



Admission Necessity and Observation Misconceptions

Following are frequent misconceptions regarding acute inpatient admission necessity and observation status level of care assignment.

Misconception: Observation can only be used for patients with asthma, congestive heart failure or chest pain.

Reality: Observation services can be provided to any patient regardless of diagnosis. Separately payable observation services, for patients meeting criteria, are available for asthma, congestive heart failure and chest pain.

Misconception: Cardiac monitoring necessitates an acute inpatient level of care.

Reality: Cardiac monitoring does not, by itself, require an acute inpatient level of care. Cardiac monitoring, EKG, and other diagnostic tests are often performed in the Emergency Department to assist the physician to determine the patient's diagnosis and the level of care required.

Misconception: Treatment with antibiotics necessitates an acute inpatient level of care.

Reality: Antibiotic treatment, even IV antibiotic does not, by itself, require an acute inpatient level of care.

Misconception: Observation for more than 24 hours necessitates an acute inpatient level of care OR

Acute inpatient services less than 24 hours are unnecessary admissions.

Reality: Time does not determine level of care status. The appropriate level of care – acute inpatient or observation – is determined by the clinical assessment, management, and treatment the patient requires.

Misconception: Determining the appropriate facility or setting necessitates an acute inpatient level of care.

Reality: Determining the appropriate facility or setting for a patient does not, by itself, require an acute inpatient level of care.

Misconception: Chest pain necessitates an acute inpatient level of care OR

Chest pain is only appropriate for observation status.

Reality: The “symptom” of chest pain may be appropriately assessed in observation status. The physician assessment of the patient's overall condition, history, cause for the chest pain and final diagnosis will determine whether an acute inpatient level of care is required.

Misconception: Less documentation is better.

Reality: Physicians who clearly document their clinical evaluation and plan of care are at less risk for questions regarding unnecessary admissions.

Misconception: Unnecessary admissions can be identified by a particular DRG.

Reality: Unnecessary admissions cannot be identified by a particular DRG; however, several DRGs have been identified to be at risk for unnecessary admissions.