



**HOSPITAL ADMISSIONS, TRANSFERS and REFERRALS: #1175
MEDICAL/SURGICAL/REHABILITATION UNIT**

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POLICY: It is the Policy of Confluence Health, Wenatchee Valley Hospital & Clinics that:

1. Admissions shall be appropriate for the level of care that can be provided at WVH.
2. Admissions, transfers and referrals will be carried out in a consistent and efficient manner.
3. No admission will be denied based on race, creed, age, sex, sexual preference, religious status, color, national origin, disability and financial status.

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References: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and other corporate policies.

I. GENERAL

- A. WVH is a medical/surgical/acute rehabilitation facility with a defined scope of care.
- B. A patient may be admitted to WVH and treated by members of the credentialed staff. All practitioners shall be governed by the admitting policy of the Hospital.
- C. A single physician member of the Medical Staff shall be responsible for the decision to admit, provide medical care and treatment of each patient in the Hospital. “The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs.”

II. ADMISSION STATUS (Medical/Surgical Unit)

A. It is the physician's responsibility to understand and document the character of their patient's illness/condition and to order the appropriate admitting category. To assist the physician in understanding the appropriate admitting category and process, the following guidelines are provided. Each physician should understand these guides and if they are not clear, ask for guidance from Utilization Review or WVH Supervisory personnel.

1. Outpatient Surgery:

a. Definition:

- i. A surgical procedure that is not on Medicare's inpatient-only procedure list and the patient does not meet medical-necessity criteria for inpatient admission.
- ii. A surgical procedure performed on patients who typically do not remain in the hospital overnight. Note: Occasionally a patient may require additional routine postoperative recovery that may take place on the inpatient unit and may last into or through the night. For these cases, the extended stay for routine recovery is to remain an outpatient service.
- iii. Outpatient surgery may be performed in inpatient operating suites, outpatient surgery suites, or procedure rooms within an outpatient care facility.

2. Outpatient routine post surgical monitoring:

- a. The patient is discharged from care after the routine postoperative recovery period of up to 6 hours, or up to 8 additional hours of extended postoperative recovery if necessary.
- b. Note: If the patient experiences complications from the procedure, they may be appropriate for observation to begin after the routine recovery period.
- c. If the physician determines that the patient needs to stay longer than 8 additional hours of extended postoperative recovery after the routine recovery period of up to 6 hours for unanticipated or non routine observation and services, the admission status should be converted to observation as of the hour patient started the extended 8 hours of additional postoperative monitoring. This requires a written or verbal physician order as well as clear documentation of the condition requiring additional monitoring by the attending or on-call physician.
- d. Patient may be transferred from WVH Surgery Department to a bed in the WVH Medical/Surgical unit until discharged while still maintaining outpatient status.

3. OBSERVATION (SEE APPENDIX A)

- a. **Definition:** Observation services are those services furnished on a hospital's premises, including use of a bed and appropriate monitoring by nursing or other staff, which is reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible inpatient admission.
- b. **Purpose:** The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.
- c. **Observation IS for:**
 - i Evaluating a patient for possible inpatient admission.
 - ii Treating patients expected to be stabilized and released in 24 hours, or less than two midnights, however, with appropriate documentation patients may stay in observation longer than 24 hours but will not be reimbursed after 48 hours.
 - iii Recovery following a complication of an outpatient procedure (e.g., abnormal postoperative bleeding, poor pain control, intractable vomiting, delayed recovery from anesthesia).
- d. **Observation is NOT:**
 - i A substitute for an inpatient admission.

- ii For routine prep or recovery prior to or following diagnostic or surgical services.
- iii For continuous monitoring or routine post-operative monitoring of an outpatient surgery.
- iv For medically stable patients who need diagnostic testing.
- v For patients who need therapeutic procedures (e.g., blood transfusions, chemotherapy, dialysis) that are routinely provided in an outpatient setting.
- vi For patients awaiting nursing home placement.
- vii To be used as a convenience to the patient, his/her family, the hospital or attending physician.

4. **Orders and Documentation:**

- a. A physician order with documented medical justification in the medical record is required for placing a patient in observation. The order must be specifically written, such as “place patient in observation”. The order can be generated by Utilization Review or other appropriate personnel and cosigned by the physician.
 - i Physician orders must be printed by hand or electronically. Cursive writing is not allowed.
- b. Once the patient is in the surgical outpatient or observation setting for **24 hours**, or after one midnight, the physician must:
 - i Discharge the patient, **OR**
 - ii Document need for continued hospital care in the medical record along with the expected length of continued hospital stay, and order the appropriate continued admission category.
- c. Once the patient is in the observation setting for greater than two midnights, the physician must:
 - i Discharge the patient, **OR**
 - ii Document need for continued hospital care in the medical record along with the expected length of continued hospital stay, and order the patient to be converted to inpatient status.
- d. All patients placed in observation will have a medical record review for medical necessity prior to discharge. The physician must document that he/she was physically present at some point during observation and that he/she personally performed an evaluation of the patient during the course of the observation state.

5. **Inpatient Admission**

- a. Definition: The patient has been evaluated and determined to need inpatient admission due to:
 - i. Medical Necessity: Meeting medical necessity criteria and severity of illness/intensity of service which cannot be treated elsewhere, i.e., physician’s office, home or nursing home.
 - ii. Medical Necessity Criteria for inpatient hospitalization includes:
 - a. to prevent the onset or worsening of an illness, condition or disability.
 - b. to establish a diagnosis.
 - c. to provide palliative, curative or restorative treatment for physical conditions.
 - d. to assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
 - iii. Undergoing a “Medicare inpatient-only procedure”. Refer to WVH P&P #2105, *Medicare Inpatient Only Procedures*.
 - iv. An anticipated length of stay of greater than two midnights.

