

SUBJECT: ADMISSION INTENT	REFERENCE
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DEPARTMENT: COMPLIANCE	EFFECTIVE: 1/10/2014
	REVISED:
APPROVED BY:	

**POLICY:** It is the policy of Ferry County Public Hosp. Dist. 1 to ensure that all patients meet admission criteria severity of illness and intensity of service.

**PURPOSE:** To ensure regulatory and corporate compliance through consistently applied guidelines and definitions in the process of assigning and billing the appropriate level of care for patients requiring services at Ferry County Public Hosp. Dist. 1 (FCPHD #1). FCPHD # 1 applies regulations as set forth by the Centers of Medicare and Medicaid Services (CMS) to all patients regardless of payer source, in order to maintain consistency.

**DEFINITIONS:**

**Observation:** Admission of a patient for active treatment to determine if a patient’s condition is going to require that they be admitted as an inpatient or if the patient may be discharged. Observation services include the use of a bed and periodic monitoring by nursing and other staff, which are reasonable and necessary to evaluate the patient’s condition.

**Inpatient:** Admission of a patient with condition/diagnosis (es) meeting established criteria requiring inpatient status, diagnostics, treatments and nursing care that can only be supplied in an inpatient setting.

**Extended Recovery (Same Day Surgery SDS):** Admission of a patient for a planned outpatient procedure/surgery for which a patient requires an extended recovery time following the procedure. The patient may be recovered in the outpatient department or on the nursing unit.

**Outpatient Reoccurring (REC OP) or OUTP):** Admission of a patient for a planned procedure, treatment or therapy (such as blood transfusion, IV antibiotic therapy, Non-Stress Test).

**PROCEDURE:**

**Observation:**

1. Observation Order must include:
  - a. Provider must order “Observation” and use verbage “Place in Observation” in order
  - b. Initial order clearly indicating **intent** of why patient **needs assessed** and the **goal for the care**
  - c. Triggers that will indicate to the care team that the orders were met
  - d. Provider must be actively involved with charting of condition updates with corresponding orders, changes documented with dated, timed and signed notes
  - e. Observation section of “96 HR Inpatient Admission Certificate Form” must be completed and signed by Admitting Provider

2. Nursing
  - a) Develop tasks and triggers to aggressively monitor all orders
  - b) Actively manage the patient with ongoing interventions
  - c) Provided and documented care **each hour that is tied to the provider's orders**
  - d) Contact provider with update of patient's condition in 4-6 hours

**Inpatient:**

1. The provider must ensure the patient meets admission severity of illness and intensity of service for Inpatient admission.
  - a) The provider must order "Inpatient", using "Admit to Inpatient" verbage
  - b) All orders must be dated, timed and signed by the provider
2. Nursing
  - a) Document all care and treatments
3. Inpatient Admission Certification section of "96 HR Inpatient Admission Certificate Form" must be completed and signed by Physician.

**Extended Recovery (Same Day Surgery)**

1. Provider must order status with a dated, timed and signed order
2. Nursing must document all care and treatments

**Outpatient (REC OP, OUTP)**

1. Provider must order Outpatient status with a dated, timed and signed order
  - a) All orders must be dated, timed and signed by the provider
2. Nursing must document all care and treatments

**96 HR Inpatient Admission Certificate Form**

Date/ Time	Patient Status	Inpatient Admission Certification
	Date of Service:	<p align="center"><u>Must be completed by provider for Inpatient Admissions</u></p> <p><input type="checkbox"/> <b>Box A</b> This patient is admitted for inpatient services. The patient is medically appropriate and meets medical necessity for inpatient admission in accordance with CMS section 42 C.F.R. 412.3 I reasonably expect the patient will require inpatient services that span a period of time over two midnights. My rationale for determining that inpatient admission is necessary is noted in the section below. Additional documentation will be found in progress notes and admission history and physical.</p> <p><b>Primary Diagnosis:</b> _____</p> <p><b>Expected Length of Stay:</b> Select One:</p> <p><input type="checkbox"/> 2 midnights (MN) Inpatient</p> <p><input type="checkbox"/> 1 MN Outpatient (ER or Obs) and 1 MN Inpatient</p> <p><b>For Initial Certification</b></p> <p><input type="checkbox"/> I Expect Length of Stay to not Exceed 96 hrs</p> <p><b>For Re-Certification</b></p> <p><input type="checkbox"/> The Length of Stay is Exceeding 96 hrs ____ (date) Reason: _____</p> <p><b>Supportive findings to Primary Diagnosis/Reason for Admit:</b> [examples: co-morbidities, abnormal findings, diagnostic abnormalities, exacerbations, new onset of disease with _____ (co-morbidities)]</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Plans for Post-Hospital Care:</b> See Discharge Summary</p>
	Type of Insurance:	
	<b>Check appropriate box for patient status:</b>	
	<input type="checkbox"/> <b>Place in Outpatient Observation</b> Diagnosis: _____ Reason for Placement: _____	
	<input type="checkbox"/> <b>Admit to Inpatient Services (Medical)</b> <u><i>Provider Must Complete Certification</i></u>	
	Diagnosis:	
	<b>Attending Provider (Print Name)</b>	
	<b>PCP (Print Name)</b>	

