TITLE: HOSPITALIZATION & MEDICAL NECESSITY REVIEW

PURPOSE: To provide guidelines for the hospitalization of patients and for assignment of the appropriate Status to patients in the Harris Health System.

POLICY STATEMENT:

Hospitalization of a patient in the Harris Health System (Harris Health) requires a physician order for Inpatient or for Outpatient Observation services. The patient’s hospitalization Status shall be based on clinical documentation of the patient’s severity of illness and documented plan of treatment.

Harris Health’s Clinical Case Management (CCM) department provides concurrent review of all Inpatient, Outpatient Observation services, and Day Surgery patients. CCM shall review the physician’s documentation and recommend a Patient Status (including Inpatient, Observation, extended recovery, or Day Surgery) based on the clinical care required.

POLICY ELABORATIONS:

Pursuant to the Texas Health & Safety Code §281 and Centers for Medicare & Medicaid (CMS), a patient may be hospitalized by a physician as an Inpatient, for Outpatient Observation services, or in Outpatient Surgery Status, including the recovery room. Healthcare payers, including Medicare and Medicaid, review medical necessity of the various hospitalization Status determinations to define whether to pay for the hospitalization. Harris Health CCM shall perform an appropriate concurrent medical necessity review for all payers. For payers that require a pre-authorization process, Harris Health shall utilize the pre-authorization process in addition to performing a medical necessity review and follow payer guidelines. The medical necessity review is based on a number of factors, including the use of nationally recognized review criteria (e.g., Milliman Care Guidelines), physician documentation of the patient’s condition (severity of illness), and the patient’s plan of care (Intensity of Service).

I. DEFINITIONS:

A. CONDITION CODE 44: A claim indicator that must be placed on the Medicare claim when a Medicare patient’s admission is determined to not meet criteria for Inpatient hospitalization and is changed to Outpatient Status.
B. **Day Surgery:** Day Surgery includes routine recovery but does not include planned post-procedure Observation. Orders for Observation following Day Surgery must meet Observation requirements as determined by the criteria (e.g., Milliman Care Guidelines) based on the medical record documentation.

C. **Healthcare Common Procedure Coding System (HCPCS):** A set of healthcare procedure codes provided by the American Medical Association’s Current Procedural Terminology (CPT) that provide a standardized coding system to describe specific items and services used in the delivery of healthcare.

D. **Hospital-Based Ambulatory Surgical Center (HASC):** Texas Medicaid publishes a list of surgical procedures (CPT codes) which will only be reimbursed if the patient is in an Outpatient Status. This list is known as the “HASC List.”

E. **Inpatient:** A person who meets the criteria for severity of illness and intensity of treatment and will likely remain in the hospital for two (2) midnights. It is important to note that this Status is not based solely on time.

F. **Intensity of Service:** A measure of the quantity or the type of resources (critical care, telemetry, outpatient, etc.) as required from various hospital departments and consumed directly or indirectly by the patient or a physician.

G. **Medical Necessity Review:** A data gathering and evaluation process that includes obtaining necessary information from appropriate facility clinical staff regarding the clinical Status, progress, and care being provided to patients to determine the medical necessity for the hospitalization. Harris Health CCM uses proprietary clinical care guidelines, clinical documentation, and discussion with the admitting physician to determine Medical Necessity for hospitalization.

H. **Medical Necessity Criteria:** Evidenced-based criteria of the generally accepted standards of medical practice. These criteria are grounded in credible scientific evidence, published in peer-reviewed medical literature, recognized by the relevant medical community, or are otherwise consistent with medical care standards. Elements that determine “medical necessity” may include, but are not limited to, medical complexities, co-morbidities, medical history,
laboratory, or radiology results that contribute to the need for hospitalization and support the medical necessity for a specific hospitalization Status. The elements used to implement review criteria must be documented by the Physician in the medical record.

I. **MEDICARE INPATIENT ONLY LIST:** A list of CPT codes that are paid only when the patient is entered into an Inpatient Status prior to the start of the procedure.

J. **NOTICE OF INTENT TO HOSPITALIZE:** A communication between the Admitting or Attending Physician and Clinical Case Management of the intent to place a patient in a hospital bed.

