DIGNITY HEALTH
ADMINISTRATIVE POLICY AND PROCEDURE

FROM: Compliance Oversight Committee

SUBJECT: Patient Status Determination and Change Policy

EFFECTIVE DATE: May 9, 2014

REVISED: 

ORIGINAL EFFECTIVE DATE: May 9, 2014

REPLACES: New Policy

APPLIES TO: System Offices: 
Acute Care Entities: X 
Non-acute Care Entities: 

I. POLICY:

All physician orders must be documented (electronic or hard copy) and authenticated with signature, date, and time. The hospital legal record (medical record) must reflect the most recent accurate physician order placed prior to discharge. Retrospective or post-discharge orders for changes in patient status are not permissible.

II. PURPOSE:

Establish policies that satisfy CMS requirements for patient status changes to Medicare beneficiaries and Non-Medicare Patients. This policy helps to define physician documentation requirements when changes in patient status are indicated as well as supportive documentation pertaining to delivery and duration of services to ensure appropriate billing of services.

Clearly define roles, responsibilities and relationships between Case Management, Nursing, Admitting/Registration (Patient Access), HIM/Coding staff, and Billing (Central Business Office (CBO) / Patient Financial Services (PFS)) personnel related to changes in patient status.
III. DEFINITIONS:

InterQual® Level of Care Acute Criteria is the criteria set chosen and implemented by Dignity Health to meet the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP) requirement pertaining to the use of standard criteria. InterQual® criteria are also used by the CMS to determine appropriate inpatient admissions.

IV. PRINCIPALLY AFFECTED DEPARTMENTS:

The following entities are principally affected by the policy elements and shall receive the required training, as provided in Administrative policy 70.1.003, Compliance Policy Dissemination and Implementation Process:

- Hospitals
- Central Business Offices (CBOs) / Billing Offices

Specifically, the following departments:

- Senior Management
- Case Management
- Hospital Coding
- Hospital Health Information Management
- Hospital Billing Services (CBO/PFS)
- Inpatient Admitting / Registration
- Medical Staff Physicians
- Quality Management
- Utilization Review Committee

A Dignity Health entity may, in the exercise of its reasonable judgment, determine that other departments are affected by this policy and provide necessary training to the workforce in those departments.

It is the responsibility of the Hospital President to ensure adherence to this policy. It is the responsibility of the Hospital Chief Financial Officer to ensure adherence to the coding and billing requirements of this policy.

Adherence to the elements of this policy is subject to audit by Corporate Compliance, Internal Audit and/or Case Management.
V. GUIDELINES:

1. Initial Status Determination: The Physician’s decision to admit a patient is a complex medical determination based on the information available to the physician at the time of the initial determination.

The status order must be furnished by a physician or other practitioner (“ordering practitioner”) who is: (a) licensed by the State to admit inpatients to hospitals, (b) granted privileges by the hospital to admit patients to that facility, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for hospital placement and provides the status order.

A. Physician Inpatient Status Determination: The physician’s decision to admit a patient as Inpatient should be based on a determination that the patient will require medically necessary, hospital based, inpatient care.

i. For Medicare Prospective Payment System (PPS) patients, the physician’s inpatient determination should include certification that the patient is expected to require active treatment for a period spanning a minimum of two midnights.

ii. Patients with procedures on the Medicare Inpatient Only list should be admitted as inpatients regardless of expected length of hospitalization.

iii. The physician order should specify “Admit” and “Inpatient Status”.

iv. Unforeseen circumstances may result in a shorter beneficiary stay than the physician’s expectation that the beneficiary would require a stay greater than 2 midnights and includes:

   1. Death
   2. Transfer
   3. Departure against medical advice (“AMA”)
   4. Unforeseen recovery
   5. Election of hospice care

Such claims may be considered appropriate for hospital inpatient payment. The physician’s expectation and any unforeseen interruptions in care must be documented in the medical record.