6. **Orders and documentation:**

- a. A physician order must be specifically written, timed and dated prior to patient discharge, such as “Inpatient admission”.
- b. The physician must document medical justification in the medical record, including:
 - i **Severity of illness:** physical findings include acute onset of symptoms, severe pain, hemorrhage, and abnormalities in vital signs, x-ray and lab. Prevent the onset or worsening of an illness, condition or disability;
 - ii **Intensity of care** indicates a plan of care that includes: isolation, surgery or close monitoring, i.e., IV or IM meds, frequent vitals that cannot be provided by other organizations.
 - iii **Anticipated length of stay** indicates the time anticipated by the physician that the patient will need to stay in the hospital receiving inpatient services.

III. GENERAL ADMISSION GUIDELINES BASED ON SERVICES AVAILABLE

- A. WVH is a medical/surgical/acute rehabilitation hospital facility with a defined scope of acute and chronic care.
- B. In order to match healthcare service capabilities to patient requirements, preadmission screening will be performed.
- C. The admitting physician will assess clinical evidence provided by the patient, other physicians, and records prior to admission to determine medical necessity and appropriate level of care.
- D. If the patient does not meet WVH admission criteria and/or would be better served at a different facility and/or level of care, the patient will be referred to a facility that will best serve the patient’s needs.
- E. **Table 1: Inappropriate for Admission to WVH**, below, is a guide to assist in determining appropriate patients for admission and/or transfer. The general guidelines are subject to review on a periodic basis and will be changed to meet WVH capabilities for care and treatment.
 1. Patients with situations listed in Table 1 as inappropriate for admission can be admitted to WVH only by authorization of the Medical Director or his designee.
 - a. **Exception:** Patients with a terminal condition who are admitted for end of life care or other treatments (e.g., pain management, transfusion). These patients must have established no-code orders.
 2. If during the hospital course, a change in patient status occurs and the patient develops any of the situations listed below, an evaluation by a physician for indication that a higher level of care is required will be performed.

TABLE 1: INAPPROPRIATE FOR ADMISSION TO WVH

Level of Care
<ol style="list-style-type: none"> Requires critical care services. Requires use of technology and/or resources not available at WVH.
General
<ol style="list-style-type: none"> Does not meet medical necessity criteria. Significant acidosis, i.e., diabetic ketoacidosis (DKA). Acute overdose requiring continuous suicide precautions. Actively suicidal or psychotic requiring continuous suicide precautions. Psychiatric patients with acute diagnosis. Any patient with severe agitation or combativeness.
Surgery Patients
<ol style="list-style-type: none"> Patients with high-risk preoperative evaluation scores: <ol style="list-style-type: none"> ASA Status VI. ASA Status IV or V only if approved by anesthesiologist and surgeon prior to surgery being scheduled. Procedure Related Risk Classification Category 4 only if approved by anesthesiologist and surgeon prior to surgery being scheduled. Patients with specific medical conditions other than for minor local procedures. Surgical procedures may be performed in the facility ONLY with prior specific discussion with anesthesiology and/or other appropriate physician input. Such medical conditions include: <ol style="list-style-type: none"> A history of new onset, or unstable angina, or current congestive heart failure. Myocardial infarction within the last six months. Chronic lung disease with dyspnea at rest while on continuous oxygen therapy. Asthmatics poorly controlled for last 1 month. Any patient that cannot ambulate independently for cardiopulmonary reasons. Patient weight over 350 pounds. Severe dementia with agitation requiring continuous monitoring and restraints therapy. Active tuberculosis.
Age
<ol style="list-style-type: none"> Inpatient surgical: Under eleven (11) years of age. Inpatient medical: Under sixteen (16) years of age. Outpatient surgical: Under six (6) months of age. (Unless approved by Anesthesia Practitioner) Inpatient Rehabilitation: Under eighteen (18) years of age.
Cardiovascular
<ol style="list-style-type: none"> Acute myocardial infarctions, where the patients are candidates for intervention, should not be admitted to Wenatchee Valley Hospital. These patients should be transferred to a facility where interventional care is provided. Ventricular tachycardia. Atrial Fibrillation which is hemodynamically unstable. Acute arterial thromboembolism. High –risk chest pain.
Gastroenterology
<ol style="list-style-type: none"> No unstable G.I. Bleeding requiring ICU admission or continuous cardiac monitoring.
Neurological
<ol style="list-style-type: none"> A new neurologic event requiring intensive care or continuous cardiac monitoring. Any patient with severe agitation or combativeness. A quadriplegic.
Respiratory (see below, Guidelines for Admitting Patients with Pulmonary Conditions)
<ol style="list-style-type: none"> Severity of condition that will require admit to a facility with critical care should include: <ol style="list-style-type: none"> Respiratory acidosis with pH of less than 7.3. High risk of needing intubation and ICU admission. Acute tracheostomy. Respiratory Therapy Services <ol style="list-style-type: none"> Requires complicated, intensive respiratory therapy. Requires therapy not available at WVH. Respiratory treatments <ol style="list-style-type: none"> Continuous tracheal suction required. Assisted ventilation devices (exception CPAP or BIPAP), oxygen tent.
Renal
<ol style="list-style-type: none"> Requires inpatient dialysis.
Infections
<ol style="list-style-type: none"> Severe or suspected sepsis with hypotension, sinus tachycardia, increased respiratory rate, confusion.
Pediatric Considerations
<ol style="list-style-type: none"> Requires chemotherapy. Suspected increase of intracranial pressure or other emergent neurology conditions. Requires hemodialysis or has other emergent nephrology conditions. Cardiac conditions. Rule out meningitis.

