TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INVESTIGATIONS AND ENFORCEMENT

UTILIZATION REVIEW DEPARTMENT

Medicaid Hospital Inpatient

SCREENING CRITERIA

Effective Date: **07/01/2002**

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American Association of Oromaxillofacial Surgeons, Texas Chapter
American College of Cardiology, Texas Chapter
American College of Obstetricians and Gynecologists, Texas Section
American College of Surgeons, North Texas Chapter
American College of Surgeons, South Texas Chapter
Pulmonary Medicine and Critical Care
Renal Physicians of Texas
Society of Critical Care Medicine
Society of Vascular Surgeons
Texas Academy of Family Physicians
Texas Academy of Internal Medicine, the Texas Chapter of American College of Physicians-American
Society of Internal Medicine
Texas Allergy and Immunology Society
Texas Association of Neurological Surgeons
Texas Association of Obstetricians and Gynecologists
Texas Association of Otolaryngology Head and Neck Surgery
Texas Dermatological Society
Texas Division of International College of Surgeons
Texas Geriatric Society
Texas Infectious Disease Society
Texas Medical Association
Texas Neurological Society
Texas Ophthalmological Association
Texas Orthopedic Association
Texas Osteopathic Medical Association
Texas Pain Society
Texas Pediatric Society
Texas Physical Medicine and Rehabilitation Society
Texas Radiological Society
Texas Society of Anesthesiologists
Texas Society of Child and Adolescent Psychiatry
Texas Society of Colon and Rectal Surgeons
Texas Society of Gastroenterology and Endoscopy
Texas Society of Medical Oncology
Texas Society of Oral and Maxillofacial Surgeons
Texas Society of Pediatric Surgeons
Texas Society of Plastic Surgeons
Texas Society of Psychiatric Physicians
Texas Society of American College of Osteopathic Family Physicians
Texas Surgical Society
Texas Thoracic Society
Texas Transplantation Society
Texas Urological Society

Texas Health and Human Services Commission
Utilization Review Department

SCREENING CRITERIA

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PREFACE

Medicaid Inpatient Hospital Screening Criteria

The criteria in this manual will be used by Texas Health and Human Services Commission (HHSC) Utilization Review Department nurse reviewers in performing utilization review of Medicaid hospital inpatient stays for fee for service clients.

This manual is a product of a collaborative effort between the HHSC UR Department and the Texas Medical Foundation (TMF), the Quality Improvement Organization (QIO) for the State of Texas. The TMF Screening Criteria Manual was produced with funds from federal contract number 500-99-TX03, sponsored by the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (DHHS). The latest revision was released in September 2001. Physician Consultants from HHSC participated in the review and update of the TMF Screening Criteria Manual to ensure that the criteria applicable to the Medicaid population were adequately reviewed. The TMF screening criteria was then shared with HHSC to be adapted and published for use in the HHSC UR Department, and as a tool to be used by health care facilities across Texas. It is our hope that this consolidation of medical necessity and treatment criteria will enable Texas hospitals to perform their utilization work with greater efficiency.

The criteria do not represent standards of care and should not influence the medical decision to hospitalize a patient or the treatment provided to a hospitalized patient. The criteria are not used by the physician reviewer to make review decisions.

Use of Admission Screening Criteria

The admission criteria sets for acute hospitalization contain general information concerning medical reasons for a patient's hospitalization and subsequent treatment. Each admission criteria set includes three elements:

- Indication for hospitalization
- Treatment
- Discharge screens

The admission criteria are used to verify the medical necessity of an inpatient stay. For the purposes of hospital utilization review performed by the HHSC Utilization Review Department, medical necessity means the patient has a condition requiring treatment than can be safely provided in the inpatient setting only.

In order for the nurse reviewer to approve the inpatient admission, an indication for hospitalization (IH) element and a treatment (T) element must be met. The nurse reviewer may use elements (indication for hospitalization and treatment) from one specific criteria set alone, from the general criteria set, or one element from a specific criteria set and one element from the general criteria set. The criteria may be met at any point during the hospitalization.

For the Medicaid program, in order for criteria which have been marked with an ***** to be met (indications for hospitalization, monitoring, treatments, procedures), physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure. Some of the criteria in N. PSYCHIATRIC has been modified or added (bolded and italicized text) from the original TMF criteria, for use in the Medicaid program.

Both discharge screens and Centers For Medicare and Medicaid Services (CMS) Generic Quality Screens are used in determining a patient's stability for discharge. Discharge screens are included in each admission criteria set (treatment element). The screens will be compared to the patient's condition at discharge. If the discharge screens are not met, a referral for a physician review may be made to determine the patient's medical stability at discharge. The CMS Generic Quality Screens are also applied during the review. If the Generic Quality Screens are failed, the patient may be considered not stable for discharge, even when meeting discharge screens.

Pediatric Elements

Certain screening criteria elements have been designated as pediatric. These criteria are in bold, unitalicized text. The age range for the use of pediatric criteria elements is 0-17 years. Any criteria element may be used to approve a pediatric admission; however, the pediatric elements should be used when applicable. Pediatric screening elements cannot be applied to adult patients.

Geriatric Elements

Some criteria are designated as geriatric. The age range for the use of geriatric criteria elements is 65 years of age or older. Any criteria element may be used to approve a geriatric admission; however, the geriatric elements should be used when applicable. Geriatric screening elements cannot be applied to pediatric patients.

Outpatient Observation

Some patients, while not requiring hospital admission, may require a period of observation (less than 24 hours) in the hospital environment as an outpatient while the physician evaluates the patient to determine the need for inpatient admission, or when the physician has reason to believe that the patient will respond rapidly to treatment (within 24 hours). Observation services may be provided in any part of the hospital where a patient can be assessed, examined, monitored, or treated.

In the Texas Medicaid program, observation room charges are considered as outpatient room charges. Hospitals may bill medically necessary services provided during the period of observation as outpatient services (type of bill 131).

To receive reimbursement for services that are medically indicated and exceed the 24-hour period from the initial point of contact with the hospital, the claim may be submitted as an inpatient stay. The admission date for the inpatient stay is the date the client was placed in observation. It is important to realize that any inpatient stay billed to the Texas Medicaid program is subject to retrospective utilization review with the possibility for denial if the admission is determined not medically necessary. If the inpatient admission is denied as not medically necessary, services rendered during the first 23 hours (less than 24 hours) may be re-billed to the claims administrator as an outpatient claim, according to instructions noted in the admission denial letter, if the physician's order for outpatient observation is present in the hospital medical record.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA)
PHYSICAL STATUS CLASSIFICATION SYSTEM

The American Society of Anesthesiologists (ASA) Physical Status Classification System was designed to describe a patient's current health status as an important factor in assessing overall preoperative risk. The ASA rating system considers the various organ systems. The ASA classification system has six categories. The patient is placed in a higher category for each additional malfunctioning organ system.

Class	Description	Examples
1	**A normal, healthy patient**, without organic, physiologic or psychiatric disturbance	Healthy patient with good exercise tolerance
2	**A patient with mild systemic disease**, controlled medical conditions without significant systemic effects	Controlled hypertension, controlled diabetes mellitus without system effects, cigarette smoking without evidence of COPD, anemia, mild obesity, age less than 1 or greater than 70 years, pregnancy
3	**A patient with severe systemic disease**, having medical conditions with significant systemic effects intermittently associated with significant functional compromise	Controlled CHF, stable angina, old MI, poorly controlled hypertension, morbid obesity, bronchospastic disease with intermittent symptoms, chronic renal failure
4	**A patient with severe systemic disease that is a constant threat to life**, having medical conditions that are poorly controlled, associated with significant dysfunction or incapacity	Unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure
5	**A moribund patient who is not expected to survive without the surgical procedure**	Multiorgan failure, sepsis syndrome with hemodynamic instability, profound hypothermia, poorly controlled coagulopathy
6	**A patient declared brain-dead whose organs are being removed for donor purposes**	
E	This modifier is added to any of the above classes to signify a procedure that is being performed as an emergency and may be associated with a suboptimal opportunity for risk modification	

Source: *American Society of Anesthesiologists Relative Values Guide, 1999.*
Anesthesia Guidelines

CLASSIFICATION OF FUNCTIONAL CAPACITY AND OBJECTIVE ASSESSMENT OF PATIENTS WITH HEART DISEASE

Functional Capacity

Class I — Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain.

Class II — Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain.

Class III — Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.

Class IV — Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Objective Assessment

A. No objective evidence of cardiovascular disease

B. Objective evidence of minimal cardiovascular disease

C. Objective evidence of moderately severe cardiovascular disease

D. Objective evidence of severe cardiovascular disease

Example:

A patient with minimal or no symptoms but a large pressure gradient across the aortic valve or severe obstruction of the left main coronary artery is classified:

Function Capacity I, Objective Assessment D

A patient with severe anginal syndrome but angiographically normal coronary arteries is classified:

Function Capacity IV, Objective Assessment A

A patient with acute myocardial infarction, shock, reduced cardiac output, and elevated pulmonary artery wedge pressure is classified:

Function Capacity IV, Objective Assessment D

A patient with mitral valve stenosis, moderate exertional dyspnea, and moderate reduction in mitral valve area is classified:

Function Capacity II or III, Objective Assessment C

Source: *Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels (Little, Brown & Co.). Ninth Edition.*
Definition revised by the American Heart Association & the New York Heart Association, March 4, 1994.