B. Physician Outpatient Status Determination: The physician’s determination of Outpatient status should be based on the following categories and decision making:
i. Medical Observation: Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

ii. Observation Post Procedure: Observation services are those medically necessary hospital services required following an outpatient procedure for an unexpected event after the normal recovery time has transpired. The physician order should specify “Place in Outpatient Observation”.

iii. Outpatient in a bed: Patients whose recovery period extends beyond the availability of outpatient services can be placed in a hospital bed for the period of time required for a safe recovery as determined by the treating physician

2. Hospital Patient Status Change general rule: The hospital provides the level of care that was ordered by the physician and the Central Billing Office (CBO) or Patient Financial Services (PFS) bills that level of care, unless specifically instructed by the payer to bill under a level of care different from what was ordered.

   A. **Patient Status Changes**: Case Managers are required to refer all admissions that do not meet medical necessity criteria to a physician member of the Utilization Review committee, usually the Physician Advisor (PA) following primary review and initial communication or attempted communication with the practitioner responsible for the care of the patient.

   B. **Use of Condition code 44 for Medicare Patient Status Changes**: Code 44 is for use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet inpatient criteria.

   Patient status can be changed from inpatient to outpatient as long as all Condition Code 44 requirements are met and the patient is still a patient in the hospital.
i. Case Management:

- If a Medicare patient is admitted to the hospital as an Inpatient and upon application of InterQual® criteria by Case Management the patient doesn’t meet the Inpatient criteria but does meet criteria for Observation level of care, the Case Manager will discuss with the Attending Physician to determine if there is any additional information that may be documented in order to meet medical necessity for an Inpatient admission.

- If Inpatient admission criteria still are not met, the Case Manager will refer the case to the Physician Advisor (or other designated physician member of the Utilization Review Committee).

- The Physician Advisor will determine if the patient meets medical necessity for Inpatient level of care.

- If the Physician Advisor believes the patient does not meet medical necessity for an Inpatient level of care, he or she will contact the Attending Physician to discuss the case.

- If the Physician Advisor and Attending Physician agree that Outpatient Observation Services are appropriate for the patient, documentation to that effect will be placed in the patient’s chart.

- The Attending Physician (or an RN taking a verbal order ie: Case Manager) must cancel the Inpatient admission order and place an Outpatient Observation order in the chart (do not backdate the order). If the Case Manager is initiating the order, they will state “CC44 criteria met”.

- The Case Manager will call or e-mail the Financial Counselor assigned to the patient to notify them of the change in status.

- If the Attending Physician disagrees with the Physician Advisor’s determination, the Inpatient order will stand and the hospital Case Management department will follow the Federal Register’s CoP’s Medical Necessity Determination and CMS inpatient admission denial process (CMS Beneficiary Notice HINN 1)

ii. Each Facility will indicate how Condition Code 44 process is validated and the code gets on the claim Patient Registration:

- Patient registration/designee will deliver the Observation letter to the patient after the order is changed.
• The Financial Counselor will verify that the patient has Medicare Part-B benefits and/or other outpatient benefits and discuss the change in financial responsibility with the patient.

• Patient Registration will ensure that a copy of the signed observation letter is scanned into Electronic Documentation Management EDM during their audit review.

iii. Health Information Management (HIM)

• HIM can identify if the MD ordered an Inpatient admission and subsequently cancelled the Inpatient order and ordered Outpatient Observation services. HIM will look for documentation of the Physician Advisor and Attending physician concurrence to change the patient status from Inpatient to Outpatient Observation. (Located in the Case Management notes in Cerner.)

• If the required documentation is not in the medical record, HIM will ask Case Manager for clarification.

• HIM will verify that all steps took place before the time of discharge; as long as all documentation is in the chart, HIM will enter the condition code 44 in MIRA.

• If HIM finds that not all of the criteria is met, they will discuss the account with Case Management and if Case Management agrees that condition code 44 criteria is not met, HIM will place a condition code “99” in MIRA.