K. **OUTPATIENT OBSERVATION SERVICES:** Services ordered for patients who present for care but require a period of treatment or monitoring in order to make a decision concerning their hospitalization or discharge. Typically, the decision to discharge a patient from an Outpatient setting or to admit the patient can be made in less than (24) hours. In only rare and exceptional cases do reasonable and necessary Outpatient Observation Services span more than forty-eight (48) hours.

L. **PATIENT STATUS:** A designation entered into the patient’s medical record as a part of a Physician order for inpatient hospitalization or Outpatient services. A Patient Status may include Inpatient, Observation, and Outpatient Services.

M. **PHYSICIAN:** Physician means an individual with an M.D., D.O. or equivalent degree currently licensed to practice medicine in the State of Texas.

N. **PHYSICIAN ORDER:** Physician order means an order from the Physician admitting the patient a Harris Health System hospital or the Physician responsible for the patient’s general medical management during the admission. The order may be in writing or be a telephone/verbal order as allowed by the Harris Health System Medical Staff Bylaws.

O. **PRE-AUTHORIZATION:** A process by which the hospital contacts the payer to seek pre-authorization/precertification/authorization for the Patient Status and treatment ordered by the admitting Physician.
P. **PRE-REGISTRATION:** A business process to be completed with the patient, physician and service areas to prepare scheduled patients for Inpatient, Day Surgery, or a medical procedure. This process consists of verification and entry of demographic, financial Status, insurance verification, and clinical information.

Q. **SECONDARY PHYSICIAN REVIEWER:** The Secondary Physician Reviewer may include but is not limited to the Chief of Service, Chief of Staff, Chief Medical Officer, Chairman of the Utilization Review Committee, Utilization Review Physician Advisor.

R. **SEVERITY OF ILLNESS:** The extent of organ system derangement or physiologic decompensation of a patient (part of the Center for Medicare & Medicaid Service (CMS) medical classification, used to provide a basis for evaluating hospital resources or to establish patient care guidelines).

II. **HOSPITALIZATION PROCESS OVERVIEW:**

A. A Physician requesting hospitalization of a patient communicates to CCM his/her intent to hospitalize the patient. The Physician provides CCM with information regarding: accommodation, service, special instructions, bed type (ICU, IMU, Isolation, etc.), and Patient Status.

B. CCM activities include the following:

1. A Medical Necessity Review including Medical Necessity Criteria;
2. Discussion of the Medical Necessity Review and the patient’s condition and plan of care;
3. Initiate assignment of a treatment team;
4. Bed assignment; and
5. Pre-authorization as necessary.

Note: The conversation between the Physician and CCM is designed to determine the level of care in order to provide the type of bed being requested and the most appropriate use of healthcare resources for the patient. As soon as possible after completing the medical necessity review or pre-authorization process, the CCM shall discuss the results of the Medical Necessity Review or pre-authorization process with the Admitting or Attending physician. CCM may educate the Physician on the differences between Inpatient and Outpatient...
Status and on Observation Level of Care within the Outpatient Status is Health System employees are prohibited from leading the Physician to a certain Patient or Level of Care or attempting to influence the Physician’s order.

Following the discussion with Clinical Case Management, the physician, using his or her own independent clinical judgment will enter an order for Inpatient or Outpatient Observation Services.

C. Harris Health Bed Management department receives notification of an order to hospitalize the patient and processes the order.

III. SECONDARY PHYSICIAN REVIEW:

For beneficiaries of payers that do not provide pre-authorization, the Director of CCM shall ensure the case is referred for Secondary Physician Review. The Secondary Physician Review shall also be performed when after the CCM has discussed the results of the Medical Necessity Review with the Admitting or Attending Physician, and the Admitting or Attending Physician there is a disagreement with the CCM’s suggestion.

A. The Secondary Physician Reviewer shall review the patient’s medical record and, if appropriate, discuss the patient’s clinical needs with the Admitting or Attending Physician. The Secondary Physician review shall solely be based on the patient’s clinical needs. Patient, family, Physician or hospital staff convenience or availability should not be considered.

B. The Secondary Physician Reviewer shall document the results of the review in the medical record, or in a letter. The documentation shall include, at a minimum, his or her clinical rationale for the Patient Status determination.

