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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

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Outpatient level of care.

- F. **“Patient Status”** means Inpatient or Outpatient.
- 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® or other Tenet approved clinical screening criteria”** means clinical decision support guidelines licensed for use by hospitals and managed care companies to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.
- K. **“InterQual®”** means the McKesson product housed in Tenet’s case management documentation system. InterQual® is a tool that may be 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.
- L. **“Secondary Physician Review”** means a clinical review performed by a physician on the Utilization Management Committee other than the ordering

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physician when InterQual® or other regulatory and/or Tenet approved guidelines suggest a different Patient Status or Level of Care than that ordered.

- M. **“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.
- N. **“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.
- O. **“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.
- P. **“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.
- Q. **“Two Midnight Rule”** means the CMS regulation effective October 1, 2013 to establish Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admission is reasonable and payable under Medicare Part A. Inpatient admissions will generally be payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights from the onset of care and the medical record supports that expectation. Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights from the onset of care with some exceptions.

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IV. POLICY:

All Tenet Hospitals must establish a process to support the appropriate patient status for hospitalized patients. The patient status must be reflected in the medical record and on all billing documentation to ensure proper billing to all payers. To the extent that the Centers for Medicare and Medicaid Services has issued a blanket waiver of any of the requirements of this policy during times of national emergency (e.g. COVID-19 pandemic), the requirements of this policy are waived during the effective period of the waiver.

V. PROCEDURE:

A. Physician Orders

It is the responsibility of the Physician to determine the appropriate patient status and document the patient status order on admission.

All Physician Orders must be patient-specific and tailored to the clinical needs of each patient.

Patient Access, Nursing, Emergency Department, and Case Management staff are responsible to make every effort to ensure that appropriate electronic, written, or verbal status orders are obtained from the Physician.



Patient Access is responsible for verifying that an appropriate order has been obtained before a patient is registered. 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. The Hospital Case Manager (HCM) may educate the Physician on the differences between Inpatient and Outpatient Status, the Two Midnight Rule and Outpatient Observation Level of Care based on regulatory guidance and/or clinical screening criteria.

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

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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. Tenet Approved Clinical Screening Criteria

1. Medicare Fee for Service

- a. The Hospital Case Manager (HCM) will complete the Medicare Physician Certification Checklist for admission process for inpatient stays when the total length of stay is less than two midnights from onset of care which starts with treatment in emergency department, outpatient or outpatient observation services.
- b. Hospital Case Manager will utilize Tenet approved clinical screening criteria for continued stay reviews.

2. Medicaid/Self Pay



- a. The Hospital or Tenet Call Center (TCC) Case Manager will complete the clinical review according to state requirements.

3. Payers with an authorization process

- a. The HCM or TCC will follow the payer’s authorization process and utilize Tenet approved clinical screening criteria when there is a dispute with the payer regarding patient status, level of care and/or length of stay ordered by the physician.



D. 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 usually within 24 hours before a decision is made whether to admit the patient as an inpatient or discharge from the Tenet Hospital.
2. Patients may also be placed in outpatient observation from short-procedure units after 4-6 hours of recovery time, other outpatient units, or a Physician’s office.

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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 2 or more midnights from the onset of care, inclusive of Emergency Department services;
 - c. The outpatient observation “starts 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.

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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 federal or state requirements, the Two Midnight Rule 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, before the second midnight for federal program patients, and outpatient observation services should not typically exceed 48 hours.¹

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;
 - 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:
 - (l) 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



¹ 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

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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 using 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;² and
 - (iv) The patient's condition and the specific monitoring or therapeutic interventions

² 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.

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required and furnished are documented and meet the Two Midnight Rule regulations or Tenet approved clinical screening 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).³
 - (b) The Tenet Hospital’s Medical Staff may require extended recovery time beyond normal recovery in the PACU for specific particular outpatient procedures.⁴
 - (c) Patients remaining at the Tenet Hospital for extended recovery time 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 time must be billed pursuant to the usual procedures for outpatient services. When the time for extended recovery has elapsed, the patient must be processed for discharge in accordance with the Physician’s Order and normal outpatient surgery discharge procedures.⁵ If a patient expresses a desire to remain in the Tenet

³ To avoid confusion regarding these services, the term “extended recovery” should be used in place of “extended observation.”

⁴ This 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.

⁵ 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.



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Hospital beyond the extended recovery time 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. Patients must be placed in an outpatient observation bed based on Physician Orders, when appropriate, without regard to their ability to pay or insurance status.
 - b. In the absence of a designated outpatient observation unit, outpatient observation patients may be placed in an available acute care bed.⁶
 - 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

⁶ 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 use 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® or 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.

