POLICY AND PROCEDURE MANUAL

Policy Title: Authorization for Observation vs. Inpatient Admission Level of Care	**Policy Number: B.02**
Primary Department: Medical Management	**NCQA Standard: N/A**
Affiliated Department(s): N/A	**URAC Standard: N/A**
Last Revision Date: 03/08/2019 **Revision Dates: 12/16/2011; 07/06/2012; 08/04/2012; 09/12/2014; 08/20/2015; 06/06/2016; 10/03/2016; 3/29/2017; 03/21/2018; 09/2018; 03/08/2019** **Effective Date: 08/29/2008**	**Next Review Date: 03/31/2020** **Review/Revision Dates: 04/24/2009; 03/26/2010; 03/25/2011; 12/16/2011; 09/26/2012; 09/27/2013; 10/24/2014; 09/25/2015; 06/24/2016; 10/13/2016; 03/31/2017; 03/28/2018; 09/26/2018; 03/20/2019**
Applicable Lines of Business: ☐MeridianCare ☒MeridianHealth ☐MeridianComplete ☐MeridianChoice	
Applicable States: ☐All ☒MI ☒IL ☐OH ☐_____ ☐_____	
Applicable Programs: ☒All ☐Other _____	
Policy is to be published: Internally Only ☐ Internally & Externally ☒	

Definitions:

Outpatient Observation Services	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 acute inpatient treatment in the hospital or if they are able to be discharged.

Policy: Observation care spans the gap between outpatient and inpatient care. Observation may be appropriate for a patient who requires care that is beyond the scope of a usual outpatient care episode. Such an episode is expected to be short term, may need diagnostic evaluation, acute treatment, response evaluation, or monitoring of an event (e.g., arrhythmia) or recovery (e.g., from drug ingestion). [1]Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Procedure:

Criteria for Coverage:

Specific considerations for determining observation status include the following:

Outpatient care, although rendered in a hospital

- Intended for short-term monitoring- generally <48 hrs.

[1] Medicare Benefit Manual, Chapter 6, 20.6 – Outpatient Observation Services (Rev. 215, Revised: 12/18/2015)

- Continuous monitoring, such as telemetry, can be provided in an observation or inpatient status; in determining admission status, overall severity and intensity of services will be considered rather than any single or specific intervention
- Level of care, not physical location of the bed, dictates admission status hospitals can use specialty inpatient areas (including CCU or ICU) to provide observation services (e.g. for telemetry).
- Conditions potentially appropriate for observation services include asthma, chest pain, CHF, TIA, closed head injury, blunt abdominal trauma, unexpected outpatient postsurgical complications.

Observation care may be appropriate when time beyond the outpatient care is required to assess the patient, for example:

- Testing or re-evaluation to determine the patient's diagnosis and care needs.
- Initial history, symptoms, signs and/or diagnostic tests are inconclusive but the patient is clinically stable
- Disease treatments and determination of whether the patient's response is adequate
- Patient's immediate condition is not life threatening and initial response to any treatment is favorable
- Intervention requirements are low or moderate and staffing requirements to manage the patient are low
- The patient shows initial and progressive improvement with treatment suggesting rapid resolution of the presenting problem
- In the majority of cases, the decision whether admission or discharge is warranted can be made in less than 48 hours, usually in less than 24 hours. In exceptional situations, outpatient observation services may span more than two calendar days. Outpatient observation stays exceeding 23-hours are not automatically converted to inpatient admissions. Appropriate use of observation status includes: Patients with symptoms suggesting a diagnosis that must be ruled out (e.g., chest pain)
- Patients requiring medication adjustments or hydration management
- Patients requiring pain management
- Patients with post-procedure complications which do not require an inpatient level of care but do require on-going monitoring

Inappropriate use of observation status includes:

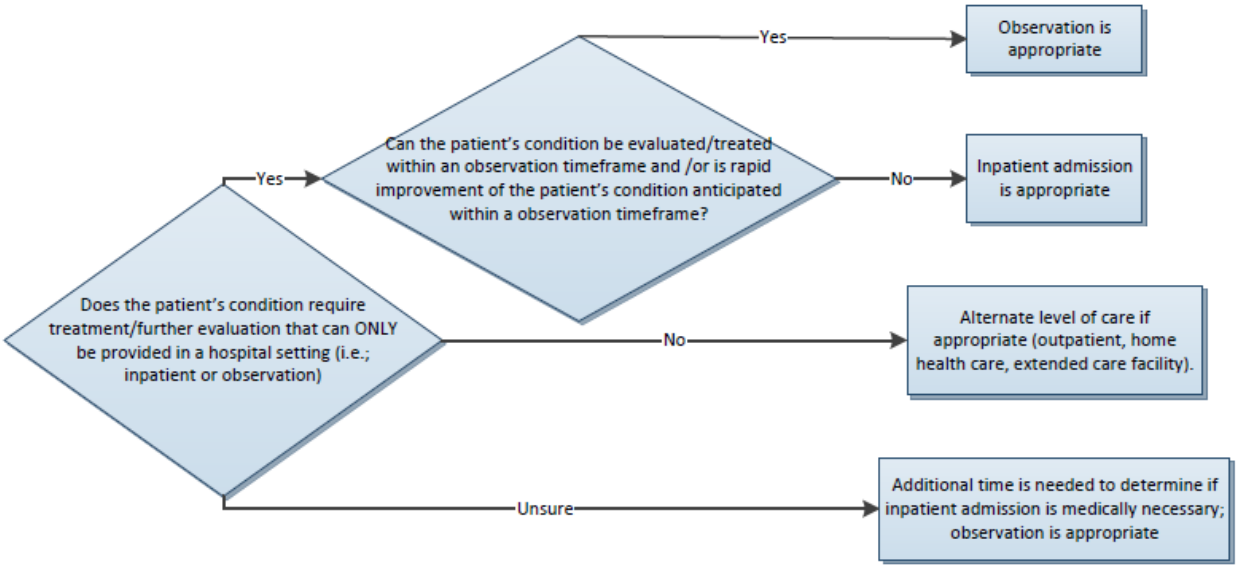
- Patients maintained onsite due to socialeconomical factors
- Patients held at physician convenience for later testing or examination
- Patients onsite in preparation for, or routine recovery from, ambulatory procedures (including surgery
- Patients onsite for routine outpatient procedures (i.e., transfusion or chemotherapy)
- Services routinely performed in the emergency department or outpatient department
- Custodial Care

Out of Network Post Stabilization authorization for INPATIENT admission

- Meridian shall provide 24-hour per day, 7-day per week telephone coverage for post-stabilization authorization requests.
- Upon receipt of a telephonic prior authorization request for post-stabilization, pre-admission services, Meridian will review the clinical information provided by the requesting provider and will issue an authorization decision within one hour.
    - The decision will be made in accordance with the Texas Medical Foundation Decision Tree, based upon the clinical information provided, including vital signs, current diagnostic results, preadmission services obtained immediately prior to the request for post-stabilization care, and the treatment rendered. The decision shall be made based on the information available at the time of the call. Meridian's reviewer may refer to InterQual criteria in reaching the decision, but is not required to adhere to any single published criteria.
    - If the requesting provider is not satisfied with Meridan's original decision, the provider may submit records for full review. If the provider can then proceed with normal authorization process including reconsideration, peer-to-peer discussion with a Meridian Medical Director, or an appeal according to applicable state or contract timeframes.
    - Should Meridian fail to respond within one hour of the request, authorization for admission and additional services will be automatically approved.

- The hospital shall not be required to make more than one phone call, provided that the one call includes all necessary clinical information.

To aid the physician in determining when observation may be appropriate, this decision tree developed by the Texas Medical Foundation (TMF) Health Quality Institute and supported by CMS, outlines the thought process for determining whether observation or inpatient admission is appropriate.



* The decision to hospitalize a patient for further treatment in either an inpatient or observation status requires complex medical judgment including consideration of the patient's medical history and current medical needs, the natural course of the presenting disorder, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.**

**** Adapted from materials developed by the Texas Medical Foundation Health Quality Institute, MPRO, the Medicare Quality Improvement Organization for Michigan, under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services.