C. For Medicare patients, in accordance with CMS Conditions of Participation for Hospitals, as well as Medicare payment policies, if Harris Health’s Utilization Review Committee determines, based on documentation in the medical record regarding the patient’s illness or condition, and after a discussion with the Physician responsible for the care of the patient, the hospitalization of a patient does not meet Inpatient criteria, Harris Health may change the Patient Status from Inpatient to Outpatient and will use Condition Code 44 on the Medicare claim to indicate the Patient Status change. (See Appendix C and Attachment D).
IV. HOSPITALIZATION PROCESSES:

The integration of operational hospitalization processes with the medical record hospitalization processes will be developed, implemented, and maintained specific to the following hospitalization situations:

A. Emergency Center (EC) Admissions;

B. Changes in Patient Status (Observation to Inpatient or Inpatient to Observation);

C. Direct Admissions;

D. Day Surgery; and

E. Scheduled Surgery.

Note: The processes listed above will be documented in the form of flow sheets.

V. RESPONSIBILITIES:

A. Physician:

1. Informs CCM of the intent to hospitalize the patient.
2. Submits information to CCM to obtain:
   a. Medical Necessity Review;
   b. Bed assignment; and
   c. Team assignment.
3. Places an order for the appropriate hospitalization status:
   a. Inpatient;
   b. Outpatient Observation Services;
   c. Day Surgery; and
   d. Extended Recovery.

B. Clinical Nurse Case Manager (CNCM):

1. Provides Concurrent and Medical Necessity Review based on the
Physician’s documentation in the medical record at each point of access to the hospital to include:

a. Emergency Centers;
b. Hospital Units;
c. Day Surgery;
d. Bed Management; and
e. Direct Admissions.

2. Initiates assignment of a treatment team; and
3. Obtains bed assignment from Bed Management and informs the Physician of the bed assignment, as appropriate.

C. Patient Financial Service (PFS) Representative:

1. Screens the patient for eligibility and financial responsibility.
2. Obtains pre-authorization as necessary.
3. Contacts CCM prior to completing a registration request for Direct Admission or Day Surgery hospitalization.
4. Has the responsibility to explain to and obtain signatures from the patient or the patient’s surrogate decision-maker, as well as, provide copies of hospital registration forms to the patient or surrogate, to include:

a. Consent for Medical Treatment;
b. Patient Information Guide - which contains information regarding the patient or patient’s surrogate decision-maker’s rights and responsibilities while receiving care, treatment, and services;
c. Patient Acknowledgement form;
d. Agreements, Authorizations & Irrevocable Assignments form which includes information about charges for which the patient or patient’s surrogate decision-makers is responsible;
e. Statement of Minor’s Capacity to Consent to Medical Treatment form, as applicable; and
f. Important Message from Medicare letter, as appropriate.

5. Completes the patient’s hospitalization demographics, name labels, and patient identification (I.D.) bracelet;
6. Visits the patient or surrogate decision-maker within 24 hours of hospitalization to provide financial review for potential payment resources and/or other financial arrangements, as needed;
7. Assigns a financial counselor to patients who arrive to the hospital and are unable to sign consents and hospital documents and are without a surrogate decision-maker to proactively identify opportunities to obtain document signatures during the patient’s hospitalization.; and
8. Processes billing and claim denials and appeals, as indicated.

D. Bed Management:

1. Receives all requests for a hospital bed assignment, except for newborns; and
2. Confirms hospital bed availability for patients requiring hospitalization.
REFERENCES/BIBLIOGRAPHY:

CMS Manual System, Department of Health & Human Services, A-0652 C.F.R. § 482.30/82.30/482.12.

CMS Manual System, Department of Health & Human Services, 20.6- Outpatient Observation Services (Rev. 107; Issued: 05-22-09; Effective: 07-01-09; Implementation: 07-06-09).

CMS- Medicare Benefit Policy Care Manual. Chapter 1 – Inpatient Hospital Services Covered Under Part A.


Harris Health System Policy and Procedures 4600 Transfer of Patients

Harris Health System Policy and Procedures 4119 Day Surgery

Harris Health System Policy and Procedures 7.11 Patient Identification

Harris Health System Policy and Procedures 2325 Financial Approval for Same Day Admission


CFR, Title 42, Chapter IV, Subchapter G, Part 482, Subpart C, Section 482.30. CMS-Medicare & Medicaid Services, Department of Health & Human Services, Part 482 – Conditions of Participation for Hospitals. §482.30.


http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HINNs.html

**OFFICE OF PRIMARY RESPONSIBILITY:**
Harris Health System Utilization Management and Clinical Case Management

### REVIEW/REVISION HISTORY:

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A. INITIAL REQUEST TO HOSPITALIZE:

1. The Physician decides to hospitalize a patient and enters an order “Request for Hospitalization” to include;
   a. Accommodation Code;
   b. Requesting providers pager number;
   c. Anticipated Service; and
   d. Facility.
   