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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 Case Management 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 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.
 - (l) 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

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hour.⁷ 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).
- (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

⁷ 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.

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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

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intervals as determined by the Tenet Hospital's UM Plan.

E. 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 two or more midnights from the onset of care including Emergency Department services; 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 document a clear admission status order for inpatient admission in the electronic health record (medical record) prior to discharge.
4. Inpatients whose payers do not have an Authorization process:
 - a. Medicare Fee for Service – HCM will complete the Tenet Physician Certification Checklist for patients with an inpatient stay when the length of stay is less than two midnights which begins with the onset of care including Emergency Department, Outpatient, and Outpatient Observation services, as soon as all supporting documentation is present and no later than 48 hours post discharge
 - (1) Physician Certification of inpatient services is required for cases that are 20 inpatient days or more (long stay cases). The physician certification must sign and document in the medical record, no later than 20 days into the inpatient portion of the stay. The documentation must include the following information
 - (a) Reason for inpatient services: The physician

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certifies the reasons for either

- (i) Continued hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study
- (ii) Special or unusual services for outlier cases.
- (b) Estimated or actual time the patient requires in the hospital
- (c) If the reason an inpatient is still in the hospital is waiting for a SNF bed they can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed.
- (d) Plans for post-hospital care
 - (i) Medicaid – HCM or TCC will follow the state requirements for clinical review as soon as all supporting documentation is present
 - (ii) Self-Pay – HCM or TCC will follow the state requirements for Medicaid beneficiaries
- (e) Inpatients whose payers have an Authorization process:

For patients whose payers have an Authorization process, the HCM will follow the payer's Authorization process and will complete an InterQual® or other Tenet approved clinical screening criteria review along with clinical summary when the payer authorization does not agree with the Physician order. See *CMT.104 Hospital Case Management Utilization Review Process*.

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- (f) 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.
- (i) Delivering mothers and newborns' stays will be reviewed only if they develop complications or if they exceed the federally mandated timeframe for vaginal or C-section deliveries.
- (ii) Patients who do not meet the payer's approval or Tenet approved clinical screening criteria for continued stay, but meet Discharge Screens or the payer's discharge criteria, and do not have discharge orders, the case must be discussed with the Physician
- 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 the case must be referred for secondary review by the PA or other designated UM committee Physician for review and determination.
- (g) 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

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(Including Important Message from Medicare).

- (h) Medicaid patients must be notified regarding their discharge and/or if the continued stay is determined to be medically unnecessary in accordance with each state's specific guidelines.



F. 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.

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- (b) Pursuant to UM Committee delegation, CM personnel must screen inpatient admissions for satisfaction of admission criteria.
 - (c) CM staff must apply the Two Midnight Rule and 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 require inpatient admission, 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.

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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.



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

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- 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

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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

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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 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 PAD and 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 Hospital 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

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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 CMT.101 InterQual® Application and Training
- Case Management policy CMT.104 Hospital Case Management Utilization Review Process
- CMS 1694-FC Final Rule; 42 CFR Parts 410, 411, 412, et al. Medicare and Medicaid Programs; Interim and Final Rule CMS-1694-FC (October 1, 2018)
- Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 6, section 20.5
- Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 16, Section 110
- Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 1, Section 10.2
- Medicare Claims Processing Manual (CMS Pub. 100-04), Transmittal 787, Change Request 4259 (December 16, 2005)
- Medicare Claims Processing Manual (CMS Pub. 100-04), Chapter 30
- Medicare Claims Processing Manual (CMS Pub. 100-04), Chapter 4, Section 290
- Medicare Conditions of Participation (42 C.F.R. §§ 482.13 & 482.30)
- Medicare Learning Network MLN Matters Article MM10080 Clarifying Medical Review of Hospital Claims for Part A Payment (June 13, 2017)
- Medicare Learning Network MLN Matters Article SEE19002 Total Knee Arthroplasty (TKA) Removal from Inpatient-Only (IPO) List and Application of the 2-Midnight Rule (January 24, 2019)
- Medicare Learning Network MLN Matters Article SE0622, Clarification of Medicare Payment Policy When Inpatient Admission is Determined Not to be Medically Necessary, Including the Use of Condition Code 44: “Inpatient Admission Changed to Outpatient,” (April 4, 2006, updated October 1, 2012)
- Medicare Learning Network, MLN Matters Article MM4259, January 2006 Update of the Hospital Outpatient Prospective Payment System (January 20, 2006, updated April 3, 2013)
- Quality, Compliance, and Ethics Program Charter

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VII. ATTACHMENTS:

- Attachment A: Tenet Healthcare Monitored Procedure Carve Out List
- Attachment B: Condition Code 44 Tool
- Attachment C: Physician Certification Checklist