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## RECORDING OBSERVATION PATIENTS

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides policy for the definition and recording of observation patients.

### 2. BACKGROUND

a. Placing patients in the most appropriate clinical setting often requires “observing” a patient for an extended period of time without admitting them as an inpatient. Observation units are considered to be outpatient or ambulatory services. The goal of observation is to resolve symptoms or to clarify a patient’s diagnosis.

b. Admission Discharge and Transfer (ADT) package patch DG\*5.3\*176 was originally released to implement this Directive. Appropriate Veterans Health Information Systems and Technology Architecture (VistA) Integrated Billing (IB) patches have been released and will be released in the future.

#### c. Definitions

##### (1) **Observation Patient**

a. An observation patient is one who presents with a medical condition showing a significant degree of instability, needs to be monitored and evaluated, receives ongoing short-term treatment, assessment, and re-assessment while a decision is being made as to whether the patient requires further treatment as a hospital inpatient, will be discharged or assigned to care in another setting. *NOTE: Standardized criteria used by Utilization Management needs to be considered in the decision to admit or discharge the patients to the most appropriate level of care.*

b. An observation patient can occupy a special bed set aside for this purpose, or may occupy a bed in any unit of a hospital (i.e., an urgent care medical unit). These beds are not designed to be a holding area for emergency rooms. The length-of-stay in an observation bed is not to exceed 23 hours and 59 minutes. *NOTE: Routine post-procedure recovery from ambulatory surgery is not observation. Examples are: (1) Recovery from a cardiac catheterization and release from the facility within 6 hours of the completion of the catheterization would not constitute post-surgical observation since the normal recovery time is 4 to 6 hours. (2) A patient may report to the medical center for laser removal of cataracts. During the laser procedure, the patient may have a reaction to some of the medication and would be admitted to the appropriate bed section for evaluation of the reaction. It is appropriate to consider utilizing post-surgical observation for patients that develop short-term complications or require extended observation*

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*past the routine recovery time from ambulatory surgery or procedures. Examples of such complications may include bleeding, pain, headache, vomiting, unable to void, and delayed recovery from anesthesia.*

(2) **Lodger.** A lodger is a person who is housed in the medical facility for non-medical purposes and who is not receiving health care services while lodged; they are not considered inpatients.

(3) **Gains and Losses (G&L) Sheet.** The G&L Sheet provides information concerning patient movement for a given date. It shows all gains (admissions, transfers in from other facilities, returns from authorized and unauthorized absence) and losses (discharges, transfers out, and deaths). Inter-ward transfers are counted as both a gain and loss. The G&L Sheet also displays lodger check-ins and check-outs. Admission type (direct, ambulatory care, etc.) and discharge type (regular, service connected, non-service connected, etc.) are specified. Applicable patient names and ward locations are listed under the appropriate sections. The patient's social security number is printed in whole or in part, dependent on the locally-defined G&L parameters. The total number in each category is displayed next to the heading.

(4) **Non-Count.** A non-count situation is one that is "workload or statistic only." A non-count is neither an encounter nor an "occasion of service."

**3. POLICY:** It is VHA policy that patients must be assigned a treating specialty code of observation, as applicable, and that all services and costs associated with the observation treating specialty are captured and assigned to inpatient services.

**4. ACTION:** The facility Director is responsible for ensuring that:

a. The following Patient Treatment File (PTF) treating specialties and revised Monthly Program Cost Report (MPCR) account numbers are utilized for recording observation patient activity.

<u>Treating Specialty</u>	<u>PTF Number</u>	<u>MPCR Number</u>
Medical Observation	24	1150.00
Surgical Observation	65	1250.00
Psychiatric Observation	94	1350.00
Neurology Observation	18	1151.00
Spinal Cord Injury Observation	23	1156.00
Rehabilitation Medicine Observation	41	1153.00
Emergency Department (ED) Observation	1J	1150.00

**NOTE:** *ED Observation Treating Speciality became effective October 1, 2009 (part of Vista ADT patch DG\*5.3\*813). PTF Treating Specialty 1J must be used for ED providers admitting patients to the ED for observation. For other observation admissions, the appropriate PTF treating specialty number must be used based on the type of clinical observation versus where*

*the patient is physically being observed (i.e., a medical provider may admit a patient to Medical Observation in the ED using treating specialty 24).*

b. Only the treating specialties outlined in this Directive are used for setting up observation units. The service for the observation unit ward needs to be non-count, and must include the G&L location.

c. Observation status is used appropriately (i.e., a patient should not be discharged from inpatient and re-admitted to an observation treating specialty for the same episode of illness).