IV. ADMISSION GUIDELINES FOR SURGICAL PATIENTS

- A. **Case appropriateness:** Determining whether a case is appropriate for the surgical facility is decided between the surgeon/proceduralist, the Chief of Surgery and the anesthesiologist.
- B. **Anesthesia Preoperative Evaluation:** The American Society of Anesthesiologists (ASA) Classification System and the Procedure Related Risk Classification System are utilized to rate the significance of a patient's illness as well as procedure risks prior to anesthesia services, and to assist in determining the appropriateness of performing the patient's surgery at WVH. Refer to, *Preoperative Evaluation and Preparation Guidelines* by Wenatchee Anesthesia Associates in the Surgery Department of WVH.
 - 1. **ASA Status:**
 - a. **ASA IV or V:** These patients require individual consideration by the surgeon and anesthesiologist before surgery or admission to WVH will be scheduled.
 - b. **ASA VI:** These patients are not appropriate for surgical services or admission to WVH.
 - 2. **Procedure Risk Category:**
 - a. **Category 4:** These procedures will be performed at WVH only with individual consideration by the surgeon and anesthesiologist before surgery will be scheduled at WVH.
- C. **Pre-operative testing and evaluation:**
 - 1. It is the surgeon's responsibility to establish that a patient can undergo the proposed procedure and to perform or arrange appropriate pre-operative consultations. WVH Surgery Department P&P #SUR 4.1, *Preoperative Instructions, Evaluations and Policies* are helpful.
 - 2. There is no requirement for "routine" preoperative tests. Studies and tests are to be obtained as suggested by the pre-operative history and physical and the nature of the procedure.
 - 3. Refer to VII.C.4, below, and WVH P&P # 1178, *Coding and Billing for Preoperative Evaluation*.
- D. **Age requirements:**
 - 1. **Outpatient surgery:** Recommended minimum age is 6 months of age, unless approved by Anesthesia Practitioner.
 - 2. **Inpatient surgery:** 11 years and over. Patients under age 11 will not be admitted as an inpatient to WVH.

V. ADMISSION OFFICE HOURS AND PROCEDURES

- A. Physician or his/her nursing staff member will call Admission Coordinator at ext. 5738 to determine bed availability, bed assignment and surgery scheduling.
- B. Admission Coordinator will correlate a surgery time with hospital bed availability, and will schedule the surgery and bed assignment in the computerized schedule.
- C. The physician will complete the appropriate admitting documents, per VI. *Physician Requirements for Medical Records*, below.
- D. The Admission Coordinator will notify the hospital Unit Secretary at ext. 5937. The Unit Secretary will notify the WVH receptionist and the nursing staff.
- E. **After Hours (after 2000) and Weekends**
 - 1. Call ext.5738 for bed availability, bed assignment and surgery scheduling, if necessary.
 - 2. The physician will complete the appropriate admitting documents.
 - 3. **After Hours Surgery:**
 - a. Should be uncommon and done primarily on an emergency basis.
 - b. The surgeon will communicate to staff where he/she can be located if needed.
 - c. The hospital receptionist will initiate notification of the on-call surgery staff per WVH Surgery Department P&P # SUR 2.3, *On Call Team Process*.
 - d. Patient is expected to go to the OR in approximately 30-60 minutes from time of request.
 - e. After hours and weekends, the patient's family will be directed to WVH 3rd Floor to wait while patient is undergoing surgery.
- F. Direct admission.

VI. PHYSICIAN REQUIREMENTS FOR MEDICAL RECORDS

- A. See also WVH P&P #8050, *Physician Requirements for Medical Records*.
- B. Admitting documents
- C. The physician must:
 - 1. Order an inpatient or outpatient (including observation) status for each patient (see Appendix A). The order must be signed prior to discharge.
 - 2. Designate the **physician responsible** for the patient.
 - 3. Indicate the **diagnosis** or working diagnosis.
 - 4. Complete the **History & Physical, treatment plan and orders** ensuring that there is documentation of medical necessity and appropriateness for the admission type chosen.
 - a. See Appendix B, *History & Physical Exam Requirements*.
 - 5. Complete necessary **consents**. Informed consent will be considered valid if obtained within 30 days prior to procedure.
 - 6. Date and time all entries to the medical record.
- D. Begin pre and post-operative teaching and review the patient's *Preparing for Surgery* booklet. The patient can expect a phone call from the surgery department the day before their scheduled surgery.
- E. Send completed packet to WVH Surgery Center preferably two days before but no later than 1300 the day before surgery.

VII. SAME DAY READMISSION

Definition: When a patient is discharged from a hospital, and then returns to be readmitted on the same calendar day to the hospital. This may also include patients who are discharged from one hospital and are readmitted to another hospital.

- A. **Admitting Department** responsibilities include:
 - 1. Create a new hospital chart for the new admission. The patient's hospital medical record containing past hospitalization records will be kept on the nursing unit for reference for all hospital admissions.
 - 2. If the patient is readmitted with the same physician and diagnosis, the patient is assigned the same stay number as the previous admission.
 - 3. Alert Hospital staff to discard the old addressograph card used during the previous admission and to use the new addressograph card assigned for the readmission.
- B. **Physician** responsibilities include:
 - 1. The previous History and Physical may be used, but an interval admission note must include the patient's current complaint, physical findings and any additions or changes in the prior H&P.
- C. **Nursing Staff** responsibilities include:
 - 1. Complete all standard admission procedures, assessments, documentation, etc. in the new hospital chart.
 - 2. Ensure that the new addressograph card is used and that the old card has been discarded.
- D. **Reimbursement Department** responsibilities include:
 - 1. Evaluate readmission and ensure appropriate billing, per Quality Review findings.
 - 2. Coordinate billing and reimbursement if patient was readmitted after being discharged from another hospital.