   Note: Telemetry, Isolation, Sitter will be entered under a different order set.

2. The Clinical Nurse Case Manager (CNCM) receives the Request for Hospitalization, performs an medical necessity review and lists the admitting team assignment in the medical record, including:
   a. Suggested Patient Class;
   b. Medical Necessity Review Number;
   c. Admitting Provider (Medicine patients only) – Ben Taub Hospital (BTH);
   and
   d. Admitting Service (Medicine patients only) – BTH

3. When the Request for Hospitalization is received by the CNCM and there is no available team to receive the patient, the request will be processed for medical necessity but completion of the team assignment order will remain on hold until a team is available to receive patients;

4. If an order for Observation or Inpatient is not written in ≥ 4 hours from the time of the initial Request for Hospitalization, the CNCM will re-review the medical record for medical necessity and document changes in the suggested Patient Status.

5. Following discussions by the requesting Physician and admitting medical team, if there is a change in accommodation code from the initial request, a new Request
for Hospitalization should be entered so that CNCM may re-review for Medical Necessity.

6. A Patient Status is suggested by CNCM. The emergency Physician or admitting Physician enters the order “Hospitalize Patient” to determine the appropriate Patient Status.

7. A request is routed to Bed Management to locate a bed for the requested level of care based on the anticipated services requested, ordered Patient Status and associated service needs.

B. CONTINUED STAY:
Medical Necessity Reviews are documented in the medical record based on:

1. Patient Status
2. Status Changes (i.e. higher level of care required evident by medical record documentation)

A Patient Status of “Observation” is reviewed by CNCM for Medical Necessity criteria daily.

Patients who remain in an Inpatient Patient Status are reviewed every third day, or when the days approved by a third party payer have expired or weekly if the length of stay is ≥30 days.

C. ESCALATION PROCESS – Medical Necessity Review:

1. If an ordered Patient Status and Medical Necessity review does not match with the Medical Necessity criteria, the CNCM will immediately notify the Admitting Physician to discuss additional medical record documentation, or clarification, or a change in Patient Status;

2. If additional documentation does not justify the Patient Status, the Service Attending will be contacted by the reviewing CNCM; or

3. If no substantial medical record documentation is provided by the Service Attending, the case shall be sent to the Physician Advisor or their Designee(s), for Secondary Medical Review.
APPENDIX B
SECONDARY MEDICAL REVIEW

A. A concurrent review process is implemented during business hours to maximize real-time medical review and feedback to providers. (See Attachment A).

B. Retrospect review(s) are accomplished on select cases, based on the length of stay and other regulatory requirements. See Attachment B.

C. Monitoring, Peer-to-Peer review and/or provider letters (educational or provider liable) are initiated by the Physician Advisor with communication to medical staff. Action plans and education are based on utilization patterns, trends and service requirements identified. See Attachment C.

Additional guidelines and processes as to when Condition Code 44 and Provider Liable is appropriate are further delineated in Appendix C.
ATTACHMENT A

CLINICAL NURSE CASE MANAGEMENT (CNM)
RECOMMENDS CHANGE IN HOSPITALIZATION STATUS
(Physician's Agreement)

**Observation to Inpatient**
- CNM Notifies Ordering Physician
  - CNM Documents in Epic the discussion with Physician
  - Order placed within 30 minutes
  - CCM Discusses w/ Attending agrees with CNM
  - If Attending agrees with change to inpatient
  - Order placed within 30 minutes

**Inpatient to Observation**
- CNM Notifies Ordering Physician
  - CNM Documents in Epic the discussion with Physician
  - Order placed within 30 minutes
  - CCM Discusses w/ Attending agrees with CNM
  - If Attending agrees with change to observation
  - Order placed within 30 minutes

**Concurrent Medical Necessity Review Process**

**For Inpatient**
- Process and documentation required for a Condition Code 34
  (see Policy 4118)

**For Observation**
- Process and documentation required for a Condition Code 35
  (see Policy 4119)

**If Attending disagrees with CNM and Physician Advisor CNM & Chief of Service notified & Physician Educator Letter is sent**
- Physician Advisor has peer to peer with attending
  - If attending agrees with change to inpatient
  - Order placed within 30 minutes
  - Inpatient Audit & Monitoring by Utilization Management