• Adding Condition Code 44 and/or 99 can be achieved by:
  o While in the MIRA Abstract, hit <Shift F3>
  o Select Billing Code Entry
  o The Occurrence codes will be displayed, enter “44”

iv. Patient Financial Services

• If the Code is entered in MIRA by HIM, then it will automatically be on the claim and billing will not be delayed.

• The hospital Case Management department will have an audit process in place to perform admission reviews not done concurrently (after the patient has been discharged and is no longer a patient of the hospital):

C. Retro-Review before the Account is dropped to bill: Case Management will conduct audits to verify that all Medicare accounts meet applicable Medicare criteria for the level of care billed.

The hospital coding staff will have all 1-day Inpatient stays validated by Case Management prior to coding and dropping to bill. This will be done by an audit process described below:
i. HIM runs the Medicare 1-day stay report in the MS4 billing system and pulls charts for review.

ii. The Case Manager assigned to review the case has a commitment to complete the review within 1 business day.

iii. If Inpatient criteria for an inpatient account was not met, Case Management will send to Electronic Health Resources (EHR) for final determination (more timely than using internal Physician Advisor (PA) resource but optional if you want to use your internal PA).

iv. If EHR overrides criteria and approves Inpatient stay, coding can drop to CBO/PFS as Inpatient (be sure and place the EHR justification in the medical record).

v. If EHR determines Inpatient is not justified, coding will use Condition Code 99 on account and drop to CBO/PFS to bill for Part-B services only.

D. **Retro-Reviews after the Account has dropped to bill:** The Case Management Director or designee will run the MIDAS Validation report weekly to identify any Medicare Inpatient or Observation account that did not have an Admission Review done concurrently via the above post discharge pre-bill drop process. The Admission Review will be documented in MIDAS.

   i. If the criteria for the ordered level of care was not met, Case Management will send to the Physician Advisor for final determination.

   ii. If the Physician Advisor overrides criteria and approves Inpatient stay, no further action is needed.

   iii. If the Physician Advisor determines Inpatient is not justified, the Case Management Rebill log will be completed and the following steps will occur.
For those accounts determined not to meet medical necessity for the ordered level of care the following process is to be followed:

- Notify CBO/PFS within 24-hours of final determination for completion of corrective claim activity.
- When all identified claims on the Case Management Rebill Log are processed by CBO/PFS, a copy of the Rebill Log is returned to the originating department for record retention.
- The original rebill information is maintained by CBO/PFS.
- All rebill/refund claims adjustment activity must be documented on the Dignity Health Case Management Rebill Log including concurrent and retrospective reviews.
- Dignity Health policy 70.1.008 (Government Refunds and Voluntary Disclosures) requires PFS to record all voluntary refunds on the facility Government Payer Refund Log.
- Each facility is responsible to have an effective process in place to ensure the appropriate refund is recorded on the government payer refund log. This process should include the departments that are responsible for this flow, who initiates the workflow, how the information will be transferred (Fax, E-Mail, Shared Drive) etc.
- The notification of rebill decision is to be sent to the ordering physician when it is determined they ordered services that did not meet medical necessity per Medicare Guidelines.

E. **Patient Status Changes for Non-Medicare Patients**: If the patient is a government payer other than Medicare or is a non-government payer, we must provide the level of care ordered by the physician; however, the admitting physician is able to change the status while the patient is in the hospital. The hospital must bill the level of care ordered by the admitting physician unless there are specific, documented instructions from the payer to bill differently.

“Specific, documented instructions” means some form of written instruction from the payer to bill in a certain way (letter, memo, e-mail, note by on-site reviewer, etc) or, after we have received verbal instructions from the payer, we send the payer a patient specific e-mail (or letter) confirming the payer’s instruction to bill the claim differently than ordered by the physician.
(Example: “On March 27th at 4:06 pm, Jane Doe from Blue Shield of California, instructed hospital to bill the services for patient Mary Smith (Blue Shield enrollee # xxx-xx-xxxx) as Observation, even though Dr. Jones, the patient’s admitting physician ordered Inpatient services. If this instruction is incorrect, please let us know within 72(?) hours or we will bill the claim as instructed by Ms. Doe.” We should also copy Ms. Doe on the e-mail.)

i. Correcting Clerical Errors: A clerical error exists when the physician orders inpatient or outpatient observation services but another status is inadvertently entered into the hospital computer systems. An error by the physician in initial patient status determination is not a clerical error.