	<p style="text-align: center;"><b>Provider Signature</b></p> <hr/> <p>DATE/TIME _____</p>	<p style="text-align: center;"><b>Certifying <u>PHYSICIAN</u> Signature</b></p> <hr/> <p>DATE/TIME _____</p>
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SUBJECT: ER ADMISSION	REFERENCE 20.12.001
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	REVISED:

**FERRY COUNTY HOSPITAL DISTRICT #1  
dba/ FERRY COUNTY MEMORIAL HOSPITAL**

**POLICY:**

It is the policy of this facility to comply with all Centers of Medicare and Medicaid (CMS) requirements for patients admitted to Emergency Room Status.

**PURPOSE:**

The purpose of this policy is to educate providers and other clinical staff on the requirements for meeting medical necessity and appropriateness of care for Emergency Room Patients.

**PROCEDURE:**

1. Medical Screening Examination
  - a. The hospital shall provide a medical screening examination performed by a qualified medical provider for every individual who comes to the emergency department or comes to the hospital seeking or appearing to need medical treatment.
  - b. Medical Screening is performed by on-call provider.
  
2. Individuals With An Emergency Medical Condition
  - a. Within the capability of the staff and facilities available at the hospital, stabilize the individual to the point where the individual is either stable for discharge or stable for transfer, OR
  - b. Provide for an appropriate transfer of the unstabilized individual to another medical facility.
  
3. Individuals Who Have an Emergency Medical Condition but Refuse to Consent to Treatment or to Transfer:
  - a. If the Hospital offers examination and treatment and informs the individual or legally responsible person of the risks and benefits of refusing the examination and treatment, but the individual or legally responsible person refuses to consent to the examination and treatment, the Hospital shall take all reasonable steps to have the individual or legally responsible person sign a "Leaving the Emergency Department Without Being Seen of Against Medical Advice form.
  - b. If the hospital offers an appropriate transfer but the individual refuses to be transferred, the hospital shall take all reasonable steps to have the individual or legally responsible person sign the "Informed Consent to Refuse Transfer" for. In addition, the medical record shall contain a description of the reasons for the proposed transfer.
  
4. Leaving the Emergency Department Without Being Seen
  - a. Patients who leave without informing a staff member of their decision to leave the facility.
  - b. When attempts to explain the risks of leaving and the benefits of staying for a medical screening exam and/or treatment are unsuccessful due to the inability to locate patient the

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“Leaving the Emergency Department Without Being Seen or Against Medical Advice” form must be completed.

5. Leaving the Emergency Department Against Medical Advice
  - a. Leaving against medical advice is the term used to describe patients who choose to leave after they have received a medical screen exam and/or treatment but prior to an approved discharge.
  - b. Staff shall make reasonable efforts to obtain the patient’s signature on the “Leaving The Emergency Department Without Being Seen or Against Medical Advice” form, and if no signature is obtained, staff shall notate this on the form.
  
6. Place in Observation
  - a. If patient’s condition merits additional care and meets criteria to place in Observation, provider/physician will write orders to change patient status to Observation
7. Admit to Inpatient
  - a. If patient’s condition merits additional care and meets criteria to place as Inpatient, provider/physician will write orders to change patient status to Inpatient
  
8. On-Call Physicians/Providers
  - a. The hospital shall maintain an on-call schedule for physicians/providers, including other qualified medical providers who are available to examine and treat patients with emergency medical conditions.
  - b. On-call physicians/providers shall respond to hospital calls for emergency coverage within 20 minutes for trauma or 30 minutes for non-trauma after receiving communication indicating that their attendance is required.
  
9. An “ER Log” shall be kept to document date, time of arrival, patient name, provider, nurse, chief complaint, emergent status, care received, discharge time, disposition.
  
10. Documentation
  - a. Tform completed by physician/provider
  - b. ER Report if care of service is complicated for instance, chest pain
  - c. Physician Orders
  - d. List of home medications
  - e. Test results
  - f. Consent for Treatment
  - g. Discharge Orders
  - h. Progress Notes