ADMISSION CRITERIA SETS
FOR ACUTE HOSPITALIZATION

Indications for Hospitalization

Treatments

Discharge Screens

A. GENERAL
Indications for Hospitalization

Laboratory-blood

01. Serum sodium < 130 mEq/L or > 150 mEq/L
02. Serum potassium
    Adult: < 3.0 mEq/L or > 6.0 mEq/L
    Pediatric: < 2.5 mEq/L or > 5.5 mEq/L
03. Serum calcium
    Adult: < 7.5 mg/dL or > 12.0 mg/dL
    Pediatric: < 7.0 mg/dL (for ionized calcium values see newborn criteria)
04. Serum bilirubin
    Adult: > 2.5 mg/dL
    Pediatric: > 15.0 mg/dL indirect or total bilirubin
05. CO_2 combining power shows non-compensated acidosis/alkalosis by arterial blood gas documenting either HCO_3 < 20 mEq/L or > 36 mEq/L or $PaCO_2$ < 30 mmHg or > 50 mmHg
06. Arterial blood pH < 7.30 or > 7.55 (identified within the last 48 hours)
07. Hemoglobin (Hgb) 10 g/dL or less with active bleeding or a 3 g/dL drop from baseline
08. Toxic drug level as evidenced by laboratory report
09. White blood count < 3,000 μ/L or > 16,000 μ/L
10. Hemoglobin (Hgb) < 9 g/dL or > 20 g/dL with signs of volume depletion
11. Hematocrit (Hct) < 24% or > 55%
12. Positive blood culture
13. **Pediatric: Metabolic acidosis with venous lactate level ≥ 2 mEq/L**

Functional impairment (identified within last 72 hours)

14. Unconsciousness
15. Disorientation
16. Delirium
17. Motor function loss--any body part
18. Loss of sensation--any body part
19. Severe articular restriction and somatic dysfunction
20. Change in mental status from baseline or an abrupt deterioration over previous functional level
21.* Fall with inability to ambulate, in a previously ambulatory person

Physical findings

22. Penetrating wounds
23. Continuous hemorrhage from any site
24. Wound disruption (requiring closure)
25. Dehiscence/evisceration
26. Seizures uncontrolled by medication
27. Congenital abnormality admitted for surgical intervention requiring hospitalization
28. Documentation of malignancy and admitted for treatment requiring hospitalization
29. Generalized edema
30. Clinical signs of dehydration to include two or more of the following: altered mental status, lethargy, light-headedness, syncope, decreased skin turgor, dry mucous membranes, tachycardia, or orthostatic hypotension
    Pediatric: Other symptoms of dehydration including sunken eyes or fontanels, weight loss > 5% and/or decreased urine output ≤ 1ml/kg/hr

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

Pediatric:

31. Present or potential respiratory depression

32.* Observation for head trauma

33. Vomiting and/or diarrhea with dehydration

34. Shock or potential shock

Vital signs (taken at rest)

35. Temperature:

Adult: > 101° F (38.3° C) oral temperature with white blood count (WBC) > 12,000 μ/L or hypothermia with a core temperature < 95° F (35° C)

Pediatric values reflect rectal or tympanic temperature readings. To convert rectal temperatures to an oral value, subtract one degree.

Pediatric:	**< 8 weeks**	**≥ 100.4° F (38.0° C)**
	8 weeks - 1 year	**≥ 101° F (38.3° C)**
	> 1 year - 3 years	**≥ 102° F (38.9° C) with WBC > 15,000μ/L**
	> 3 years - 17 years	**≥ 104° F (40° C) with WBC > 16,000μ/L**

36. Pulse: beats per minute (bpm)

Adult: < 50 bpm (with symptoms if sinus rhythm) or > 120 bpm

Geriatric: < 50 bpm and symptomatic or > 100 bpm

Pediatric:	**< 6 weeks**	**< 80 or > 200 bpm**
	6 weeks - 1 year	**< 70 or > 180 bpm**
	> 1 year - 3 years	**< 60 or > 170 bpm**
	> 3 years - 12 years	**< 60 or > 160 bpm**
	> 12 years - 17 years	**< 50 or > 140 bpm**

37. Respirations:

Adult/Geriatric: < 10 or > 30/minute

Pediatric:	**Newborn (first 12 days of life)**	**≥ 60/minute sustained or Pa O_2 < 50 mmHg on room air with O_2 saturation < 90%**
	> 12 days - 1 year	**< 25 or > 60/minute**
	> 1 year - 3 years	**< 15 or > 40/minute**
	> 3 years - 12 years	**< 15 or > 40/minute**
	> 12 years - 17 years	**< 12 or > 30/minute**

*****Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

38.	Blood pressure:	Systolic (mmHg)	Diastolic (mmHg)
	Adult:	< 80 or > 200	> 120
	Geriatric:	< 100 or > 180 with symptoms	> 120
	Pediatric:		
	birth to 1 year	**< 65 or > 100**	**< 30 or > 65**
	> 1 year – 3 years	**< 75 or > 110**	**< 45 or > 75**
	> 3 years – 6 years	**< 80 or > 115**	**< 50 or > 80**
	> 6 years – 12 years	**< 80 or > 130**	**< 50 or > 90**
	> 12 years – 17 years	**< 80 or > 170**	**< 50 or > 100**

Related areas

39. Suspected or known ingestion of a toxic substance with potentially serious side effects

Pediatric:

40. Suspected or proven child abuse/neglect
41. Failure to thrive
42. Suspected or known ingestion of foreign body
43. Suspected apnea > 20 seconds (0 - 1 years)

Other

44. Admitted for surgical procedure which required hospitalization (indication for the surgery is documented)
45. Admitted for day surgery procedure (indication for procedure is documented) and patient has American Society of Anesthesiologists (ASA) Classification of Physical Status of III, IV, or V, or Classification of Heart Disease III or IV

NOTE: See pages v and vi of this criteria manual for further information on ASA and AHA classification and status.

Monitoring

51.* Continuous electronic monitoring/telemetry
NOTE: Does not include Holter-monitor. Pediatric patients may appropriately be on continuous monitoring in a non-critical care setting.

52.* Apnea monitoring

The following criteria (53-59) must be performed for two consecutive days with documented indication for monitoring:

53.	EKG	54.	Drug levels	55.	Blood gases
56.	Enzyme levels	57.	Electrolytes	58.	Hemoglobin/hematocrit levels
59.	Seizure precautions				

Medications

60. Intravenously (IV) administered medications at least two times daily or one time daily for IV antibiotics with one time daily recommended dosage
61. IV fluid with KCl (only if patient is hypokalemic and unable to take po meds):
    Adult - K^+ 3.0 mEq/L or less
    Pediatric - K^+ 2.5 mEq/L or less
62. Hypertonic saline (3% or 5% solution)

Procedures

Adult

63.* Invasive procedure performed with general or regional (excluding local anesthesia) and requiring post-procedure observations for documented actual or suspected complications (Observations must be documented)

Pediatric:

64. Invasive procedure performed on an infant or a child that requires sedation, pre-procedure stabilization or preparation, or post-procedure observation that cannot be performed in an outpatient setting (e.g., cardiac cath, angiogram, lymph angiogram, MRI, or CAT)

Treatments

65. Hyperalimentation other than maintenance (for neonatal or oncology patients see specific criteria sections L and O)

Pediatric:

66. Treatment for failure to thrive to include all of the following
- **a. Daily weight**
- **b. Documentation of intake**
- **c. Documentation of mother/child interaction**

67. Reverse/protective isolation and/or isolette for isolation purposes

Other

68.* Documented social services intervention (e.g., home evaluation, foster home placement, etc.)