VIII. BED AVAILABILITY & BED PLACEMENT

- A. The number of days a patient is booked for inpatient stay is based on the average length of stay per diagnosis or on information provided by the physician.
- B. Communication between physicians, Utilization Review, supervisory personnel, nursing, Admission Coordinator, and the discharge planner/social services is necessary for:
 - 1. Effectively assigning rooms for future surgical or medical patients.

2. Determining staffing needs.
 3. Coordinating discharge planning with other facilities.
 4. Determining whether utilization of short stay rooms is necessary.
 5. Reassigning patient rooms if discharges do not occur as scheduled.
- C. Patients are admitted depending on bed availability (See Rehabilitation Unit procedures in this policy, as they differ).
- D. If a bed is available, patient will be transported or directed to admissions department.
- E. Pediatric (Age 11-17) Room Assignments
1. Patients under age 11 will not be admitted as inpatients to WVH.
 2. Room assignments are determined after reviewing requirements for observation needs and developmental age needs, thus ensuring patient safety.
 3. The charge nurse will make the room assignment.
 4. If possible, pediatric patients will be placed in a bed that is visible from the nurses' station. If this is not possible, a family or staff member will be asked to stay with the patient to ensure safety.
- F. Full House (Overflow): Bed Overflow Emergencies
1. The facility is licensed for 20 beds and occasionally will need to have more than 20 patients during emergencies. During an emergency overflow situation, all pertinent transfusion patients will be transferred to the WVH Surgery Department or Walk In Clinic.
 2. When necessary, patients of the same sex will be scheduled to share the same room. The following rooms, in the order listed, can be used as semi-private rooms if necessary: Rooms 323 and Room 322.
 - a. Patients will be properly screened for these rooms (preferably, these patients are expected to be ready for discharge by the following morning).
 - b. Patients with pulmonary problems, NG tubes, who are confused, very hard of hearing, require unusually frequent assessments or electronic equipment that might be disruptive to a room-mate should not be scheduled to share a room due to the way these rooms are set up.
 - c. Double rooms will be utilized when possible for surgical patients with clean surgical procedures vs. medical admit. Patients with suspected or identified infections will be scheduled for a single room per policy # 5200 *Isolation Precautions*.
 3. In the event a patient will be sharing a room, the following steps will be taken:
 - a. Phase One Recovery will be called and informed that the patient will be sharing a room, which requires a certain amount of time to set it up.
 - b. The family will be informed that the patient will be sharing a room.
 - c. Staffing needs will be discussed with the Charge Nurse or Supervisor.

IX. DIVERSION

A. Wenatchee Valley Hospital on Diversion

1. In the case that all patient beds, including short-stay beds, are full, and other options are unavailable, patients will be diverted to the nearest appropriate facility. (See WVH P&P #1790, *Emergency Care, Persons Presenting For*, regarding the EMTALA act) notify physician offices of the diversion status if they call to admit a patient.
2. The primary physician will refer patients who require hospitalization to another facility that is equipped for the patient's needs.

B. Central Washington Hospital on Diversion

1. When Central Washington Hospital (CWH) declares "Diversion" status they will contact the WVH Nursing Supervisor or Charge Nurse to determine bed availability and staffing availability. The Nursing Supervisor or Charge Nurse will inform the Hospital Manager.
 - a. The Hospital Manager, Supervisor or Charge Nurse will determine bed availability by checking bed assignments in WallChart. The receptionist will assist as directed.
 - b. The Hospital Manager, Supervisor or Charge Nurse will determine staff availability.

2. If sufficient bed and staffing availability has been determined, the Hospital Manager, Nursing Supervisor or Charge Nurse will call CWH and inform them.
3. If CWH calls for a bed, the Hospital Manager, Nursing Supervisor or Charge Nurse will:
 - a. Check the status of the admitting physician's admitting privileges.
 - b. Determine whether patient has an appropriate admitting diagnosis and condition.
 - c. Determine expected length of stay.
 - d. Determine Code status of patient.
4. If the Hospital Manager and/or Supervisor and/or Charge Nurse are unavailable and the appropriateness of admission is in doubt, the Hospital Operations Administrator will be contacted.

X. TRANSFERRING PATIENTS TO ANOTHER FACILITY

To ensure appropriate care, our patients shall be transferred to a more comprehensive facility when their condition warrants.

A. Transfer Procedures:

1. Primary physician will consult with nursing and write order for transfer.
2. Hospital Department will be notified of intent of transfer.
3. Receiving facility will be contacted for arrangements and time.
4. Provide **copies for receiving facility** to be sent with patient:
5. Patient Identification Data (face sheet).
6. History and Physical.
7. Discharge Summary (stat dictation).
8. Transfer Form.
9. Documentation of patient's illness or injury and condition on transfer.
10. Treatment received at WVH.
11. All diagnostic data: laboratory results, X-rays, EKGs.
12. **COBRA "Authorization for Patient Transfer"** *must be completed and a copy sent to receiving facility.*
13. Notify family of patient transfer.
14. Arrange transportation appropriate to the patient's condition (ask patient preference for ambulance company, if appropriate).
15. Transferring nurse will call a report to receiving nurse prior to transfer.

