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Observation Care:

Frequently Asked Questions

June 2023

When a patient is admitted to an acute care hospital, admission status (i.e., inpatient status vs. observation status) can have important consequences on hospital reimbursement and a patient's financial responsibility for the services rendered. Therefore, assignment of admission status is a very important decision; unfortunately, observation care can be a confusing and misunderstood concept. Many organizations, including the U.S. Centers for Medicare and Medicaid Services (CMS), have previously published their definitions and perspectives on observation care.[1,2,3]

MCG Health continues to receive questions on the proper use of observation care for medical patients. Here is a summary of common inquiries and MCG responses with respect to how to use our content effectively:

- **What is observation care? Is this care that is provided in the emergency department (ED)?**
  - Observation care is care that is provided beyond the emergency department (ED) care time frame (ie, beyond 3 to 4 hours) when additional time for patient testing, monitoring, and treatment is needed to help determine if inpatient care is warranted.
  - These first few hours of care in the ED should be dedicated to establishing a diagnosis and formulating an initial treatment plan. At the end of these first few hours, a decision has to be made on patient disposition. Options include: (1) discharge from ED to home (or to a skilled nursing facility or other lower level of care), (2) admit to observation care, or (3) admit to inpatient care.

- **What are the best practices for using MCG Observation Care Guidelines?**
  - When possible, a specific diagnosis (or a leading provisional diagnosis) should be made before reviewing MCG care guidelines.
  - Criteria and other information will be much more specific and useful when a diagnosis (e.g., pneumonia, COPD, heart failure, asthma) steers guideline selection and review, rather than signs and symptoms (e.g., dyspnea, tachycardia). This is because a clinical finding may have a different meaning depending on the diagnosis. For example, hypoxemia upon presentation would indicate a need for inpatient care for pneumonia patients, but a trial of observation care is appropriate for COPD patients (if hypoxemia were the principal finding driving the admission decision).
  - Symptom-based guidelines (e.g., chest pain, abdominal pain) are specifically designed for use when a specific alternative diagnosis is not apparent. In most cases, a decision concerning ED disposition should be made after a diagnosis or provisional diagnosis is made.

[1] https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r42bp.pdf
[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf
[3] https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule

- **What is meant by "…despite observation care" in the Clinical Indications of a guideline?**
    - When a Clinical Indication in an MCG Inpatient & Surgical Care or General Recovery guideline says "…despite observation care," the intent is that despite a sincere and reasonable attempt to address a sign/symptom/finding (or multiple) in observation care, the sign/symptom/finding persists such that the patient does not meet observation care discharge criteria.
    - Failure to meet observation care discharge criteria is reflected in the inpatient admission criteria; for example:
        - Observation Care Guideline discharge criterion: *"Sinus rhythm or acceptable ventricular rate (e.g., asymptomatic)"*
        - Inpatient guideline (Optimal Recovery Guideline) admission criterion: *"Persistent symptomatic tachycardia (e.g., chest pain, dyspnea) despite observation care (e.g., rate cannot be sufficiently controlled on regimen suitable for outpatient care)"*

- **What is a sincere, reasonable attempt in observation care?**
    - Unfortunately, MCG cannot define this in all clinical scenarios other than to say that there should be a true attempt to improve the patient's condition with appropriate treatment. There cannot be delays in care that prolong the patient's length of stay to cross a specific time threshold (e.g., across a second midnight). The provider should be able to defend the treatment given as a true attempt to meet the relevant observation care discharge milestones.

- **When does observation care end, and what is the duration of the "observation care time frame"?**
    - MCG does not set a specific time frame for observation care. The duration of observation care is often determined by prevailing regulation (e.g., CMS' Two-Midnight rule) or payer-provider contractual agreement. When writing criteria pertaining to observation care, it is helpful to have a general duration in mind; MCG feels that the appropriate use of observation care necessitates that observation care should be finite, short, and not mandatory. This is in keeping with our understanding of the definition and purpose of observation care. Rubrics such as the Two-Midnight Rule provide a good estimation of what is meant by "short." Different payers may have different durations for observation care; however, our view is that the Two-Midnight Rule is a good rubric to have in mind. Time frames beyond this (e.g., 72 hours, 3 days) are not what MCG envisions for observation care.