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

Vital signs

100. Vital signs within the following limits for age for 24 hours prior to discharge or an abnormal reading within 24 hours, followed by a subsequent normal reading

Temperature (all ages):	Oral	< 101° F (38.3° C)
	Rectal	< 102° F (38.9° C)

Blood pressure:	Systolic (mmHg)	Diastolic (mmHg)
Adult/Geriatric:	85-180	50-110

Pediatric:

birth to 1 year	**65 - 100**	**30 - 65**
> 1 year – 3 years	**75 - 110**	**50 - 70**
> 3 years – 6 years	**80 - 120**	**50 - 80**
> 6 years – 12 years	**90 - 130**	**60 - 80**
> 12 years – 17 years	**80 - 140**	**70 - 85**

Pulse: beats per minute (bpm)

Adult/Geriatric: 50-120 bpm (> 45 if the patient is on a beta blocker)

Pediatric:

≤ 1 year	**80-160 bpm**
> 1 year - 3 years	**80-130 bpm**
> 3 years - 6 years	**70-120 bpm**
> 6 years - 12 years	**70-110 bpm**
>12 years - 17 years	**50-105 bpm**

Respirations: per minute

Adult/Geriatric: 12-30

Pediatric:

≤ 1 year	**30-50**
> 1 year - 3 years	**20-40**
> 3 years - 12 years	**15-30**
> 12 years - 17 years	**12-25**

Patient education

101. Patient and/or family competent for care, patient having received maximum benefits of education in hospital

Functional

102. Prescribed diet tolerated for last 12 hours prior to discharge without nausea/vomiting, excluding chemotherapy patients
103. Self-initiated and self-effected activities of daily living or documented provision for such in an alternate setting
104. Voiding or draining urine without difficulty for last 12 hours or arrangements have been made for drainage of urine, voiding activities in an alternative setting, or hemodialysis/continuous ambulatory peritoneal dialysis (CAPD)
105. Parenteral analgesic administration not to exceed one dose within 3 hours prior to discharge, excluding patients expected to require regular analgesic administration for a persistent condition

Pediatric:

106. Infant has grown or shown a steady weight gain on po or tube feedings
107. Infant has demonstrated good sucking mechanism
108. Infant able to maintain body temperature in an open crib
109. No apnea for 24 hours
110. Responsible caretaker demonstrates ability to care for infant/child

B. BLOOD
Indications for Hospitalization

Laboratory (identified within last 72 hours)

01. Hemoglobin (Hgb) < 9 g/dL or > 20 g/dL if patient is symptomatic
02. Hematocrit (Hct) < 24% or > 55% if symptomatic
03. WBC < 3,000 μ/L or > 16,000 μ/L
04. Platelet count < 40,000/mm^3 or > 1.0 million/mm^3 if patient is symptomatic (including petechiae or ecchymosis in children)
05. INR > 10 with active bleeding
06. PT > 18 seconds with bleeding in patients not on Coumadin
07. Positive blood culture
08. Temperature $\geq$ 100° F (37.8° C) with absolute neutrophil count $\leq$ 500 μ/l

Physical findings

09. Acute occlusion of vessel
10. Active uncontrolled bleeding
11. Incapacitating joint pain or abdominal pain
12. Bleeding into joint, viscus, brain, or retroperitoneum

Other

13. Patients on oral anticoagulants who require invasive procedures and must be switched from an oral agent to heparin pre-operatively if this cannot be accomplished in the outpatient setting

B. BLOOD
Treatment

Medications

51. Initiation of oral anticoagulation therapy (Coumadin, warfarin sodium)
52. Parenteral anticoagulation therapy (heparin) with monitoring of PTT level
53. Active treatment of an acute condition with dalteparin or enoxaparin (not valid for prophylactic treatment)
54. High dose oral or parenteral analgesics for sickle cell crisis

Treatments

55. Reverse/protective isolation and/or isolette for isolation purposes
56. Multiple blood/component transfusions, > two units within a 24-hour period, or > 2 units during hospital stay for patients with a medical condition contraindicating > 2 units within 24 hours (e.g., CHF, chronic renal failure)
    Pediatric: ≥ 10 cc packed red blood cells/kg
57. Cytopheresis for WBC > 100,000 μ/L if symptomatic
58. Apheresis or plasma pheresis for hyperviscosity associated with abnormal proteins; for TTP; or for platelets > 1 million/mm^3 associated with vascular occlusive symptoms

Discharge Screens

100. No evidence of bleeding for 24 hours
101. INR controlled or plans for follow-up as outpatient

C. CARDIOVASCULAR
Indications for Hospitalization

Laboratory - blood

01. CPK above normal range and associated with abnormal EKG
02. LDH above normal range and associated with abnormal EKG
03. PaO_2 < 60 mmHg
04. Elevated Troponin I or Troponin T level
05. Elevated CK-MB
06. Elevated CPK and LDH with non-specific EKG changes

Clinical studies

07. EKG diagnostic or probable for acute myocardial infarction/acute myocardial ischemia
08. Nonspecific EKG findings with elevated acute myocardial injury enzymes (e.g., Troponin I and/or CK-MB)

EKG, telemetry or ambulatory monitoring (Holter monitor) evidence of (initial onset within last 72 hours):

09. Fibrillation < 24 hours or poorly controlled rate
10. Flutter < 24 hours or poorly controlled rate
11. Bradycardia (< 50 beats per minute [< 45 if patient is on beta-blocker])
12. Tachycardia (> 120 beats per minute)
13. Dysrhythmia producing a rate > 120/min
14. New onset of junctional rhythm any rate
15. Abnormal function of pacemaker not correctable by reprogramming
16. EKG with 3rd degree AV block

Radiology

17. Aneurysm of great vessels if symptomatic and/or > 5 cm
18. Radiological evidence of massive cardiac enlargement/aneurysm or pericardial effusion
19. Radiological evidence of pulmonary edema or pulmonary vascular redistribution

Physical findings

20. Acute cardiac-related pain/pressure
21. Acute dyspnea/respiratory rate over 30 per minute
22. Acute absence of pulse at axilla, wrist, elbow, groin, knee, or ankle
23. Suspicion of pulmonary embolism, by history (documented by physician)
24. Acute occlusion of vessel
25. 4+ pre-tibial edema
26. Malfunction of pacemaker or implanted cardioverter/defibrillator
27. Carotid artery stenosis, narrowing, or disease, with symptoms (e.g., transient speech dysfunction, dysarthria, gait disturbance, amaurosis fugax, transient hemiparesis)
28. Generalized edema
29. Syncope
30. Orthopnea

Other

31. Admitted for acute congestive heart failure or exacerbation of chronic CHF as evidenced by one of the following: S_3 gallop rhythm; pulmonary edema or pleural effusion; distended neck veins; use of accessory muscles; persistent symptoms of dyspnea or weakness; or edema unresponsive to ambulatory management

Pediatric:

32. Admitted for preprocedure stabilization or post procedure observation for cardiac catheterization or arteriogram

33. Congenital cardiac malformations associated with cardiorespiratory instability

34. Cardiac transplant complications of rejection crisis, hypertension and infection

C. CARDIOVASCULAR
Treatment

Monitoring

51.* Continuous electronic monitoring/telemetry
NOTE: Does not include Holter-monitor. Pediatric patients may appropriately be on continuous monitoring in a non-critical care setting.

52.* Intravascular pressure monitoring

53.* Serial cardiac enzymes (q 8-12 hours or daily x 3) and EKGs

Medications

54. Initial antiarrhythmic medications
55. Initial anticoagulation medications (Coumadin, heparin, warfarin sodium)
56. Parenteral antiarrhythmic medications
57. Parenteral digitalization
58. Initial antihypertensive medication (parenteral or sublingual)
59. Parenteral diuretic therapy
60. Parenteral pressor therapy for CHF or hypertension
61. Parenteral antianginal medications

Procedures

62. Enzymatic clot dissolution (e.g., Streptokinase)
63. Cardioversion, performed on an urgent basis for a new onset arrhythmia

Pediatric:

64. Cardiac catheterization
65. Coronary angiogram
66. Aortogram
67. Arteriogram
68. Angiographic placement of stents and obstructive devices

Treatments

69. Circulatory assistance (e.g., Intra-Aortic Pump) device in use
70. Left or right ventricular assist device

Pediatric:

71. Extracorporeal membrane oxygenation (ECMO)/heart-lung machine

Discharge Screens

100. Documented evidence of controlled chest pain after 2 days of appropriate activity as indicated for this patient (e.g., ambulatory if patient is capable)
101. No further progression of EKG changes and/or serial acute cardiac injury enzymes normal or decreasing for 24 hours
102. Prothrombin time controlled or plans for follow-up as outpatient
103. No intravenous antiarrhythmic drugs for last 24 hours
104. Vital signs stable for age for last 24 hours

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

D. CENTRAL NERVOUS SYSTEM/HEAD
Indications for Hospitalization

Laboratory - spinal fluid

01. Elevated spinal fluid pressure (> 200 mm/H_2O)
02. Spinal fluid positive for five or more white blood cells
03. Red blood cells consistent with subarachnoid hemorrhage and/or unexplained xanthochromia (yellow discoloration of spinal fluid)
04. Pathogens in spinal fluid
05. Spinal fluid sugar < 40 mg/dL or 40% of concurrent blood sugar
06. Malignant cells in spinal fluid

Radiology (identified within last 72 hours)

07. Skull x-ray reveals new fracture
08. Space-occupying lesion
09. Block of ventricular system
10. Infarction or hemorrhage demonstrated on CAT scan or magnetic resonance imaging, or stenosis or occlusion of a vessel demonstrated by ultrasound or angiogram
11. Acute herniated intervertebral disc with debilitating pain and/or neurologic signs
12. Confirmation of spinal cord compression with associated clinical findings

Physical findings suggestive of increased intracranial pressure, hemorrhage, or structural deformity as evidenced by:

13. Spinal fluid discharge from ear or nose
14. Unequal or fixed pupils
15. Papilledema
16. Recent onset or increased seizure activity resulting in an unstable condition
17. Vomiting
18. Increased blood pressure (reference general criteria for parameters)
19. Altered level of consciousness or acute change in behavior
20. Syncope
21. Cardiac arrhythmia
22. Language dysfunction
23. Visual disturbance (blurred vision or diplopia)
24. Sensory, motor, personality, or mental deficit
25. Acute ataxia (with or without vertigo, nausea, or vomiting)
26. Episodes of sudden loss of consciousness
27. Acute onset of intractable headaches with changes in mentation
28. Increased or decreased muscle tone or focal weakness
29. Bulging fontanelle
30. Acute or semi-acute onset of motor weakness with or without pain or paresthesias (e.g., myasthenia gravis, Guillian-Barre syndrome, congenital neurologic disorders, etc.)
31. Acute urinary retention
32. Lethargy or confusion of acute onset that is progressive

Pediatric (any of the indications listed above and/or):

33. Rapidly increasing head size
34. Presence of any focal neurologic finding (i.e., extra ocular movement [EOM] deficits)
35. Prematurely closed sutures of skull
36. Widening of sutures of skull

D. CENTRAL NERVOUS SYSTEM/HEAD
Treatment

Monitoring

51.* Neurological status (pupil reaction/size, orientation to time/place, motor or sensory deficit) at least every four hours
52. Intracranial pressure monitoring
53.* Seizure precautions, with seizure within last 12 hours

Medications

54. Adjustment of anticonvulsant medication for recent and intractable seizures
55. Parenteral steroids with monitoring requirement (as described in 51-53)
56. Parenteral anticoagulants with monitoring of PTT
57. Thrombolytic administration/therapy requiring monitoring

Procedures

58.* Ventriculogram
59. Intubation and hyperventilation in cases of acute increased intracranial pressure
60.* Gamma radiosurgery/stereotactic focused proton beam
61. Pallidotomy for movement disorder
62.* Vagal stimulation
63.* Baclofen pump placement and trial
64. Laminectomy, discectomy and fusion procedure
65. Craniotomy
66. Burr holes for hematoma drainage
67. Brain biopsy

Pediatric:
68. Arteriogram

Discharge Screens

100. Adult - No seizures for 48 hours
Pediatric - No seizures for 48-72 hours
101. Stabilization of neurologic status
102. Anticoagulants and/or other medications are adequately adjusted and regulated

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

E. EAR, NOSE, THROAT
Indications for Hospitalization

Physical findings

01. Acute trauma requiring surgical reconstruction

Ear

02. Incapacitating vertigo
03. Purulent drainage and/or post auricular swelling with documentation of failed outpatient management
04. Acute extreme swelling of the external auditory canal or auricle not resolved by outpatient treatment
05. Acute sudden sensorineural hearing loss

Nose

06. Epistaxis with persistent bleeding and failure of outpatient treatment

Throat

07. Acute trauma to neck or throat (including facial burns) requiring observation for possible airway compromise
08. Acute laryngeal or pharyngeal obstruction (e.g., peritonsillar abscess)

Related areas

09. Soft tissue swelling which compromises the airway (e.g., cellulitis of face and neck, deep neck abscess, acute parotiditis)
10. Acute ophthalmoplegia or orbital edema

Radiology

11. Radiologic evidence of acute mastoiditis

E. EAR, NOSE, THROAT
Treatment

Treatment

51. Initial tracheostomy care
52. Control of epistaxis by operative or other procedures
53. Implantation of radioactive materials requiring isolation or observation for side effects
54. Endotracheal intubation

Discharge Screens

100. No evidence of new bleeding for 12 hours after packing removed
101. Tolerating p.o. feedings for last 12 hours without nausea/vomiting or feeding causing threat to incisions
102. Patient or significant other person demonstrates ability to clean and care for tracheostomy

F. ENDOCRINE/METABOLIC
Indications for Hospitalization

Laboratory - blood

Abnormal endocrine/metabolic laboratory studies:

01. Adult: Serum calcium < 7.5 mg/dL or > 12.0 mg/dL (without significant increase in albumin)

Pediatric:

Ionized calcium	**mmol/L**
0 - 1 months	**< 0.9 or > 1.45**
1 - 6 months	**< 0.95 or > 1.50**
> 6 months	**< 1.10 or > 1.30**

02. Serum acetone present and pH < 7.35
03. Serum cortisol > 3 times lab normal or less than normal
04. Non-fasting blood sugar < 50 mg/dL with altered mental status or
or > 300 mg/dL with serum osmolality > 295
05. Adult: Blood sugar > 500 mg/dL with at least one of the following:
    a. BUN > 45 mg/dL and/or creatinine > 3.0 mg/dL
    b. change in mental status

OR

Blood sugar of > 250 associated with:
a. arterial pH < 7.35 and HCO_3 < 18 mEq/L and
b. ketonuria

OR

Blood sugar < 50 mg/dL with:
a. Change in mental status, and
b. Unresponsive to glucose 50% bolus and on insulin, or
c. On an oral agent regardless of response to glucose bolus

Pediatric: **Blood sugar > 250 mg/dL with at least one of the following:**
a. ketonuria
b. arterial pH < 7.3
c. HCO_3 <15 mEq/L

OR

Blood sugar < 50 mg/dL and unresponsive to glucose 50% bolus

06. HgbA1C > 12% with documentation of failed outpatient management
07. Significantly increasing ACTH level, documented by physician from laboratory evaluation
08. Significantly decreasing ACTH level, documented by physician from laboratory evaluation
09. T-4 < 2 or > 16 mcg/dL with significant or serious symptoms
10. Decreasing ADH with polyuria
11. PaO_2 < 60 mmHg
12. Hyper or hypo-osmolarity (serum sodium < 130 mEq/L or > 150 mEq/L)

Laboratory - urine

13. Vanillylmandelic acid (VMA) > 9 mg (24 hour urine) diagnostic for adrenal tumor producing hypertension

Pediatric:

14. Presence of acetone in urine

Physical findings

15. Thyroid mass compressing trachea
16. Thyroid crisis
17. Tetany
18. Newly diagnosed adrenal, pancreatic, or pituitary mass, or patient admitted for definitive treatment of a known adrenal, pancreatic, or pituitary mass
19. Malignant exophthalmos
20. Morbid obesity with cyanosis, edema, lethargy, and/or sleep apnea

21. Hypertension

Adult:

Systolic > 200 mmHg, or diastolic > 120 mmHg

Pediatric:

	Systolic (mmHg)	**Diastolic (mmHg)**
birth to 1 year	**< 65 or > 100**	**< 30 or > 65**
> 1 year – 3 years	**< 75 or > 110**	**< 45 or > 75**
> 3 years – 6 years	**< 80 or > 115**	**< 50 or > 80**
> 6 years – 12 years	**< 80 or > 130**	**< 50 or > 90**
> 12 years – 17 years	**< 80 or > 170**	**< 50 or > 100**

F. ENDOCRINE/METABOLIC
Treatment

Monitoring

51.* Continuous electronic monitoring/telemetry
NOTE: Does not include Holter-monitor. Pediatric patients may appropriately be on continuous monitoring in a non-critical care setting.

52.* Blood pressure monitored every two hours for a minimum of eight hours

Monitoring of metabolic/endocrine laboratory parameters:

53. Serum calcium daily
54. ACTH every 3 days
55. Blood sugars at least 2 times per day

Medications

56. Initial parenteral insulin
57. Insulin adjustment with blood sugars monitored morning and night, or > 2 times/day
58. Initial parenteral or sublingual medication for treatment of hypertension
59. Parenteral medications for treatment of renal dysfunction (e.g., diuretics, glucose and insulin, hypertonic sodium bicarbonate, etc.)

Pediatric:

60. Initiation and continuing parenteral therapy for hypertension

Treatments

61. Radioisotope with danger to patient, danger to others, or observation for side effects
62. Initiation of treatment for hypertension

Other

63.* Requires observation by hospital personnel for Regitine or vasopressin treatment, insulin tolerance test, metapyrone or dexamethasone suppression tests

Discharge Screens

100. No change in dosage or types of insulin for 12 hours, unless documentation reflects planned outpatient follow-up
101. No change in steroid therapy for 12 hours or patient receiving prescribed tapered dose of steroids
102. Blood calcium within acceptable range for last 12 hours
103. Blood sugar in acceptable range for 24 hours
104. Blood pressure controlled for 24 hours
105. Symptoms stabilized for 12 hours
106. Patient or significant other demonstrates ability to administer correct dose of insulin

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

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Physical findings

01. Acute loss of sight
02. Anterior chamber flat
03. Acute angle closure glaucoma with documentation of failed outpatient treatment
04. Penetration or laceration of eyeball
05. Severe corneal ulcer with documentation of failed outpatient treatment
06. Endophthalmitis
07. Severe ocular pain
08. Retinal detachment or threatened detachment
09. Presence of intraocular or intraorbital foreign body
10. Gonorrheal conjunctivitis
11. Orbital fracture
12. Acute swelling of the globe
13. Acute chemical burn
14. Orbital or periorbital cellulitis

Pediatric:

15. Severe purulent conjunctivitis in a child 0 - 3 months of age

Other

16. Admit for cataract extraction, glaucoma filtering operation, or surgical iridectomy, when one of the following is documented:

    a. Legally blind (< 20/200 or < 20° visual field) in the non-operated eye
    b. History of post-operative complications (endophthalmitis, acute glaucoma, massive Intraocular hemorrhage) sustained in the past in the eye undergoing subsequent intraocular surgery

Pediatric:

17. Evaluation of intraocular or extraocular tumor
18. Procedures related to retinopathy of prematurity

G. EYE
Treatment

Treatments

51. Eye drops requiring instillation and/or observation by hospital personnel
52. Frequent ocular monitoring (e.g., pressure measurements with expandable gases)
53. Positioning requirements such as face-down posturing

Discharge Screens

100. Intraocular pressure < 24 mmHg for 24 hours
101. Improving status of intraocular or extraocular inflammation/infection
102. Absence of remediable ocular abnormality that could be treated surgically or that requires hospitalization for specified reasons

H. FEMALE REPRODUCTIVE
Indications for Hospitalization

Diagnosed pregnancy with any one of the following:

01. Uterine contractions every 15 minutes or more often
02. Vaginal bleeding
03. Diastolic blood pressure elevated to > 15 mmHg over recorded normal or > 140/90 mmHg
04. Urine positive for protein
05. Abdominal tenderness or rigidity
06. Leakage of amniotic fluid
07. Protrusion of fetal part from cervix
08. Fetal distress
09. Post-maturity (> 1 week past estimated date of confinement)
10. Admitted for Cesarean section
11. Uncontrolled vomiting with documentation of failed of outpatient management
12. Intrauterine death
13. Premature labor
14. Fasting blood sugar > 120 mg/dl
15. Blood sugar > 200 mg/dl after two hours on a three hour glucose tolerance test
16. Blood sugar > 200 mg/dl one hour after taking 50gm of Glucola
17. Known diabetic or gestational diabetic on insulin who is unable to maintain blood glucose levels within an acceptable range, with documentation of failed outpatient management
18. Admitted for intrauterine exchange transfusion for Rh factor incompatibility
19. Admitted for induction of labor for medical indications
20. Maternal dehydration

Physical findings

21. Profuse vaginal bleeding with hemodynamic instability
22. Postmenopausal bleeding
23. Persistent pelvic inflammation with documentation of failed outpatient management
24. Postpartum hemorrhage
25. Postpartum fever or endometritis requiring IV antibiotics
26. Rectovaginal fistula, admitted for repair

Pelvic pain associated with one of the following elements (27-32):

27. Pelvic mass
28. Vomiting
29. Temperature > 101° F (38.3° C)
30. Palpable extrauterine mass
31. Inability to void
32. Urinary obstruction

Other

33. Delivery prior to hospitalization
34. Peritonitis
35. Post partum mastitis that is unresponsive to outpatient treatment

H. FEMALE REPRODUCTIVE
Treatment

Monitoring

51. Internal fetal monitoring
52. Continuous or intermittent external fetal monitoring, or every 30 min per fetoscope with documented need for monitoring for more than 23 hours and 59 minutes
53. Monitoring of blood sugar (at least two times daily)

Medications

54. Cervical ripening with prostaglandin or parenteral medication for induction of labor (e.g., Pitocin)
55. Control of toxemia/eclampsia (e.g., antihypertensives, anticonvulsant)
56. Medication for premature labor (e.g., terbutaline sulfate)
57. Adjustment of insulin

Procedures

58. Normal delivery
59. Cesarean section
60.* Invasive fetal procedures
61.* Postpartum care following delivery outside of hospital
62.* Cervical cerclage
63. Attempted external version-fetal

Treatments

64. Implantation of radioactive materials requiring isolation or observation for side effects
65. Blood transfusion at least 2 units/24 hours

Discharge Screens

100. No unusual bleeding for last 12 hours
101. Absence of contractions for 4 hours as documented by fetal monitor
102. No change in cervix for 4 hours in cases of premature labor
103. Parenteral analgesic administration not to exceed one dose within 3 hours prior to discharge, excluding patients expected to require regular analgesic administration for a persistent condition
104. Blood sugars within an acceptable range x 24 hours

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

I. GASTROINTESTINAL/ABDOMEN
Indications for Hospitalization

Laboratory-blood

01. Serum bilirubin > 2.5 mg/dL (unless chronically abnormal)
    NOTE: See Newborn and Premature criteria for bilirubin values specific to newborns.
02. Serum amylase above lab normal range
03. Serum calcium < 7.5 mg/dL or > 12 mg/dL

Radiology

04. Imaging studies suggestive of mass, obstruction, perforation, abscess, or other acute process
05. Failure of passage of contrast material

Physical findings

06. Blood in vomitus or gastric aspirate
07. Blood in peritoneal lavage/aspiration
08. Unexplained palpable abdominal mass
09. Abdominal rigidity
10. Rebound tenderness
11. Progressive acute or subacute dysphagia
12. Lower GI bleed with Hematocrit (Hct) < 30% or 10 mmHg drop in systolic BP from baseline
13. Acute onset (within last 24 hours) of encephalopathy or altered mental status
14. Incarcerated hernia
15. Ileus
16. Suspicion of ruptured organ
17. Esophageal obstruction
18. Asterixis (liver flap)
19. Ascites
20. Incapacitating, acute abdominal pain (NPO, non-ambulatory)

History of 48 hour vomiting, diarrhea, anorexia, and any one of the following elements (21-26):

21. Serum sodium above 150 mEq/L
22. Hematocrit (Hct) above 55%
23. Hemoglobin (Hgb) above 20 g/dL
24. Urine specific gravity above 1.026
25. BUN above 30 mg/dL, excluding patients with chronic renal disease
26. Creatinine above 1.5 mg/dL, excluding patients with chronic renal disease

Pediatric:

27. Congenital malformations of the intestinal tract or abdominal wall
28. Suspected biliary atresia
29. Dehydration with any of the following symptoms: sunken eyes, sunken fontanels, decreased skin turgor or dry mucous membranes accompanied by lethargy and/or weight loss > 5% urine output ≤ 1 ml/kg/hr
30. Admit for liver biopsy

Other

31.* Presence of ostomy, admitted for revision or closure

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

I. GASTROINTESTINAL/ABDOMEN
Treatment

Medications

51. Parenteral antiemetic or anti-nausea medications at least two times daily
52. Parenteral replacement of fluids/electrolytes with evidence of dehydration (clinical signs or laboratory values), or patient is NPO
53. Parenteral analgesics 2 times per day

Pediatric:

54. Dehydration requiring oral or parenteral fluid/electrolyte replacement therapy

Procedures

55.* Repair incarcerated hernia
56.* Laparotomy
57.* Sclerotherapy of varices
58.* Transhepatic cholangiogram
59.* Colonoscopy for reduction of sigmoid volvulus

Pediatric:

60. Angiogram
61. Liver biopsy
62. Esophageal pH studies (24 hours)

Treatments

63. Gastric or intestinal intubation for drainage or initial feeding
64. Hyperalimentation/total parenteral nutrition (TPN) other than maintenance
NOTE: For neonatal or oncology patients see specific criteria sections L and O

Discharge Screens

100. No purulent, bloody, or substantially increased drainage, increased swelling, heat, or redness of post-operative wound within 24 hours prior to discharge
101. Patient or significant other person able to clean and care for stoma and appliance, feeding tube or drainage tube
102. No evidence of new bleeding for 12 hours
103. Parenteral analgesic administration not to exceed one dose within 3 hours prior to discharge, excluding patients expected to require regular analgesic administration for a persistent condition
104. No signs of dehydration documented
105. Prescribed diet tolerated for 12 hours prior to discharge without nausea/vomiting, excluding chemotherapy patients

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

J. MALE REPRODUCTIVE
Indications for Hospitalization

Physical findings

01. Acute onset of severe testicular pain
02. Unexplained testicular mass
03. Painful sustained erection
04. Blunt trauma to and/or acute loss of a portion of external genitalia

Pediatric:

05. Torsion of testes

Treatment

Treatments

51. Penile corporal irrigation or shunting procedure
52.* Observation of/for swelling or hemorrhage

Discharge Screens

100. Stable clinical condition
101. Parenteral analgesic administration not to exceed one dose within 3 hours prior to discharge, excluding patients expected to require regular analgesic administration for a persistent condition

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

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K. MUSCULOSKELETAL/SPINE
Indications for Hospitalization

Procedures or abnormal radiologic findings

01. Fracture, subluxation, or dislocation of spine
02. Fracture of femur or pelvis
03. Fracture of sternum
04. Skull fracture
05. Dislocation of knee or hip
06. Significant filling defect on myelogram, or significant defect on CAT or MRI
07. Fracture or dislocation requiring open reduction
08. Fracture associated with significant soft tissue injury
09. Fracture requiring parenteral pain medications post-reduction
10. Closed reduction of any fracture or dislocation with documentation of actual or suspected neurologic or vascular compromise
11. Fractured pelvis requiring enforced bed rest and medication for pain