XI. REHABILITATION SERVICES

- A. The Rehabilitation Center at Wenatchee Valley Hospital provides intensive rehabilitation therapy in a resource intensive hospital environment for patients who, due to the complexity of their nursing, medical management and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care.
- B. Diagnosis examples may include, but are not limited to:
 1. Stroke
 2. Traumatic Brain Injury/ Brain Dysfunction
 3. Amputation
 4. Orthopedic Disorder with complex co-morbidities
 5. Neurologic Conditions
 6. Spinal Cord Dysfunction
 7. Multiple Trauma
- C. Criteria for IRF (Inpatient Rehabilitation Facility), to be considered reasonable and necessary:

Required Preadmission Screening: Per CMS Final Rule 2010, a comprehensive preadmission screening process will identify appropriate candidates for IRF care.

 1. Preadmission screen will be conducted by a licensed or certified clinician, designated by a rehabilitation physician.

2. A rehabilitation physician will review and document his or her concurrence with the findings and results of the preadmission screen within 48 hours immediately preceding the IRF admission.
- D. Admission Orders, History and Physical, Post-Admission Physician's Evaluation and Initial Plan of Care: Must be generated by a rehabilitation physician and documentation must demonstrate a reasonable expectation that the following criteria are met and necessary at the time of admission to the IRF.
1. Need for multiple therapy disciplines: The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy.
 2. Intensive level of rehabilitation Services: the patient must be able to tolerate and benefit from at least three (3) hours of therapy per day, at least five (5) days per week, or an average of at least fifteen (15) hours per week, with documentation in the medical record as to reasons for such.
 3. Ability to benefit from therapy program: documentation will reflect significant practical improvements, in a reasonable period of time, sufficient to allow a patient to live in a community setting with assistance.
- E. Physician Supervision; Frequent and direct close medical supervision by a rehabilitation physician. Documentation will demonstrate frequent and direct medically necessary physician involvement and supervision, and will reflect at least three – face to face visits per week throughout the patients IRF stay.
- F. Individualized Overall Plan of Care: A rehabilitation physician will develop an individual overall plan of care for each IRF admission with input from the interdisciplinary team within 72 hours of the patient's admission to the IRF.
- G. Interdisciplinary Team Meetings: Will occur at least once per week throughout each IRF stay, and will have physician documentation demonstrating concurrence with all decisions made by the interdisciplinary team at each meeting.
- H. Preadmission Screening/Referral Program:
1. The Admission Coordinator (ext. 5569, FAX 509-665-5864) makes every attempt to simplify and expedite the referral process, regardless of the referral source.
 2. The preadmission screening process includes, but is not limited to:
 - a. Obtaining all available physician, nursing and therapy notes, consultations, labs, radiology reports, psychosocial and insurance information.
 - b. The rehabilitation physician will review the preadmission screening information and admission materials and, whenever feasible, conduct a personal interview to determine the appropriate disposition plan.
 - c. Consultation will be completed within 24 hours and assist in coordinating the transfer of the patient to the Rehabilitation Unit, or the reason(s) for denial to the program will be explained and other appropriate follow up recommendations and referral to other appropriate services will be provided.
 3. The Admission Coordinator will:
 - a. Keep and update a referral log to track all referrals and their dispositions.
 - b. Contact the appropriate insurance company for pre-authorizations and follow up approvals for continued stay.
 4. A rehabilitation physician will admit the patient to the Rehab unit and complete the admission orders and History and Physical and Post Admission Physician Evaluation (PAPE).
 - a. If the patient's primary care physician will continue to follow co morbidities not related to the Rehab care this must be stated in the admitting documentation (H&P), specifying conditions to be followed by the patient's primary care physician.

5. On the day of admission, each physician ordered discipline of the Rehabilitation Service will be notified by nursing and conduct their initial evaluations within 24 normal working hours of admission time.
 6. A member of the Rehabilitation Unit staff will orient the patient and family to the unit and provide a tour of the area. A Patient Program Information Pamphlet will be given to the patient and family.
 7. Wait List Admission Assessment Tool
 - a. On the occasions when the Rehabilitation Unit is full, a list of potential rehabilitation patients will be implemented. The rehabilitation physician or designee involved will coordinate the prioritization of patient's admission with the Utilization department and/or Admission Coordinator in order to facilitate the patient's prompt admission.
 - b. Persons on the waiting list will be screened according to The IP Rehab Admission Assessment Tool.
 - c. Patients waiting for admission to the rehabilitation unit will be assigned a number based on the assessment tool. Patients waiting will be placed on the wait list. The patient who has accumulated the most points will be a top priority to admit to the first open bed.
- I. Patients Ineligible for Admission to Rehabilitation Unit**
1. The decision to divert a rehabilitation referral is based on the pre-admission intake procedure. Patients not meeting in-patient acute rehabilitation unit criteria will be referred to the appropriate facility based on individual needs or to appropriate community resources.
 2. There are four categories of ineligible candidates:
 - a. Medically inappropriate
 - b. Bed Availability
 - c. Discharge to a different level of care (cannot tolerate the demands of Acute Rehabilitation)
 - d. Alternate facility recommended (e.g., children to Children's Hospital, TBI unit)
 - e. Patients under the age of eighteen (18) years of age.
- J. Intake Referral Log Policy**
1. Intake Referral Log Policy outlines the use of the Referral Log, which will be the basis for documenting the statistics on ineligible candidates.
 2. Disposition of all candidates will be determined by the rehabilitation physician from the preadmission screen and recorded by the Admissions Coordinator as part of general statistics concerning patient outcomes.
 3. A summary report will be provided to the Rehabilitation Unit Manager at least quarterly.
 4. Summary reports for ineligible candidates shall include the following:
 - a. Numbers of patients ineligible
 - b. Reason for ineligibility by categories
 - c. Source of referral
 - d. Diagnosis
 - e. Referral actions
- K. Transfer of Rehabilitation Patients to Acute Care or Other Facility**
1. To remain eligible for continuation of rehabilitation services, the patient must fulfill the conditions of admission.
 2. The rehabilitation physician and/or attending physician assist in evaluating the need to transfer a patient to another setting when rehabilitation criteria are not met.
 3. The decision to transfer a patient is determined based on the following:
 - a. Functional independence measurements
 - b. Medical status (medical instability beyond the capability of the hospital)
 - c. Failure to meet in-patient acute rehabilitation criteria.
 4. The patient and family are informed of the need to transfer and are presented choices for alternative placement.