1. Medicare Patients: If the physician orders a level of service, that was medically necessary and met InterQual® Criteria, and was compliant with Utilization Review process but the status in the host system is incorrect the host system can be updated and the account billed per the physician order.

2. Non-Medicare Patients: If the physician orders a level of service that was medically necessary and met InterQual® Criteria, and was compliant with Utilization Review process but the status in the host system is incorrect the host system can be updated and the account billed per the physician order.

3. Roles by Department

A. Admitting/Registration (Patient Access):

i. It is not the function of hospital administration, admitting, Utilization Review, HIM, or CBO/PFS personnel to make the admission status determination. If the medical record indicates that the patient’s status was changed from an inpatient admission to observation and the change was a Utilization Review determination, administrative or billing decision without physician concurrence, the claim will be denied by the Medicare Administrative Contractor (MAC) and the facility will be instructed to submit an inpatient claim (including telephone or verbal orders written by a nurse or a physician order sheet), which will be referred to the CMS Regional Office.

ii. Registration will not complete any changes to inpatient status until Case Management or an authorized individual reviews the case and notifies Registration to change the patient status from outpatient observation to inpatient.
B. Health Information Management (HIM)

i. Health Information Management (HIM) will assign the appropriate ICD-9-CM or ICD-10-CM diagnosis code(s) based on clinical documentation. The facility should have processes in place which encourage the HIM/Coding staff to review admission orders and ensure the correct patient type is entered into the billing system. In addition, if the patient type in the billing system is not consistent with the orders in the medical record, HIM should notify registration and case management that a change is needed and then wait for the change before assigning diagnosis and procedure codes to the record.

C. Case Management Department

i. A formalized communication link with the admitting/attending physician, bed control, and hospital admitting department regarding status and changes of admission status must be established.

ii. A Case Management or Utilization Review Department (CM or UR) notification mechanism must be in place for all patient status changes.

iii. The Case Manager is responsible for assessing the appropriateness of level of care using InterQual® criteria, for initiating discussion with the attending physician when discrepancies occur, and for referring to second level review when appropriate.

iv. The Case Manager is responsible for reviewing the medical record concurrently to ensure that documentation and billing requirements are met according to CMS guidelines.

Case Management will issue the Advance Beneficiary Notice for services that are not covered under the Medicare program prior to services being rendered including anytime during the episode of care when the patient does not meet criteria (InterQual®) and the attending physician has determined the patient may be discharged. The provider (hospital) is financially responsible when a written ABN is not issued and Medicare makes the determination that the services are not covered.
v. Each month the Case Management or Utilization Review department must report to the Utilization Management Committee the number of patient status change cases, the number of observation cases converted to inpatient status, and post procedure/post-op observation cases to identify and monitor trends.

D. Nursing Services

i. Nursing is responsible for clear and accurate documentation of discharge time in the medical record.
   1. Disposition
      a. To home or other facility (excludes acute care transfer).
      b. Process the patient as a routine discharge.
      c. Document the exact date and time the patient left the hospital.
   2. Conversion inpatient acute care:
      a. A written order stating “Admit to Inpatient” status must be written in physician orders.
      b. Notify bed control and admitting.
      c. Generate a new face sheet with updated patient admission type.

VI. STATUTORY/REGULATORY AUTHORITIES/REFERENCES:

1. CMS Transmittal 1760
2. CMS Transmittal 299
3. CMS Frequently Asked Questions
4. Medicare Claims Processing Manual, Chapter 4, Section 290
5. Medicare Claims Processing Manual, Chapter 1, Section 50.3
6. Medicare Benefit Policy Manual, Chapter 6, Section 20.6
Exhibit A: Documentation Requirement Scenarios

The scenarios below are provided to assist clinicians in determining appropriate steps and documentation requirements for allowable patient status changes:

**Scenario A: Attending Physician and one Utilization Review Physician Advisor Agree with “roll back” to Outpatient Observation Services.**

- The Attending Physician of record and the Physician representative of the Utilization Review committee (Physician Advisor #1) both document their decision and clinical rationale in the medical record.
- The Attending of record writes an order to place patient in Outpatient Status with Observation Services.
- This must occur while the patient is still registered as an Inpatient in the hospital.