(1) Patients placed on observation status are assigned to one of the preceding listed treating specialties (see subpar. 4a), enabling the facility to track the patients on the G&L. An observation patient requiring subsequent admission would be released from observation status by discharging the patient from the facility and then admitting the patient to an acute care-treating specialty.

(2) Patients already designated as inpatient status must be discharged and re-admitted to an observation treating specialty for no more than 23 hours and 59 minutes (especially normal ambulatory surgery which is not related to the reason for hospitalization). If further hospitalization is required following the observation period, the patient must be discharged from observation and re-admitted to inpatient status. Community Living Center (CLC) and Mental Health Residential Rehabilitation (MH RRTP), including Domiciliary, patients requiring observation services are to be transferred Absent Sick in Hospital (ASIH) from the CLC or MH RRTP, including Domiciliary, and assigned to an appropriate observation treating specialty. The patients must be returned to the CLC or MH RRTP, including Domiciliary, within 23 hours and 59 minutes. A principal diagnosis needs to be available for these patients at the time the patient is discharged to an appropriate ambulatory care setting, or is re-admitted to another treating specialty for inpatient care.

**NOTE:** *Utilizing this data report methodology enables data users to separate the activity of these patients for their purposes. For performance measurement purposes, these patients would not be included as acute care inpatients. Procedures performed while a patient is assigned to observation status must be considered ambulatory for performance measure purposes.*

d. Documentation is accurate and complete.

(1) PTF records for reporting observation patients, when discharged from observation status, must be completed and transmitted. If a patient is admitted following observation, the acute care PTF record is to be transmitted after discharge from inpatient care.

(2) Attachment A outlines the minimal requirements for patient record documentation of observation patients. **NOTE:** *The goal of observation is to resolve symptoms or to clarify a patient's diagnosis; this must be clearly stated so clinical care is focused and the record can be coded appropriately.*

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e. Billing is accurate and processed in a timely manner. Billing must comply with documentation and medical necessity requirements for observation services.

(1) Insurance carriers of patients on observation status are to be billed at the appropriate observation rate for the Current Procedural Terminology (CPT) code supported by the documentation in the patient's record using revenue code 760 "General Classification" or 762 "Observation Services." This is a facility charge and needs to be billed on a Uniform Billing Form (UB)-04. For billing professional services, CPT codes are to be used. **NOTE:** *For additional billing guidance on observation services, refer to VHA Standard Operating Procedure Guide 1601C.03, Chapter 6, Section H, Observation.*

(2) First-party patient co-payments for observation patients are to be billed as outpatient co-payments according to the Decision Support System (DSS) stop indicator for the observation service provided.

**5. REFERENCES:** None.

**6. FOLLOW-UP RESPONSIBILITY:** Director, Health Data and Informatics (19F) is responsible for the content of this Directive. Questions may be addressed to (760) 777-1170. For issues concerning billing, contact the Chief Business Office (16), at (202) 461-1595.

**7. RESCISSIONS:** VHA Directive 2004-018 is rescinded. This VHA Directive expires November 30, 2014.

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Attachment

**DISTRIBUTION:** E-mailed to the VHA Publications Distribution List 12/2/2009

ATTACHMENT A

**OBSERVATION PATIENT RECORD  
DOCUMENTATION REQUIREMENTS**

DOCUMENT OR ITEM	COMPLETION TIME	COMPONENTS OF DOCUMENT REQUIRED
1. Admission Order	On Admission	A timed and dated order for admission of the patient to an Observation Bed.
2. Initial Assessment and History and Physical (H&P)	Immediately	<p>a. An Initial Assessment and screening of physical, psychological (mental), and social status to determine the reason why the patient is being admitted to an Observation Bed, type of care or treatment to be provided, and need for further assessment.</p> <p>b. An extensive Emergency Department (ED) note or Progress Note, documented by the admitting physician, encompassing the normal criteria for an H&amp;P is sufficient as an initial assessment, and H&amp;P for the Observation patient.</p>
3. Progress Notes	Within the observation period or as clinically indicated.	<p>a. Progress Notes need to reflect the status of the patient's condition, course of treatment, patient's response to treatment, and any other significant findings apparent at the time the progress note is documented.</p> <p>b. Reassessments need to include a plan for (1) discharge or transfer; (2) admission or readmission to inpatient status; or (3) continued observation with evaluation and rationale.</p>
4. Discharge Order	On Discharge	A timed and dated order for discharge from the Observation status.
5. Discharge Diagnoses	On Discharge	A complete listing of all final diagnoses including complications and comorbidities.
6. Discharge Note	On Discharge	A summarization of the reason for the Observation admission, the outcome, follow-up plans and patient disposition, and discharge instructions (such as diet, activity, medications, special instructions). <b>NOTE:</b> <i>This summary may be documented in the Progress Notes, or dictated according to local policy.</i>