5. Pertinent clinical information will be copied and sent to the accepting facility with the patient or faxed when appropriate. Information sent will include:
 - a. History and Physical
 - b. Face sheet
 - c. CPR directive
 - d. Discharge summary
 - e. Recent labs
 - f. Intake and output sheet
 - g. Recent diagnostic studies
 - h. Medication records
 - i. Progress notes by MD/nurse that includes reason for transfer
 - j. Vital sign flow sheet
 - k. Intraoperative record
 - l. Post anesthesia care record
 - m. EKG
 - n. COBRA form (if appropriate)
 - o. Consent forms

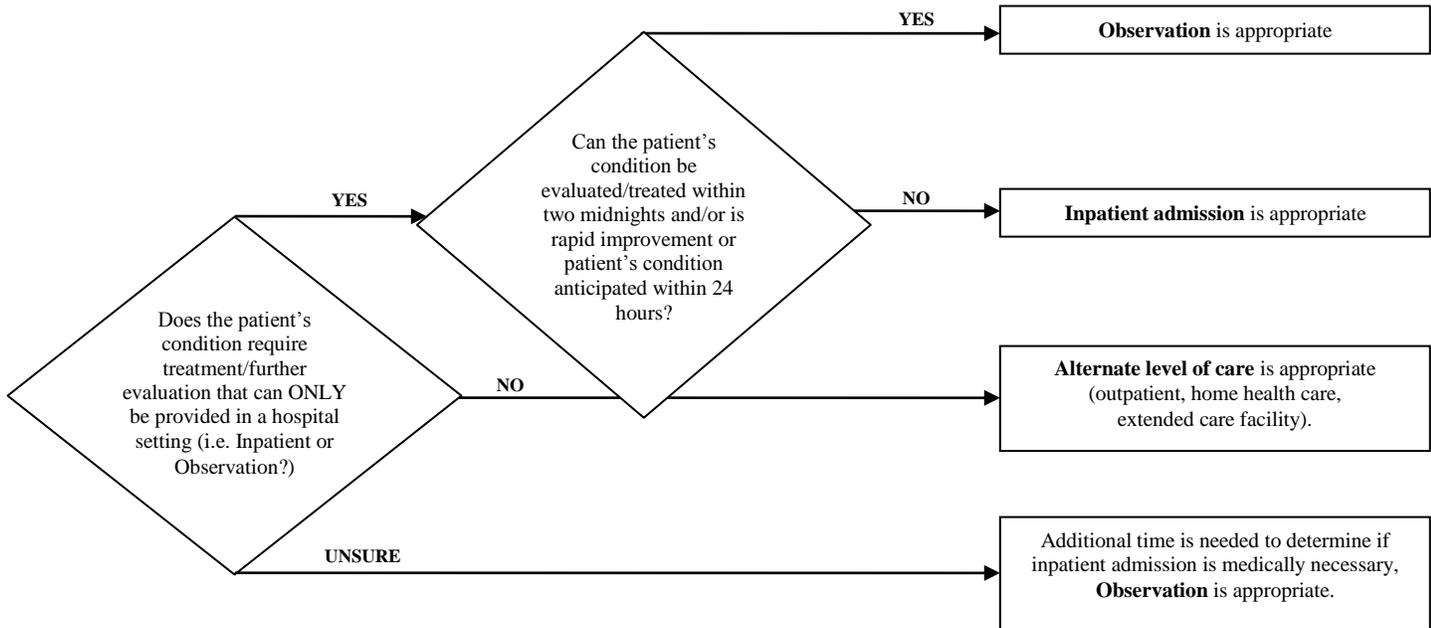
L. Transfer of WVH Acute Patients to WVH Rehabilitation Unit

- a. Transfer and admission policies and procedures per *X. Transferring Patients to Another Facility*, and *XI. Rehabilitation Services*, above, will be followed.
- b. Patient will be discharged from WVH Acute Care and admitted to WVH Rehabilitation Service.
 - i The patient will be issued a new stay number for the Rehabilitation admission.
 - ii The patient will be transferred to a designated Rehabilitation bed.
- c. Pertinent clinical information will be copied and a Rehabilitation chart will be initiated. Information will include:
 - i Physician order for transfer
 - ii History and Physical
 - iii Face sheet
 - iv CPR directive
 - v Discharge summary
 - vi Recent labs
 - vii Intake and output sheet
 - viii Recent diagnostic studies
 - ix Medication records
 - x Progress notes by MD/nurse that includes reason for transfer
 - xi Vital sign flow sheet
 - xii Intra-operative record
 - xiii Post anesthesia care record
 - xiv EKG
 - xv COBRA form (if appropriate)
 - xvi Consent forms

APPENDIX A

OBSERVATION VS. INPATIENT ADMISSION DECISION ALGORITHM

The decision to admit a patient as an inpatient requires complex medical judgment including consideration of the patient’s medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents. The following algorithm is a tool to aid physicians, Utilization Review and Supervisory personnel in determining when **Observation** or **Inpatient** admission may be appropriate.