Key Points:

- Care in outpatient observation status can be the same as inpatient care,
- An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.

Line of Business Applicability:
This policy applies to Michigan Medicaid and Illinois Medicaid.

For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

State specific special instructions:

None: ☐

MI: Medicaid/Michigan: Non-Contracted Hospitals are subject to a Short Stay Reimbursement Rate for certain qualifying inpatient and outpatient claims. Determination of qualification for the Short Stay rate will be determined on a post-service basis.

- In order to qualify for a Short Hospital Stay rate, a claim must include one of the primary diagnosis codes listed in a table that will be maintained and updated on the MDHHS website at www.michigan.gov/medicaidproviders>> Billing and Reimbursement >> Provider Specific Information.

IL:
OH:

References:

1. Hale, Deborah K., Observation Services: A Guide to Compliant Level of Care Determinations. Third Edition. HC Pro, Inc., Apr 14, 2011, pg. 112.
2. Michigan Department of Health and Human Services. Medicaid Provider Manual. Hospital-Sec. 3.23. Version Date: April 1, 2017.
3. Medicare Benefit Manual, Chapter 6, 20.6 – Outpatient Observation Services, (Rev. 215, Issued: 12/18/2015, Effective: 01/01/2016, Implementation: 01/04/2016)
4. Illinois DHFS. Handbook for Practitioners rendering Medical Services. Chapter A-200, Sec. A-220.4-220.5.(Issued: October 2016).
5. Michigan Department of Health and Human Services. Administration Bulletin MSA 07-07: Observation Care Services. Issued: February 1, 2007. Effective Date: April 1, 2007.
6. Code of Federal Regulations, Title 42, Section 412.3.
7. Medical Services Administration, MSA 15-17, Michigan Department of Health and Human Services, Issued May 29, 2015, Subject: Inpatient and Outpatient Hospital Short Stay Reimbursement

State Letters/Bulletins			
CMS National/Local Coverage Determination (NCD/LCD)			
Medicare Managed Care Manual:	Medicare Benefit Policy Manual (Chp. 6, Sec. 20.5 & 20.6)		
Medicaid CFR:	FR, vol. 72, No. 227, Nov. 27, 2007 p. 66810		
State Administrative Codes:			
Contract Requirements:			
Related Policies:			
Related Desk Level Procedures/ Job Aids/Template Letters:			
Related Algorithms/Flowcharts/ Attachments			

Appendix A: Adult and Pediatric Conditions Initially Reviewed as Observation Stays

Group	Condition
General	• Anemia / Bleeding • Back pain • Pain Management • Weakness • Sickle Cell Pain Crisis • Rib Fracture • Alcohol Intoxication • Drug overdose, caustic or poison ingestion • Syncope • ABD Pain • Dehydration • Extremity fracture without surgical intervention within 24 hours • R/O Sepsis • Fever • DKA
Neurological	• Altered Mental Status • Dizziness / Headache • Seizures • Concussion / Mild TBI • Transient Ischemic Attack (TIA)
Cardiovascular	• Atrial Fibrillation / Flutter • Chest pain • Deep Vein Thrombosis (DVT) • Supraventricular Arrythymias
Respiratory	• Croup • Shortness of Breath / Dyspnea • Pneumonia / Bronchitis / Bronchiolitis • Asthma
GI	• Diverticulitis • Esophageal Disease • Ileus • Gastroenteritis • Acute Pancreatitis • Gallbladder / Bile duct infection or ductal stone • GI Bleeding • Diarrhea
GU	• Chronic Kidney Disease (*ESRD will be reviewed under presenting symptom B.02 vs. InterQual) • Hematuria • UTI • Vaginal Bleeding • Hydronephrosis • Renal Colic/Kidney stones
Skin	• Abscess • Cellulitis • Rash
OB	• Ectopic Pregnancy • Hyperemesis Gravidarium • Failed Pitocin induction • False labor • Incomplete Abortion / Miscarriage • Preterm Labor