*Updated – 10/28/16*
Medical Necessity Review Process – Medicare One-Day Stays

Daily review of cases to include:
- Quality issues
- LOS (2-5 Day Rule)
- Timing of orders & services
- ETO treatment V/S - detailed in the ETO
- Document of Tx plan for hospitalization
- ASA level
- Social reasons for hospitalization
- Lab or imaging abnormalities

Enter Account Note and prepare PA packet

Completed

Physician Advisor reviews the red copy packet with Medicare One-Day Stays requiring secondary Medical Review

Revised - 2/2016

Enter billing information & detailed rate on both the accounts to billed at impatient and inpatient
- 62- LOS audit review complete - bill inpatient
- OSHE = Provider billed claim required for account

Refer to billing team (when case is ready for billing)

Update Medical Necessity Database

Update Excel Spreadsheet with Secondary Medical Determination Report

Submit Report for validation

Analyst or Supervisor reviews reports

Report provided to Sr. Leadership
ATTACHMENT C

Medical Necessity Program - Provider Utilization Performance - Process Flow

Secondary Medical Review Completed

Provider Communication Required
Office of the Chief Medical Officer - Physician Advisor
with the Attendings/Residents of record

Requires Educational Letter

Standardized Letters may include:
- Patient Demographics
- Dates of Service
- Total Charges
- DRG
- Explanation of Medical Necessity Status, Peer Review Findings and Appropriate Classification
- Copies of the Letter are sent to:
  - All Attendings of record
  - All Residents of record
  - Hospital Chief of Staff
  - Medical School Compliance/Quality Officer
  - Medical Staff Office
  - Utilization Management - Medical Necessity Program Office

Requires Provider Liable Letter

Appeals and Trend Reports
(2 or more Letters)
Provider Liable or Education Letters
Utilization Review Committee
Medical Executive Board

Medicare Payor
- Order for Inpatient
- Meeting Medical Necessity for Observation Status
- Not meeting Medical necessity for Hospitalization

Medicare
(One-Day Stay)
- Order for Inpatient
- Meeting Medical Necessity for Observation Status
- Not meeting Medical necessity for Hospitalization

All 3rd Party Payors
- Order for Inpatient
- Meeting Medical Necessity for Observation Status
- Not meeting Medical necessity for Hospitalization

No Pre-Authorization
- Order for Observation Status that medical necessity indicated Inpatient
- Discharged in Observation Status that only met for Outpatient

All 3rd Party Payors
- Order for Observation Status
- Meeting Medical Necessity for Inpatient
- Discharged in Observation Status
- Received Denial from Third Party Payor

Peer to Peer
- Reviewed by Denials Management
- Referred to Physician Advisor (PA)
- No Outcome or reply back to the PA within 48 hrs.

Reporting via:
Credentialed Committee

Updated 2/2/16
APPENDIX C
CONDITION CODE 44 & PROVIDER LIABLE

Condition Code 44 may only be used when the following conditions are met:

A. The change in the patient’s Status from Inpatient to Outpatient Observation is made prior to the patient’s discharge or release from the hospital;

B. Harris Health has not submitted a claim to Medicare for the patient’s Inpatient;

C. The Utilization Review (UR) Committee, or the Utilization Review Physician Advisor (UR-PA), who is a member of the UR Committee, determines, after conferring with the Physician(s) responsible for the care of the patient and allowing the Physician(s) to present their views, that the Inpatient does not meet Inpatient criteria;

D. The Physician responsible for the care of the patient documents their agreement with the change in Patient Status in the patient’s medical record; and

E. The UR Committee, or its designee, provides written notification of the determination that the patient’s Inpatient Status does not meet Inpatient criteria [See Attachment B], to the hospital, the patient, and the Physician(s) responsible for the care of the patient no later than two (2) days after the determination is made.

Exceptions:

A. If the Physician(s) responsible for the care of the patient fail(s), after being afforded an opportunity, to present their views regarding whether the patient’s Status meets Inpatient criteria, the UR-PA may, in his or her own sole discretion, determine whether the patient’s Status meets Inpatient criteria.