KEY POINTS TO REMEMBER:

1. Observation services are reimbursed under the Outpatient Prospective Payment System.
2. Using Observation as an alternative to Inpatient admission will allow time to determine if Inpatient admission is necessary, reduce denials for unnecessary Inpatient admissions, and ensure that some payment is received for services rendered.
3. Care in Observation can be the same as Inpatient care, but reimbursement is different.
NOTE: Patients with chest pain, CHF and asthma are paid under specific observation Ambulatory Payment Classifications (APCs). Payment for all other conditions is bundled into the APC package.
4. An order simply documented as “Admit” will be treated as an Inpatient admission. A clearly worded order such as “Inpatient admission” or “place patient in Observation” will ensure appropriate patient care and prevent hospital billing errors.
5. Medicare coverage for Observation services requires at least eight hours of monitoring and is limited to no more than 48 hours unless the fiscal intermediary grants an exception. The hospital is only reimbursed for 24 hours. The clock starts with a physician order for observation services. The clock ends when all clinical or medical interventions have been completed including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient discharged.
6. An Observation patient may be progressed to Inpatient status when it is determined the patient’s condition requires an Inpatient level of care.
7. Hospitals can convert and bill an initially Inpatient admission as an Observation using Condition Code 44 if the hospital Utilization Review Committee determines before the patient is discharged and prior to billing that this setting would have been more appropriate. The Physician must concur with the decision of the Committee, and the Physician’s concurrence and status change must be documented in the medical record.
8. Services that do not qualify for Observation include services for convenience reasons, routine prep for and recovery after diagnostic testing, certain therapeutic services, normal post-procedure recovery time (4-6 hours) and procedures designated as “Inpatient only” or that are inappropriate as Inpatient, and standing orders for observation after an outpatient surgery..
9. Documentation will reflect the physician has assessed the patient’s risks and have determined that observation is appropriate. Dated, timed and signed admission orders, progress notes and discharge notes. An order for outpatient observation services will be specifically written with date and time.

Source: This information is from a publication produced by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS). The content of this publication does not necessarily reflect the views or policies of CMS or DHHS.

APPENDIX B

HISTORY & PHYSICAL EXAM REQUIREMENTS

Source: CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 1, 05-21-04). Page 267, A-0391 §482.51 (b)

1. There must be a complete history and physical work-up in the chart of every patient prior to surgery, except in emergencies. If this has been dictated, but not yet recorded in the patient's chart, there must be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient.
2. There must be a complete history and physical examination (H & P) in the medical record of every patient prior to surgery, except in emergencies.
 - a. In all circumstances, when an H & P has been conducted, but is not present on the chart prior to surgery, or in emergency situations where a complete H & P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include at minimum critical information about the patient's condition including pulmonary status, cardiovascular status, BP, vital signs.
 - b. An H & P must be performed by an MD/DO or oromaxillofacial surgeon, for patients receiving oromaxillofacial surgery, no more than 7 days prior to hospital admission/outpatient surgery or 24 hours after hospital admission but prior to surgery/outpatient surgery.
3. Review a minimum of six medical records of surgical patients to determine if a complete history and physical examination by a doctor of medicine or osteopathy is completed prior to surgery, except in an emergency, and in accordance with the methodology described above.
4. **Admission H & P**
 - a. A H&P would meet the CMS requirements that a H & P be "performed no more than 7 days prior to admission or within 24 hours after admission," if:
 1. The H & P was performed within 30 days prior to the hospital admission; AND
 2. An appropriate assessment performed by the MD/DO, which must include a physical assessment of the patient to update any components of the patient's current medical status that may have changed since the prior H & P or to address any areas where more current data is needed, was completed within 7 days prior to admission or 24 hours after admission, but prior to surgery, confirming that the necessity for the procedure or care is still present and the H & P is still current. The physician uses his/her clinical judgment based on his/her assessment of the patient's condition, and any co-morbidities, in relation to the reason the patient was admitted or to the surgery to be performed, when deciding what depth of assessment needs to be performed and what information needs to be included in the update note; AND
 3. The physician or other individual qualified to perform the H & P writes an update note addressing the patient's current status and/or any changes in the patient's status, regardless of whether there were any changes in the patient's status, within 7 days prior to, or within 24 hours after admission, but prior to surgery. The update note must be on or attached to the H & P, AND
 4. The H & P, including all updates and assessments, must be included within 24 hours after admission, but prior to surgery (except in emergency situations), in the patient's medical record for this admission.
 5. If an H & P meets all these requirements within 7 days prior to admission, or within 24 hours after admission, the H & P meets the provisions of the regulation with regard to justifying the admission and meeting the time restrictions on the currency of the H & P.
5. **Outpatient Surgery H & P**