When this has been done, the patient is considered to have never been an inpatient and any testing and/or therapies ordered by the attending and treating providers can now be billed through Part-B.

Observation Services cannot be billed retrospectively after the order change, as the Physician had not previously ordered these Observation Services. Observation Service charges can only be billed from the point of the order by the Attending Physician and documentation by nursing going forward.

There are specific requirements that the Patient, the Physician, and the Hospital, receive written notification of the “roll back” to Outpatient/Observation services. The patient is also to be oriented on the meaning of Observation Status, as they would be if they had been placed in Observation Status at initial entry to the hospital.

If the patient was discharged prior to the Utilization review and discussion regarding Outpatient Observation status, the patient could not have been notified and oriented, so it is not possible to obtain an Attending Physician’s order or change status after discharge. In this case only a limited set of Part-B testing will be allowable for billing and therapeutic services (including a surgery or procedure that may have initiated the hospital stay).

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1 This documentation is critical to ensure the billing department has accurate patient status information to correctly bill.
Scenario B: Attending Physician does not agree with Utilization Review Physician Advisor #1

If the Attending Physician of record does not agree with the assessment of the first Physician representative of the Utilization Review Committee (PA #1), the case is to be reviewed by a second Physician representative of the Committee (PA #2 or other Physician member of the Utilization Review Committee).

- If the second Physician review agrees with the Attending Physician of record that the patient warrants Inpatient status, the case remains Inpatient and is appropriately billed as such.
- Documentation of the process by all should be included in the medical record.
- If the second Physician review agrees with the first Utilization review that the patient is not appropriate for Inpatient status, both Physician Advisor representatives of the Committee document this in the medical record, and the patient should then be issued a HINN1 Denial.
- The patient must have this presented prior to discharge with understanding and ability to initiate appeal rights.

The Utilization Review Committee does not have the capability to write the order for Inpatient status, so if an Attending of record does not agree w/ two Physician Advisors’ reviews the patient remains in Observation status and the hospital is limited to the Outpatient Observation billable services.

This can represent a major patient’s rights issue, as a patient stuck in Observation status inappropriately is having their Medicare post-discharge rights unfairly limited. For example, a patient may not qualify for skilled nursing coverage because they have not met the necessary 3-day qualifying stay. The Utilization Review Committee physicians must escalate this situation to the appropriate Medical Staff level immediately.

The patient, however, does not have a status change occur and is discharged in the Inpatient status. The hospital has the ability to bill a limited number of Part B tests only, and not therapeutic services.

Observation Services cannot be billed as they were never ordered in this case.

The patient has been notified in writing of the HINN1 denial (as above), and the Attending Physician and Hospital are to be notified in writing as well.

The case and Attending Physician involved should be reviewed at the next UM Committee meeting, and if there is full agreement that the patient did not meet Inpatient Status criteria, the case should then be sent to the appropriate Medical Staff committee for review as a potential episode of overutilization and Medicare abuse.
Scenario C: Patient Admitted as Outpatient/Observation Services but qualifying for Inpatient Status.

The Utilization Review Committee does not have the capability to write the order for Inpatient status, so if an Attending of record does not agree with two Physician Advisors’ reviews in regards to this scenario, the patient remains in Observation Status and the hospital is limited to the Outpatient Observation Status billable services mentioned above in Scenario A.

This can represent a major patient rights issue, as a patient stuck in Outpatient Status inappropriately is having their Medicare post-discharge rights unfairly limited. For example, a patient may not qualify for skilled nursing coverage because of not obtaining the necessary 3-day qualifying stay. The Utilization Review Committee Representative Physicians (Physician Advisors) must escalate this situation to appropriate Medical Staff level immediately.