B. If the Physician(s) responsible for the care of the patient do/does not agree whether the patient’s admission meets Inpatient criteria, then two (2) members of the UR Committee, one of which may be the UR-PA, may determine, in their sole discretion, whether the Inpatient Status meets criteria. The UR Committee will then determine whether to change the Patient Status to Outpatient Observation and use Condition Code 44 on the Medicare claim or leave the Patient Status as Inpatient.
A. When the above requirements are met, the process to change the patient’s Status includes [See Attachment D]:

1. A UR-PA reviews the medical record documentation and does a secondary medical review. The review includes the Medical Necessity Review results.
2. The UR-PA confers with the Physician(s) responsible for the care of the patient regarding the need to change the Patient Status to Outpatient Observation.
3. If the Physician(s) responsible for the care of the patient agrees to change the Patient Status to Outpatient Observation, then a patient’s Physician enters an order in the patient’s medical record to “Place in Outpatient Observation” or “Change Patient Status” to include an explanation in the comments section regarding the Status change required, “Condition Code 44 - change Status to Outpatient Observation Services”;
4. Case Management Director or Designee:
   a. Receives notification of a Condition Code 44 and confers with the UR-PA and Physician(s) responsible for the care of the patient;
   b. Provides written notice to the patient within two [2] days (but not later than the patient’s discharge from the hospital) regarding the change and its impact on the patient, including financial liability for applicable deductibles or co-payments. [See Addendum B] “Notification of Change in Hospitalization Status”; and
   c. Enters documentation in the medical record regarding “Condition Code 44 - change Patient Status to Outpatient Observation Services”, the effective date/time when the Outpatient Observation order was received and the appropriate change in the event management section of the medical record.

B. When the above requirements are met, but the UR-PA and the Physician(s) responsible for the care of the patient do not agree to change the Patient Status from Inpatient to Outpatient Observation, and after review by two (2) members of the UR Committee, one of which may be the UR-PA, the UR Committee decides to leave the Patient’s Status as Inpatient. [See Attachment D]:

1. The UR-PA or a member of the UR Committee who was involved in reviewing the case, documents the outcome in the patient’s medical record and submits the account to billing.
2. The Physician(s) responsible for the care of the patient receive(s) a letter of determination based on the review. A copy of the letter is also sent to the following individuals:

   a. All Attendings of record
   b. All Residents of record
   c. Hospital Chief of Staff
   d. Medical School Compliance/Quality Officer
   e. Medical Staff Services
   f. Utilization Management-Medical Necessity Program
APPENDIX D

Medicare - Change of Status
Inpatient to Observation
Condition Code 44 - Physician Advisor (PA) on duty

- CCM will validate the order change in Epic:
  - In 90 minutes from the time of notification, if no order,
  - In 60 minutes review Epic, if no order,
  - Notify the PA and CCM Supervisor
- The PA will notify the Executive Vice President & Chief Medical Officer of any Condition Code 44 that is not completed within the validation period.

- Provide a letter to the Patient:
  - When medical necessity for "Observation" was met, there was no inpatient order and PA’s Attending Physician agreed to change the patient status
  - "Notification of Change in Hospitalization Status" provides an explanation of the medical & financial impact to the patient

- Documents in the Medical Record: notification to the patient based on the change of patient status to "Observation," to include a statement that an Observation order was ordered by the Attending Physician.

- Makes a copy of the letter for the medical record.

- E-Mail Patient Financial Services (PFS) with the outcome and "Non-COM Supervise the Patient demographics"

Diagram:

- PA contacts the patient’s treating Physician or the attending clinical service
- Review of the medical record
- Does not agree to status change
- Physician Order "Inpatient"
- Screened for Medical Necessity
- Meets "Inpatient" Criteria
- Complete

- Physician Order "Observation"
- Physician Review of medical record & makes determination
- Meets "Observation" Criteria
- Complete

- PA reviews the medical record & makes determination
- Outcome "Observation"
- PA contacts the attending Physician to the Patient

- CCM - Notice PA
- CCM notifies the CCM Position Supervisor
- CCM Position Supervisor
- Notifies PA - Review determination, if Condition Code 44 exists, otherwise

- P.A. contacts the attending Physician of the attending clinical service
- Review of the medical record
- Does not agree to status change
- Physician Document in the medical record
- Outcome "Observation"

- PA contacts the attending Physician of the attending clinical service
- Review of the medical record
- Does not agree to status change
- Physician Document in the medical record
- Outcome "Observation"