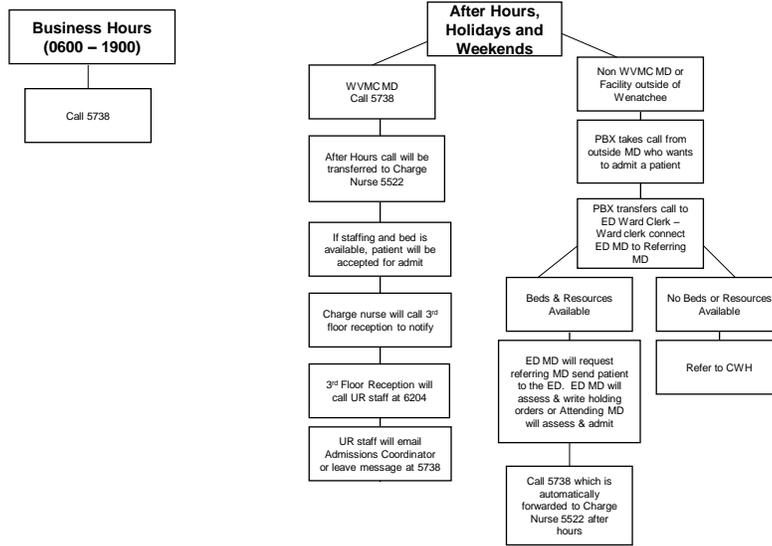
- a.** Furthermore, a H & P would meet the CMS requirement at §482.51(b)(1) that “There must be a complete history and physical work-up in the chart of every patient prior to surgery...” if:
 - 1.** The H & P was performed within 30 days prior to the outpatient surgery; AND
 - 2.** An appropriate assessment performed by the MD/DO, which should include a physical examination of the patient to update any components of the patients current medical status that may have changed since the prior H & P or to address any areas where more current data is needed, was completed within 7 days prior to outpatient surgery confirming that the necessity for the procedure is still present and that the H & P is still current. The physician uses his/her clinical judgment based on his/her assessment of the patient’s condition, and any co-morbidities, in relation to the surgery to be performed, when deciding what depth of assessment needs to be performed and what information needs to be included in the update note; AND
- b.** The physician or other individual qualified to perform the H & P writes an update note addressing the patient’s current status and/or changes in the patient’s status, regardless of whether there were any changes in the patient’s status, within 7 days prior to the outpatient surgery. The update note must be on or attached to the H & P; AND
 - 1.** The H & P, including all updates and assessment, must be included in the patient’s medical record, except in emergency situations, prior to surgery.

If an H & P meets all these requirements prior to outpatient surgery, the H & P meets all the provisions of the regulation with regard to meeting the time restrictions on the currency of the H & P.
- c.** An H & P performed more than 30 days prior to hospital admission/outpatient surgery does not comply with the currency requirements and a new H & P must be performed.

An H & P performed more than 7 days prior to admission/outpatient surgery that does not meet the above currency criteria does not comply with the requirements and a new H & P must be performed.
- d.** All or part of the H & P may be delegated to other practitioners in accordance with State law and hospital policy, but the MD/DO must sign the H & P and as applicable, the update note and assume full responsibility for the H & P (update assessments and update notes are considered part of the H & P). This means that a nurse practitioner or a physician assistant meeting these criteria may perform the H & P and/or the update assessment and note.

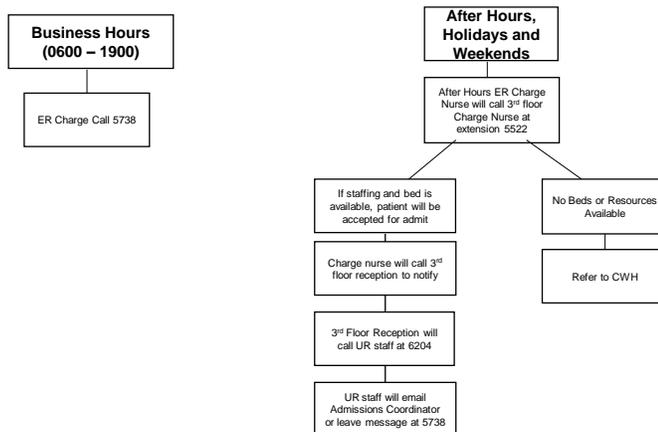
APPENDIX C

Bed Placement Process



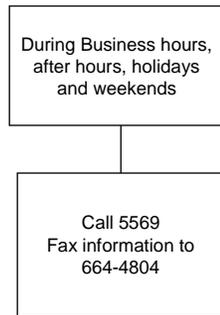
Updated 8/11/10

Charge Nurse Placement Process



Updated 8/11/10

Rehab Referral Process



Updated 8/9/10



IP Rehab Admissions Assessment Tool

Criteria	-3	-2	-1	0	+1	+2	+3	Total
WVH or CWH Acute Pt					YES			
Admission from Home or SNF		Stable at home/SNF- coming in for re-evals, update in pt/family training, etc.	Ready for intensive therapy and medically stable	Requires higher intensity or medical care and therapy than is offered in current setting				
Returning to rehab after admission to acute care							Able to tolerate 3 hours of therapy and is medically stable & still needs IPR intensity & admission criteria	
Medical Issues likely to disrupt tx - seizures, chemo/radiation tx, very light wt bearing, dialysis		YES		No significant medical issues that will disrupt tx				
1:1 needs	Will require 1:1 throughout stay- restless/agitated - family not available to assist	Will require 1:1 throughout stay- restless/agitated - family available to provide supervision at least x1 shift	Will require 1:1 upon admission but appears to be resolving quickly w/in 72 hours- OR- not currently requiring 1:1 but will likely need as pt continues to recover					
Needs Multidisciplinary treatment				Requires 2 or more therapy disciplines	Requires 3 or more therapy disciplines			
Diagnosis:				Debilty, pain, medically complex	Cardiac, ortho, pulmonary	CVA, hip fx, bilateral joints, amputee, polyarthritiis, neurologic diagnosis	SCL, BI, major multiple trauma, peds216	
Payer Issues		Compassionate Care pt	Very limited IPR benefit w/ cost est > benefit					

Criteria for rehab:
 Requires 24 hour medical care
 Requires 2 or more therapy disciplines
 Can tolerate 3 hours of therapy 5 days per week
 Reasonable potential for gain in function
 Expectation for community discharge plan