**General**

**Admission Status (Single Response)**

- Admit to Inpatient
- Place in an Observation Bed
- Place in Outpatient Bed (OP Surgery/Procedure/Treatment)

**Choose Inpatient** if the patient is expected to be hospitalized for >48 hours and is receiving Inpatient level of care or the procedure is on the **Medicare Inpatient-Only List**. Overnight Recovery alone does not warrant Inpatient admission. The surgeon should consider the complexity of the procedure and the risk of morbidity and mortality when determining Inpatient vs. Outpatient status. The justification should be documented in the record.

Outpatient is used for routine post-op care (typically <24 hours) of a planned elective OP procedure whether the patient is discharged the same day or is recovered overnight in the hospital. **Inpatient is not required** to bed a patient overnight for routine post-op recovery. Inpatient should be considered if serious post-op complications arise.

**Observation** is rarely used in the post-op setting and is usually due to a condition that is unrelated to the surgical procedure. Example: patient develops chest pain post-op and is admitted for rule-out MI. Observation should not be used for routine post-op care.

### Common Urologic Procedures & Status Designation (OP vs. IP)

**Typical Outpatient Procedures (OP) (Including Overnight Recovery)**

- Cystoscopy
- Cystourethroscopy
- Ureteroscopy
- TURP
- Ureteral Stent Placement
- Ureteral Calculus Removal
- Lithotripsy (Extracorporeal or Endoscopic)
- Cystoscopy for Bladder Cancer Treatment (Biopsy, Fulguration)
- Percutaneous Renal Biopsy
- Orchietomy
- Prostate Biopsy
- Vasectomy
- Minor Urethral Repair
- Insertion of Urethral Sphincter Device

**Typical Inpatient Procedures (IP)**

- Prostatectomy (Open or Laparoscopic) (not transurethral)
- Nephrectomy (Complete or Partial) (Open or Laparoscopic)
- Ureteral Repair
- Cystectomy (Complete or Partial)
- Ureteroileal Conduit
- Major Penile Surgery (amputation, major repair)
- Renal Transplant
- Major Urethral Reconstruction
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- The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.
- Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, 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, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:
  - The severity of the signs and symptoms exhibited by the patient;
  - The medical predictability of something adverse happening to the patient;
  - The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
  - The availability of diagnostic procedures at the time when and at the location where the patient presents.

Medicare Compliance-Red Flags & Recommendations

1. Medicare mandates that procedures on the Inpatient-Only list must be ordered and billed as an Inpatient even if it is feasible to perform the procedure in an Outpatient setting. (Specialty specific IP-Only lists will be provided to surgeons and office staff)
2. Residents, Fellows, PA's, and NP's should be mentored on IP/OP decisions since they are often writing the post-op orders.
3. 3-day Qualifying Stay for SNF- Do Not admit to Inpatient or change a status from Observation to Inpatient solely to qualify a patient for a SNF stay. The patient must meet Inpatient criteria in order to qualify for post-hospital skilled services. CMS has begun rigorously auditing these charts.
4. Do not change a patient's status without discussing with Utilization Management. There is mandatory paperwork that must be completed with certain status changes.
5. Medicare gives considerable latitude to the attending physician's medical decision-making as long as they have documented their rationale for choosing a certain status.
6. Do not use contradictory language between the orders and the chart notes. Example: Inpatient order written, but dictation states “will observe overnight” or “will admit for observation”. The chart notes should provide reasonable clinical rationale for admitting to an Inpatient level of care.
7. Medicare Regulations mandate that certain cases have a 2nd Level Physician review. Physicians should not ignore calls from the UM nurses, UM physicians, or Executive Health Resources (our contracted 2nd Level Reviewer)
8. UM Nurses cannot unilaterally assign or change a patient’s status. The order must come from the attending physician or their licensed delegate.
9. Contact Utilization Management with questions- 503-216-0830 (if nurse is unable to answer please leave a message)