- **Does this mean every patient in observation care has to stay in that status until just before the second midnight?**
    - No. If and when the attending clinician can reasonably estimate/state/document that a patient will not meet observation care discharge criteria within the observation care time frame, the patient can be admitted to inpatient care.

- **Does this mean every patient has to be admitted to observation care before being admitted to inpatient care?**
    - No. There are some patients who are severely ill upon presentation and warrant direct admission to inpatient care. MCG Inpatient & Surgical Care and General Recovery Care guidelines (Optimal Recovery Guidelines) include Clinical Indications that outline these scenarios, as well as those related to when a patient's condition does not improve despite observation care.

Illustrative Examples:

- A payer asserts that all patients with a given diagnosis have to "fail observation care" before inpatient care will be considered.
    - This is not consistent with MCG's view of observation care. Some patients present with a severity of illness such that a reasonable judgment can be made initially that hospital-based care beyond the observation care time frame will be necessary. The proportion of patients who would meet this level of severity will vary by diagnosis and patient population.
        - Example criterion: *"Pulmonary edema that is very severe (e.g., invasive or noninvasive assisted ventilation needed, imminent or likely, or need for 100% oxygen to keep oxygen saturation above 90%)"*

- A payer policy results in extended observation care (i.e., once in observation care, the patient stays in observation care indefinitely).
    - This is not consistent with MCG's view of observation care. Observation care is finite, and if the observation care discharge milestones are not met within the observation time frame, the patient should be admitted to inpatient care.

- A provider asserts that because the patient is still in the hospital beyond the observation care time frame, the patient should be admitted to inpatient care, regardless of the treatment given.
    - This is not consistent with MCG's view of observation care. The question is whether the patient required hospital-based care for this period of time. Delays in care do not "count." Observation care should be "clinically active"; appropriate care, reassessment, and, if necessary, modification of the treatment plan are expected to occur in observation care.
    - For example, for a patient with heart failure, multiple and escalating doses of a loop diuretic during observation care is an appropriate treatment course. In addition, delays in care due to hospital-level factors such as delayed evaluation or decision-making, consultant availability, or testing capabilities over the weekend do not count toward demonstrating a need for hospital-based care across two or more midnights.
    - In general, prolongation of stay in the hospital due to non-medical factors also does not "count" toward a stay across two or more midnights. An example is a patient who is medically ready for discharge but must stay in the hospital due to a delay in family arrival to transport the patient home, or time is needed to arrange appropriate housing options.

- MCG care guidelines are designed to assist in the clinical determination of medical necessity and to help focus documentation of this need (i.e., outlining the key variables pertinent to the clinical decision).

- A provider asserts after a time period less than the observation care time frame that observation care has failed, and thus the patient should be admitted to inpatient care. For example, after ED care (e.g., 3 to 4 hours), a patient is admitted to observation care, and after 6 hours of treatment in observation care (totaling 9 to 10 hours since presentation), the patient has not improved such that they meet the observation care discharge criteria. However, the patient is not so severely ill that it is clear they will fail to improve sufficiently with further observation care treatment (i.e., more observation care may still work).
    - This is not consistent with MCG's view of observation care, and this patient should not be admitted to inpatient care yet. If a clinician wants to declare observation care a failure well before the end of the observation care time frame (e.g., two midnights), this has to be based on realistic, clinically defensible findings. Simply saying "the patient is not better yet" after a period of time well short of the observation care time frame is not consistent with MCG's understanding of observation care.
    - The key is the clinical need for hospital-based care for a given duration of time (e.g., two midnights) or a reasonable prediction/expectation that such care will be needed. If there is any doubt, observation care should proceed, such that this judgment may become "easier to make."
        - For example, consider a patient who presents to the ED at 10 a.m. on Monday with COPD and does not meet any of the "severely ill" inpatient indications (ie, no clear need for inpatient care from the start), but they do meet observation care admission criteria (these criteria help distinguish ED treat and release from a need for observation care). It may be difficult to judge anytime on Monday whether the patient will meet observation care discharge criteria before midnight of Tuesday into Wednesday. However, this judgment becomes much easier and reliable by Tuesday afternoon, as it is much easier to predict how a patient will look later the same day rather than 30 hours hence.