Physical findings

12. Documented findings suggestive of disc protrusion (e.g., Laseque's sign--pain with straight leg raising; low back pain with sensory and motor impairment or severe back pain radiating down legs, to arms or to abdomen and chest) or vertebral fracture
13. Acute invasive or infectious process of bone or joint (e.g., malignant tumor, osteomyelitis)
14. Acute injury with presence of foreign body
15. Incapacitating muscle pain/spasm/edema
16. Acute incapacitating swollen or painful joints requiring parenteral medications (e.g., analgesia, steroids)
17. Presence of internal orthopedic prosthesis and admission for removal
18.* Any trauma, soft tissue injury, laceration, crush injury, or elective surgical procedure requiring observation for neurologic or vascular compromise
19. Active bleeding into joint

Pediatric:

20. Congenital orthopedic deformity requiring surgical repair in children < 12 months

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

K. MUSCULOSKELETAL/SPINE
Treatment

Monitoring

51.* Neurovascular or circulatory checks at least every 2 hours

Medications

52. Parenteral analgesic medication at least 2 times a day or continuous infusion (must have documented indication for parenteral analgesic)

Procedures

Pediatric:

53.* Venogram

54.* Arteriogram

55.* Lymph angiogram

Treatments

56. Continuous skeletal, skin, cervical, pelvic, or sternal traction

57. Skilled physical therapy other than heat and massage, at least 2 times per day

58.* Enforced bed rest with medication for pain

Discharge Screens

100. Mobilization level--ambulates without assistance; mobilizes independently with walker, cane, crutches, wheelchair, or prosthesis; ability to transfer from bed to chair or commode; or as appropriate for the patient whose level of activity is not expected to increase beyond that present at the time of admission

101. Parenteral analgesic administration not to exceed one dose within 3 hours prior to discharge, excluding patients expected to require regular analgesic administration for a persistent condition

102. Satisfactory restoration of joint range of motion and/or correction of somatic dysfunction sufficient to permit outpatient management

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

L. NEWBORN/PREMATURE*
Indications for Hospitalization

01. Delivered in hospital
02. Unattended birth outside of hospital

Physical findings

03. Birth weight 2500 grams (5 lbs., 8 oz.) and under
04. Clinical sepsis with one or more of the following symptoms: hypotension, temperature instability, metabolic acidosis, apnea, bradycardia, positive laboratory findings, WBC < 10,000 μ/l or > 35,000 μ/l, or maternal fever > 101° F (38.3° C)
05. Seizures/hyperactivity, hypotonia, lethargy, coma
06. Respiratory distress or neonatal respiratory depression
07. Persistent central cyanosis
08. Poor sucking or feeding reflexes
09. Congenital abnormalities causing functional impairment
10. Poor perfusion as evidenced by capillary refill > 3 seconds
11. Inability to retain po fluids
12. Meconium aspiration syndrome
13. Dehydration evidenced by any of the following symptoms: sunken eyes, sunken fontanels, decreased skin turgor or dry mucous membranes accompanied by lethargy and/or weight loss > 5% and/or urine output $\leq$ 1 ml/kg/hr
14. Pneumothorax
15. Major congenital abnormalities
16. Spontaneous bleeding
17. Anuria or oliguria (< 1ml/kg/hr) after the first 24 hours of life
18. Bruit over liver or skull (indicating an AV malformation)

Laboratory

19. Total bilirubin $\geq$ 15 mg/dL in infant (indirect or total)
20. Hypoglycemia - blood sugar < 40 mg/dL
21. Calcium < 7.0 mg/dL
    Ionized calcium mmol/L

0 - 1 months	< 0.9 or > 1.45
1 - 6 months	< 0.95 or > 1.50
> 6 months	< 1.10 or > 1.30

22. Metabolic acidosis with venous lactate level >2 mEq/L
23. pH < 7.30 with $PaCO_2$ < 40 mmHg (first 48 hours of life)
24. Blood pH < 7.35 with $PaCO_2$ > 45 mmHg (older than 48 hours)
25. PaO_2 < 70 mmHg on room air
26. CO_2 > 45 mmHg on room air
27. Thrombocytopenia $\leq$ 100,000/mm^3 or > 100,000/mm^3 platelet count with active bleeding

****Newborn-defined as beginning at birth and lasting through the 28th day following birth***

L. NEWBORN/PREMATURE
Treatment

Treatments

51. Environmental control (isolette, radiant warmer)
52. Requires respiratory support/therapy
53. Exchange transfusion for erythroblastosis or other cause of hyperbilirubinemia
54. Total parenteral nutrition
55. Use of phototherapy in:
    a. An infant > 34 weeks gestation without hemolytic disease with a total bilirubin ≥ 15 mg/dL
    b. An infant with hemolytic disease
    c. Preterm infant ≤ 34 weeks gestation if bilirubin level is > 10 mg/dL
56. Parenteral antibiotics
57. Gavage feedings
58. IV fluids (including umbilical catheterization)
59. Progressive formula feedings in preterm infants
60. Extracorporeal membrane oxygenation (ECMO) treatment
61. Nitrous oxide treatment

Medications

62. Parenteral administration of pressor agents or antihypertensive agents

Discharge Screens

100. Responsible caretaker demonstrates ability to care for infant
101. Infant has grown or shown a steady weight gain on po or tube feedings
     NOTE: Infant on gavage feedings is ≥ 42 weeks corrected gestational age
102. Infant has demonstrated good sucking mechanism
103. Infant able to maintain body temperature in an open crib
104. Bilirubin is < 15 mg/dL and decreasing progressively off phototherapy, or arrangements have been made to continue phototherapy at home or in an alternative care setting

M. PERIPHERAL VASCULAR
Indications for Hospitalization

Physical findings

01. Block or filling defect of major vessel
02. Evidence of aortic aneurysm with associated symptoms of impending rupture (e.g., back or abdominal pain)
03. Acute absence of pulse at axilla, wrist, elbow, groin, knee, or ankle
04. Ulceration of varicose vein or decubitus area
05. Documentation of suspected deep vein thrombosis or occlusion, or positive venous doppler study
06. Suspected trauma to a major vessel, open or closed

Pediatric:

07. Extensive cavernous hemangioma
08. Arteriovenous (AV) malformation resulting in cardiovascular compromise (e.g., CHF) unresponsive to outpatient management or requiring surgical repair

Other

09. Complications immediately following declotting of AV shunt--rethrombosis of shunt, infection of shunt discovered during declotting of shunt, or bleeding
10. Vena cava interruption by filter or surgical clip

M. PERIPHERAL VASCULAR
Treatment

Procedure

50. Vascular reconstruction of a major artery

Pediatric:

51. Arteriogram/angiogram (requires documentation of need for > 24 hours observation post procedure)

52.* Arteriovenous (AV) shunt or revision of shunt

Treatment

53. Initiation of oral anticoagulant therapy (Coumadin, warfarin sodium)
54. Parenteral anticoagulant therapy (heparin), with monitoring of PTT level
55. Active treatment of an acute condtion with dalteparin or enoxaparin (not valid for prophylactic treatment)
56. Protocol of moist heat, elevation of extremity, and strict bed rest
57. Regularly scheduled aseptic dressing changes

Discharge Screens

100. INR controlled or plans for follow-up as outpatient

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

N. PSYCHIATRIC

Indications for Hospitalization

Medicaid Recipient Age 21 and Over/Acute Care Hospital

01. Recent (within 72 hours) attempted suicide
02. Documentation of suicide ideation requiring suicide precautions
03. Assaultive behavior as a result of a psychiatric disorder or dementing disorder
04. Documentation of self-mutilative or dangerous impulsive behaviors (e.g., serious impulsive substance abuse, sexual behavior, reckless driving) as a result of a psychiatric disorder or dementing disorder
05. Substance withdrawal delirium
    a. Impending substance withdrawal delirium following abrupt cessation of the substance in a patient with substantial history of substance abuse
    b. Actual substance withdrawal delirium (e.g., hallucinations, extra-pyramidal effects, seizures) Note: can occur immediately or up to seven days after cessation
06. Acute psychosis or acute exacerbation of hallucinations, delusions, illusions with behavioral disturbance, the magnitude and severity of which threaten the patient's well-being
07. Inability to comply with prescribed psychiatric health regimens (e.g., taking prescribed psychotropic medications, going to outpatient appointments to receive prescriptions and/or IM medications, etc.) in a patient who has a chronic history of decompensation without psychotropic medications, with documentation of reasonable expectation of improved compliance with inpatient hospitalization within a short period of time (≤ 14 days)
08. Potential hazard to the health or life of a patient who, due to concurrent psychiatric illness, is unable to comply with prescribed medical health regimens (e.g., insulin-dependent diabetes, etc.)
09. Acute onset of inability to care for self or attend to activities of daily living, AND documentation of reasonable expectation that resumption of self-responsibility will occur following appropriate treatment
10. Evidence of symptoms and/or behavior or verbalizations reflecting significant risk or potential danger (or actual demonstrated danger) to self, others, or property. *(Must be documented a minimum of every seven days.) This would include:
    a. Thought disorder with ideas of reference, paranoid or disorganized thinking that impairs a person's ability to function in everyday life
    b. Obsessive-compulsive symptoms or behavior incompatible with a person's ability to function in everyday life

Medicaid Recipient Under Age 21/Freestanding Psychiatric and Acute Care Hospital

For indications for hospitalization to be met, the following three bulleted conditions must be met, and at least one of the numbered criteria must be met:

- ***The client must have been seen and evaluated by a physician (preferably a child and adolescent psychiatrist)***
- ***The client must have a valid AXIS I, DSM-III-R, or DSM-IV diagnosis as the principal admitting diagnosis***
- ***Outpatient therapy and/or partial hospitalization has been attempted and failed, or reasons why a less restrictive place of service is inappropriate have been documented by the physician***

11. Recent suicide attempt or active suicidal threats with a deadly plan and there is absence of appropriate supervision or structure to prevent suicide.