This may be a particular problem where a hospitalist or hospitalist group is applying arbitrary Observation Status policies based on directives from their contracting IPAs or insurance plans.
Exhibit B: Observation Scenarios

1. **Physician writes an order to admit the patient as an Inpatient. While the patient is still in house, and prior to submitting any claim, the Utilization Review committee determines the patient’s condition/care does not meet medical necessity criteria for an inpatient admission. The physician agrees with the recommendation to change the admission status from Inpatient to Observation.**
   - Physician documents agreement with the change from inpatient to observation status in medical record and writes an order for the observation status admission.
   - The patient is notified of the change in admission status prior to discharge.
   - The patient status is changed in the registration system to Outpatient Observation, and Condition Code 44 is reported on the claim in one of the field locator spaces between FL18 and FL28.
   - The entire stay is treated as an outpatient account; the admission date is the date of the patient’s first day in the hospital.

2. **Physician admits patient as an inpatient and after discharge it is determined that the admission was not medically necessary.**
   - The admission status for the patient remains as an inpatient level of care. The billing department is notified that a provider liability claim must be filed with the payer. After the inpatient provider liability claim is processed, the facility may submit a claim for covered Part B services (follow the claim submission guidelines provided by the MAC responsible for payment).

3. **Cancelled inpatient surgery after patient admitted.**
   - The documentation in the medical record must indicate the reason the surgery was cancelled and an order to discharge the patient is needed from the physician. An inpatient claim is submitted and the principal and secondary diagnosis codes on the claim will capture the original reason for the surgery and the reason surgery was cancelled.

4. **Admitted to observation and stays past 48 hours.**
   - In the absence of orders to discharge the patient or documentation showing the patient declined to be discharged, all hours of observation are reported on the claim.

5. **Admitted to observation and orders for inpatient stay the next day or later.**
   - This account will be billed as an inpatient claim. The admission date will be the date the order for inpatient care was written (not the date the patient was admitted for observation). The observation charges will be reported on the claim in Revenue Code 762 without a HCPCS code.
6. Admitted to observation, converted to inpatient status, does not meet inpatient criteria, new orders written for observation only stay received while patient is still in-house.
   - This is a condition code 44 scenario for the conversion from inpatient status to observation status.
   - The inpatient stay is treated as if it did not occur and the entire claim from the initial presentation to the time of discharge is treated as an outpatient claim.
   - The observation hours reported in Revenue Code 762 are counted first from the time of the first observation order to the time of the inpatient order and then the hours from the time of the second observation order to the departure time are added.

7. Patient admitted to observation for a statutorily non-covered service.
   - The observation time for the statutorily non-covered service is not a covered service and the patient should receive an ABN.

8. Patient has outpatient surgery at 20:00 hours and stays in recovery overnight.
   - In the absence of a condition requiring more than the usual post-operative care, this extended over-night recovery care is for the convenience of the patient or the facility and no observation hours are charged.

9. Day surgery with post op difficulty, physician writes order for admission to observation and documents need for the admission.
   - The patient status remains outpatient and all diagnoses/conditions are reported. The principal diagnosis remains the reason the patient was admitted for surgery.

10. During the course of an outpatient surgery procedure, the surgeon decides an inpatient-only procedure is needed.
    - If an inpatient procedure is performed during an outpatient surgery admission, immediately after surgery the physician should be asked if the patient should be admitted as an inpatient. If not, the inpatient only procedure is reported on the outpatient claim.

11. The admission is for observation and the claim is incorrectly billed as inpatient.
    - This is considered a clerical error and the claim may be re-coded, re-charged, and rebilled with the correct admission status. A comment may be added to the claim; however, condition code 44 is NOT used.

12. The admission is for inpatient and is incorrectly billed as observation.
    - This is considered a clerical error and the claim may be rebilled with the correct admission status. A comment may be added to the claim.