
<td>50</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Product Administration (per unit)</td>
<td>120</td>
<td>Yes</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>120</td>
<td>Yes</td>
</tr>
<tr>
<td>Cardiac Cath (includes recovery on nsg unit)</td>
<td>240</td>
<td>Yes</td>
</tr>
<tr>
<td>Central Line Placement</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Chemotherapy Administration</td>
<td>60 - 360</td>
<td>Yes</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>150</td>
<td>Yes</td>
</tr>
<tr>
<td>Dialysis</td>
<td>240</td>
<td>Yes</td>
</tr>
<tr>
<td>EGD</td>
<td>120</td>
<td>Yes</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>180</td>
<td>Yes</td>
</tr>
<tr>
<td>Flexible Sigmoidoscopy</td>
<td>150</td>
<td>Yes</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>120</td>
<td>Yes</td>
</tr>
<tr>
<td>Pacemaker Placement</td>
<td>360</td>
<td>Yes</td>
</tr>
<tr>
<td>PEG Insertion</td>
<td>150</td>
<td>Yes</td>
</tr>
<tr>
<td>PTCA</td>
<td>360</td>
<td>Yes</td>
</tr>
<tr>
<td>PT/OT Treatment</td>
<td>30</td>
<td>Yes</td>
</tr>
<tr>
<td>Radiation Therapy Initial Set Up</td>
<td>120</td>
<td>Yes</td>
</tr>
<tr>
<td>Radiation Therapy Treatment</td>
<td>30</td>
<td>Yes</td>
</tr>
<tr>
<td>Respiratory Treatment</td>
<td>15 - 45</td>
<td>Yes</td>
</tr>
<tr>
<td>Speech Therapy Treatment</td>
<td>30 - 60</td>
<td>Yes</td>
</tr>
<tr>
<td>Stress Test</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Surgical Procedure (includes recovery)</td>
<td>Varies</td>
<td>Yes</td>
</tr>
<tr>
<td>Thallium Stress Test</td>
<td>240</td>
<td>Yes</td>
</tr>
<tr>
<td>Trans-Esophageal Echo (TEE)</td>
<td>90</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Time includes procedure plus transport

### THE SERVICES LISTED BELOW ARE NOT DEEMED "MONITORED PROCEDURES" FOR PURPOSES OF TRACKING TIME TO CARVE OUT OF OBSERVATION LENGTH OF STAY

- CT Scan with contrast
- CT Scan without contrast
- Echo
- EEG
- MRI
- Nuclear Medicine
- PICC Line Placement
- PT/OT Evaluation
- Renal Ultrasound
- Speech Therapy Eval
- Ultrasound
- X-ray
MEDICARE PATIENT STATUS CHANGE
CONDITION CODE 44

PATIENT NAME ________________________________
ACCOUNT NUMBER ______________ MEDICAL RECORD # ______________
DATE OF ADMISSION_____________ ATTENDING PHYSICIAN_______________

A MEDICARE PATIENT MAY BE CHANGED FROM INPATIENT TO OUTPATIENT
OBSERVATION OR OUTPATIENT IF THE FOLLOWING CRITERIA ARE MET:

- After determining that the Medicare patient does not meet inpatient INTERQUAL criteria, the case manager needs to do the following:
  1. Call the attending physician to notify him/her and to obtain additional clinical information.
  2. If additional clinical information does not support the Medicare patient’s inpatient status, the case manager should refer to the UM Committee/Designee (PA).
  3. PA/CM discuss with attending physician the option of changing patient status to Outpatient Observation or Outpatient and obtains attending physician’s concurrence with option.
  4. The attending physician’s concurrence with the change in status and clinical rationale is documented in the medical record.

- The change in status from inpatient to outpatient is made prior to discharge or release, and while the patient is still in the hospital.
- The hospital has not submitted a claim to Medicare for the inpatient admission.
- The attending physician writes/gives an order to change the status to Outpatient.

If the above criteria are met the Case Manager will do the following:
- Complete INTERQUAL admission review for Outpatient Observation.
- Contact patient access to request a status change in the system. Outpatient Observation or Outpatient start time is the time the Outpatient Observation or Outpatient order is written.
- Enter a Conversation Note in the Authorization Log, stating that Condition Code 44 is to be entered on the patient’s claim for billing.
- Copy of this CODE 44 Worksheet should be forwarded to Director of Case Management, Business Office, HIM).
- Patient Access will notify the patient of the status change and financial implications.
Examples of Improper and Proper Admission Orders

<table>
<thead>
<tr>
<th>Order</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Admit”</td>
<td>Does not specify IP or OP Status</td>
</tr>
<tr>
<td>“Admit for Observation” intended</td>
<td>Unclear whether IP or OP Status is intended</td>
</tr>
<tr>
<td>“Admit to Observation”</td>
<td>Unclear whether IP or OP Status is intended</td>
</tr>
<tr>
<td>“Place in Observation”</td>
<td>Unclear whether IP or OP Status is intended</td>
</tr>
</tbody>
</table>

The following is a non-exhaustive list of examples of orders that are appropriate and may be accepted:

<table>
<thead>
<tr>
<th>Order</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Admit to inpatient telemetry”</td>
<td>Specifies Patient Status</td>
</tr>
<tr>
<td>“Place in outpatient observation”</td>
<td>Specifies Patient Status</td>
</tr>
</tbody>
</table>