MEDICAL POLICY STATEMENT		
Effective Date	**Next Annual Review Date**	**Last Review / Revision Date**
7/1/2010	**7/2014**	**7/2013**
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CSMG Medical Policy Statements are derived from literature based and supported clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services are those health care services or supplies which are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative and are not provided mainly for the convenience of the member or provider.

A. SUBJECT

Observation vs. Admission Status

B. BACKGROUND

Determinations for ongoing treatment place of service for patients presenting to the Emergency Department depend on the severity of the presenting signs and symptoms, the specific condition and the intensity of service required or expected following initial ED treatment and stabilization. Multiple industry accepted guidelines exist to guide the assignment of patients to an observation or inpatient setting for care extending beyond the ED management. These guidelines include Interqual, Milliman[1], and CMS/Medicare.

Observation care spans the gap between outpatient and inpatient care. In these circumstances, optimal care may best be provided by observation in an ED, observation in an in-hospital setting, or inpatient admission, depending on the patient's individual features (e.g., severity of illness, the speed with which the patient can meet observation care discharge criteria). [2] 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).

C. POLICY

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[2]The original *Milliman Care Guidelines*® content created by Milliman Care Guidelines has been revised. The portions of the content which have been revised are identified through the use of*: italic* text, and Milliman Care Guidelines has neither reviewed nor approved the modified material. All other unmodified content is copyright © Milliman Care Guidelines.

It is the policy of CareSource *to* define observation status as services that are required beyond an office/ambulatory setting that do not require inpatient care. The CareSource policy for determining observation status is derived from Milliman[3] guidelines, considering State and Medicare guidelines.

Specific considerations for determining observation status include the following:

- Outpatient care, although rendered in a hospital
- Intended for short-term monitoring - generally <48 hours
- 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 or Behavioral Health Units) 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 and Behavioral Health conditions such as intoxication by alcohol or drugs, sudden onset of depression and /or suicidal ideation that may present as an adjustment disorder.

Observation care may be appropriate when many hours (beyond the outpatient care) are 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

Observation care may be provided in an emergency department (ED), a dedicated observation unit, a holding or post procedure unit, or other hospital-based setting. It may be appropriate for patients requiring short-term evaluation for a condition (e.g., to rule out MI), treatment for a known condition (e.g., asthma), or monitoring for recovery (e.g., drug ingestion, alcohol or drug intoxification). [4]Depending on the individual clinical situation, observation care may prevent the need for, or be used as an alternative to, inpatient admission.

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The Milliman Observation Care Guidelines (OCGs) [5]provide information to help assess the observation care needs of any patient. The Milliman OCG's[6] are referenced prior to the Inpatient and Surgical Care Guidelines when the suggested length of stay for medical or behavioral health admissions is defined as ambulatory – 1 or 2 days. CareSource applies the OCGs if the member meets discharge criteria after short-term evaluation for a condition or monitoring for recovery. As in all clinical situations, individual assessment is needed to determine the proper level and type of care.

Observation or inpatient level of care designation assists in determining the appropriate payment status or coding designation for the services rendered. The following grid summarizes CareSource policy for determination of observation. Dates of service not authorized for inpatient admission may be billed as observation care without prior authorization required.

Presenting Clinical Condition	Working Diagnosis	Anticipated Short term Prognosis	Extended Care Needs	Initial Intensity of Service	Status
Acute, Stable, non life threatening (LT)	Prompt improvement anticipated	Good	Unlikely	Low-Moderate	Observation
Acute, Unstable, likely non LT	Slow but steady improvement anticipated	Fair. Likely short term resolution	Unlikely	Moderate	Observation
Acute, Unstable, potentially LT	High Acuity, unknown factors, potential delayed consequences	Fair-Poor	High Likelihood	Mod-high with some interventions	Likely Admit
Chronic condition(s), recent deterioration or acute flair, clinically stable and improved with initial ED treatment	Multiple factors at play but responsive to treatment, no interventional treatment required	Good	Possibly required depending on initial response and co-morbidities	Moderate	Likely Observation. Admit if condition deteriorates unexpectedly or fails to stabilize
Chronic condition, acute flair, unstable, non LT	Poor initial response, instability evident	Poor	Likely	Moderate-High	Potential Admit
Acute, severe clinical condition, unstable	Slow, uncertain response, potential worsening	Poor	Very Likely	High with ED interventions	Admit

D. REVIEW / REVISION HISTORY

Date Issued: 7/1/2010
Date Revised: 4/2011
Date Reviewed: 7/1/2010, 4/2011, 4/2012, 7/2012, 7/2013

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E. REFERENCES

1. Emergency department observation services. [Internet] Dallas, TX: American College of Emergency Physicians 2008 Jan [accessed 2009 Oct 12];
2. Mahadevan M, Graff L IV. Observation medicine and clinical decision units. In: Marx JA, et al., editors. Rosen's Emergency Medicine. 7th ed. Philadelphia, PA: Mosby Elsevier; 2010:2521-30.;
3. Mace SE, Graff L, Mikhail M, Ross M. A national survey of observation units in the United States. American Journal of Emergency Medicine 2003;21(7):529-533;
4. Crocetti MT, Barone MA, Amin DD, Walker AR. Pediatric observation status beds on an inpatient unit: an integrated care model. Pediatric Emergency Care 2004; 20 (1):17-21.;
5. Ross MA, Compton S, Richardson D, Jones R, Nittis T, Wilson A. The use and effectiveness of an emergency department observation unit for elderly patients. Annals of Emergency Medicine 2003; 41(5):668-77. DOI: 10.1067/mem.2003.153;

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Development Policy and is approved.