12. Recent self-mutilative behavior or an active threat of same with likelihood of acting on the threat, and there is absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting on self or burning self).

13. Active hallucinations or delusions directing or likely to lead to serious self-harm, or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self.

14. Significant inability to comply with prescribed medical health regimens due to concurrent psychiatric illness, and such failure to comply is potentially hazardous to the life of the client. The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.

15. Recent life threatening action or active homicidal threats with a deadly plan and with likelihood of acting on threat.

Medicaid Recipient Under Age 21/Freestanding Psychiatric and Acute Care Hospital (continued)

16. Recent serious assaultive behavior or sadistic behavior or active threats of same with likelihood of acting on the threat, and there is absence of appropriate supervision or structure to prevent assaultive behavior.

17. Active hallucinations or delusions directing or likely to lead to serious harm to others.

18. Client exhibits acute onset of psychosis or severe thought disorganization or there is significant clinical deterioration in condition in someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment and client is in need of assessment and treatment in a safe and therapeutic setting.

19. Client has severe eating or substance abuse disorder which requires 24 hour a day medical observation, supervision, and intervention.

20. Proposed treatment/therapy requires 24 hour a day medical observation, supervision, and intervention.

21. Client exhibits severe disorientation to person, place, or time.

22. Client whose evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors which may also include physical, sexual, or psychological abuse.

23. Client requires medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen.

24. Client is involved in the legal system, manifests psychiatric symptoms, and is ordered by the court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

N. PSYCHIATRIC

Treatment

Medicaid Recipient Age 21 and Over/Acute Care Hospital

51. Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others
52. Active intervention with psychiatric team to prevent assaultive behavior
53. Intensive treatment with medications for delirium tremens
54. Alcohol detoxification
55. Drug detoxification (modification of medications for a period of less than one week)
56. Parenteral neuroleptics
57. Active management with psychotropic drugs
58. Electroconvulsant therapy
59. Comprehensive therapy plan requiring close supervision because of concomitant medical conditions
60. Chemical restraints (immobile)
61. Physical restraints (immobile)
62. Initiation of lithium or other mood stabilizing drug treatment
63. Institution of psychotropic medication to manage severe depressive symptoms, thought disorders or disruptive symptoms of other organic brain disorders

Medicaid Recipient Under Age 21/Freestanding Psychiatric and Acute Care Hospitals

For treatment criteria to be met, all of the following bulleted conditions must be met, and at least <u>one</u> of the numbered criteria must be met:

- ***Active supervision by a psychiatrist***
- ***Implementation of an individualized treatment plan***
- ***Provision of services which can reasonably be expected to improve the client's condition or prevent further regression so that a lesser level of care can be implemented***

64. Suicide, homicide, assault, or self-abuse precautions with unit restriction and continual observation to limit behavior and protect self or others. Clients requiring this treatment must not be on unit or independent passes without close observation or hospital staff escort.
65. Active intervention by the psychiatric team to prevent any at-risk behaviors (i.e., behavior modification).
66. Crisis stabilization with intensive individual, family, group therapy, and/or appropriate medications.
67. Complex diagnostic evaluation including psychiatric and neurological or medical work-up.
68. Alcohol and/or drug detoxification (modification of medications for a period of less than a week).
69. Parenteral anti-psychotic medications.
70. Active management with psychotropic drugs (refer if no modification of drug or change in patient condition within six calendar days).
71. Electroconvulsive therapy.
72. Comprehensive therapy plan requiring close supervision because of concomitant medical conditions.
73. Chemical restraints (immobile).
74. Physical restraints (immobile).
75. Initiation of Lithium or other mood stabilizing drug treatment.
76. Dual treatment tracks (substance abuse and psychiatric illness).
77. Medical observation, supervision, and intensive treatment for severe eating disorders, including individual, group, family therapy, and close observation during and after meals.

Discharge Screens

100. Documented evidence of no further improvement in 10 days
101. Adequate alternative placement arranged
102 Documentation that patient is no longer suicidal or a threat to others

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O. ONCOLOGY
Indications for Hospitalization

Laboratory-blood

01. Absolute granulocyte count < 1,000 μ/L or > 50,000 μ/L
02. Positive blood culture

Physical findings

03. Significant weight loss with serum albumin < 2.6 g/dL
04. Documentation of unsuccessful outpatient management of severe side effects (intractable nausea and/or vomiting, diarrhea, GI bleeding, adynamic ileus, megacolon or stomatitis) associated with previous administration of chemotherapeutic agents

Other

05. Documentation of malignancy with symptomatology requiring treatment that can only be provided in an acute-care setting (e.g., superior vena cava syndrome, cord compression, hypercalcemia, increased intracranial pressure)
06. Extravasation of vascular access
07. Clotted vascular access
08. Documentation of malignancy and admitted for treatment requiring hospitalization

O. ONCOLOGY
Treatment

Medications

50. Initiation or adjustment of high-dose pain medications

Cancer chemotherapeutic agents

51. Induction chemotherapy with administration of chemotherapeutic agents in a patient with comorbidities who is not able to tolerate it on an outpatient basis
52. Induction or high dose consolidation chemotherapy for acute myelogenous or lymphocytic leukemia
53. High dose salvage chemotherapy for Non-Hodgkin's Lymphoma and Hodgkin's disease
54. Chemotherapeutic agents requiring pre- or post-treatment hydration, including frequent supportive measures or medications, with a total infusion time of > 16 hours (Frequent supportive measures include IV antiemetic, steroids, diuretics, foley catheter, measuring of urine output or PH, monitoring vital signs)
55. Intra-arterial infusion or intrathecal infusion that require monitoring or supportive care
56. Administration of chemotherapeutic medications, or combinations of medications, e.g., Aldesleukin (IL2); ifosfamide (IFEX), or high dose methotrexate (> 200 mg/M^2) that require special monitoring or observation

Radiation therapeutic agents

57. Emergency radiation therapy, especially for expanding brain tumors, superior vena cava obstruction, spinal cord compression, and acute obstructive phenomenon of other vital organs
58. Radiation therapy with intravenous chemotherapy
59. Brachytherapy radiation
60.* Gamma knife treatment
61.* Stereotactic radiation delivery
62. Parenteral/oral/intraperitoneal radioactive treatment administration

Procedures

63. Stem cell rescue if patient condition requires isolation
64. Bone marrow transplant if patient condition requires isolation

Treatments

65. Initiation of hyperalimentation

Other

66. Removal of infected subclavian catheter or other venous access catheters and instillation of IV antibiotics or removal of catheter associated with subclavian/axillary clot or instillation of IV thrombolytic

Discharge Screens

Patient education

100. Patient and/or family competent for care, patient having received maximum benefits of education in hospital

Functional

101. Prescribed diet tolerated for last 12 hours prior to discharge without nausea/vomiting, or appropriate arrangements made to address nutritional support in an alternative care setting
102. Optimal pain control
103. Discharged to hospice or other appropriate care setting based on level of care required

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

P. RESPIRATORY/CHEST
Indications for Hospitalization

Radiology

01. Pneumothorax
02. Hemothorax
03. Air in mediastinum
04. Foreign body in respiratory tree
05. Pulmonary edema

Radiologic evidence-To use criteria 06-11, there must be at least one physical finding present, see elements 15-25

06. Pleural effusion
07. Lung abscess
08. Infiltrate
09. Unilateral high diaphragm
10. Cavitation
11. Mediastinal shift and/or widening

Scanning

12. Embolus
13. Acute infarct
14. Filling defect

Physical findings (within the last 24 hours)

15. Dyspnea with significant stridor
16. Use of accessory muscles for breathing **Pediatric: grunting flaring, retractions**
17. Chest pain, pleuritic type
18. Respiratory rate > 30 per minute or < 10 per minute
19. Hemoptysis
20. Costovertebral and costochondral range of motion restriction reducing inhalation and exhalation capacity
21. Altered level of consciousness in patients with COPD
22. Cyanosis
23. Intractable wheezing
24. Intractable cough
25. Orthopnea

Pediatric:

26. Suspected apnea (> 20 seconds in infants 0-1 year)
27. Central cyanosis
28. Hypoventilation

Laboratory findings

29. PaO_2 < 55 mmHg
30. PaO_2 < 70 mmHg on supplemental oxygen
31. Oxygen saturation < 88%
32. Oxygen saturation < 85% in patients with COPD on supplemental oxygen
33. $PaCO_2$ > 50 mmHg (associated with a pH of < 7.3) or $PaCO_2$< 30 mmHg
34. pH Adult: < 7.30 or > 7.55
    Pediatric: < 7.30 or > 7.50

Other

35. Physician documentation of “worsening hypoxemia and hypercapnia” with symptoms (dyspnea, decreased activity) and documented failure of outpatient treatment
36. Closure of pleural drainage tracts
37. Inhalation burns with O_2 Saturation < 93%

P. RESPIRATORY/CHEST
Treatment

Procedures

51.* Chest surgery

52.* Mediastinoscopy

53.* Bronchoscopy with forced expiratory volume (FEV), < 1.0 L or abnormal blood gases

54.* Closed thoracostomy with drainage (chest tube)

55.* Bronchoscopy with Wang needle aspirate

56.* Needle biopsy of lung

57.* Thoracentesis with pleural biopsy

58.* Thoracoscopy

59.* Lung abscess drainage

Treatment

60. Acute ventilator therapy (excludes ventilator dependence)
61. Endotracheal suctioning and/or lavage
62. Chest tube drainage
63. Isolation (respiratory)--requires private room (or ward for specific organism), mask, hand washing on entering and leaving room
64.* Croup tent
65. Therapy of tuberculosis when one of the following is documented:
    a. Drug resistance
    b. Demonstrated drug intolerance or toxicity
    c. Documentation of alcoholism, vagrancy, emotional or intellectual dysfunction, which predisposes to non-compliance with therapy
    d. Documented non-compliance with outpatient treatment
66. Parenteral administration of corticosteroid, theophylline preparations, or antibiotics based on documented indications.
67. Anticoagulant therapy (either a or b)
    a. Initial treatment
    b. Stabilization of dose requiring daily prothrobin time (PT) or INR
68. Chest physical therapy (CPT) four times a day
69. Aerosolized nebulizer treatments provided by respiratory therapy with bronchodialators, mycolytics, or steroids at least every four hours

Pediatric:

70.* Supplemental oxygen requirement

Monitoring

71.* Continuous pulse oximetry or periodic pulse oximetry checks every four hours
72. Arterial line monitoring of arterial blood gases (ABGs)

Discharge Screens

100. Patient or significant other able to clean and care for tracheostomy
101. Patient or significant other able to administer medical gases
102. Blood gases improved and stabilized for 12 hours
103. Availability of necessary home therapy
104. Physician's progress notes reflect clinical improvement in respiratory status
105. Prothrombin time controlled or plans for follow-up as outpatient

*Physician documentation must substantiate the need for greater than twenty-four hours monitoring, treatment, and/or observation post procedure.

Q. SKIN/CONNECTIVE TISSUE
Indications for Hospitalization

Physical findings

01. Acute invasive infectious process, such as cellulitis or lymphadenitis
02. Loss or damage of skin > 10% of body surface (new diagnosis - within the past 24 hours)
03. Necrosis of skin/subcutaneous tissue (identified within last 24 hours)
04. Unexplained breast mass or nipple deformity requiring surgical treatment
05. Decubitus ulcers (a or b)
    a. Chronic - documentation of unsuccessful outpatient treatment
    b. Necrotic ulcer(s) involving deep muscle and bone (stage 3 or 4) or infected ulcer(s)
06. Hemorrhagic lesions

Onset of complications of auto-immune disease (see elements 7-11):

07. Petechial or eccymotic purpura with unknown etiology that is progressive with fever >100° F
08. Sepsis
09. Platelets < 40,000/mm^3
10. Hemoglobinuria
11. Hemoglobin < 9 g/dL

12. Snake bite involving envenomization
13. Contractures, limiting function and admitted for surgical release
14. First degree burn:

    Pediatric: **First degree burn involving 25% of body**

15. Second degree burn:

    Adult: Second degree burn involving 25% or more of the total surface area of the perineum, hand, face, or foot, or a second degree burn of any body part involving > 20% of the total body area

    Pediatric: **Second degree burn involving 15% of body, or involving the airway (e.g., head, neck, nose or mouth)**

16. Third degree burn:

    Adult: Any third degree burn involving more than 10% of the body surface area or any third degree burn of the perineum, hand, nose, mouth, face or foot

    Pediatric: **Any third degree burn involving 5% or more of body, or involving the airway**

Q. SKIN/CONNECTIVE TISSUE
Treatment

Procedures

51. Large wound debridement
52. Large area of skin grafting

Treatment

53. Surface burn therapy requiring administration by trained personnel
54. Isolation/reverse isolation--requiring private room, gown, glove, mask, and hand washing on entering and leaving the room
55. Intense topical treatment or skin care at least 2 times a day, requiring hospital personnel (e.g., hyperbaric chamber treatment)
56. Parenteral fluid/electrolyte replacement in burn patient

Discharge Screens

100. Electrolytes within acceptable range for last 24 hours
101. No substantial bleeding, no substantial increase in drainage, or no purulent drainage
102. Vital signs normal for age for 24 hours prior to discharge
103. Post grafting satisfactory burn wound coverage

R. URINARY/RENAL SYSTEM
Indications for Hospitalization

Laboratory-blood

01. Acute elevation of blood urea nitrogen (BUN) > 40 mg/dL and creatinine > 1.8 mg/dL

Physical findings

02. Urinary output
    Adult: < 20 cc/hr or 400 cc/24 hours
    Pediatric: anuria or oliguria ≤ 1 ml/kg/hr
    or polyuria > 9 ml/kg/hr
03. Persistent, unexplained, or gross hematuria
04. Suspected or documented stone or obstruction with one of the following symptoms:
    a. Documented pain
    b. Nausea and/or vomiting
    c. Bleeding
05. Acute onset of obstruction with hydronephrosis
06. Acute inability to void/urinary obstruction
07. Urine leakage into vagina, rectum, or colon
08. Extravasation into peritoneal cavity, pelvis, or retro-peritoneum
09. Penetrating wound or other trauma to urinary tract system
10. Urinary tract infection with systemic symptoms (e.g., vomiting, chills, fever, pain, or pyuria despite antibiotic treatment for 3 days)
11. Post renal transplant with decreased urinary output, weight gain, or significant changes in blood urea nitrogen (BUN) or creatinine
12. Complications of dialysis--infected access, pericarditis, metabolic bone disease, neuropathy, encephalopathy
13. Renal transplantation complications of rejection crisis, hypertension, infection

Pediatric:

14. Abdominal wall defect of genitourinary tract

Radiology

15. Blockage of ureter or renal pelvis
16. Newly diagnosed tumor or admitted for definitive treatment of a previously diagnosed tumor
17. Renal mass lesion (except asymptomatic cyst)
18. Obstructed or non-visualized kidney

Other

19. End stage renal disease patient admitted for placement of peritoneal catheter
20. Chronic renal failure with bleeding (e.g., nasal, gastrointestinal)
21. Renal transplant donor
22. Pre-op preparation for kidney transplantation (only applies when prep and transplant are performed in same admission)
23. End stage renal disease patient admitted for initial course of dialysis

R. URINARY/RENAL SYSTEM
Treatment

Medications

51. Parenteral analgesic medications based on documented indications
52. Parenteral medications for treatment of renal dysfunction based on documented indications

Procedures

53. Extracorporeal shock wave lithotripsy (ESWL) in face of a solitary kidney
54. Kidney transplant
55. Percutaneous nephrostomy

Pediatric:

56. Renal arteriogram
57. Renal biopsy

Treatment

58. Initial course of renal dialysis or peritoneal dialysis

Discharge Screens

100. Voiding or draining urine without difficulty for the last 12 hours, or arrangements have been made for voiding or urinary drainage, hemodialysis or continuous ambulatory peritoneal dialysis (CAPD)
101. Parenteral analgesic administration not to exceed one dose within three hours prior to discharge, excluding patients expected to require regular analgesic administration for a persistent condition
102. No unexplained gross hematuria
103. Return of baseline renal function

S. PHYSICAL REHABILITATION
Indications for Hospitalization

Physical

Must meet one element from Part I or Part II AND one element from Part III

I. Inability to function independently as demonstrated by meeting one element from 01., 02., or 03. with the potential for significant practical improvement as measured against his/her condition prior to rehabilitation.

01. Activities of daily living (any one of)
   a. Feeding
   b. Personal hygiene
   c. Dressing

02. Mobility (any one of)
   a. Transfers
   b. Wheelchair mobility
   c. Ambulation
   d. Stair climbing

03. Communicative/cognitive (must be accompanied by either element a. or b.).
   a. Aphasia with major receptive and/or expressive components
   b. Cognitive dysfunction (e.g., attention span, confusion, memory, intelligence)
   c. Perceptual motor dysfunction area (e.g., spatial orientation, visual-motor, depth and distance perception)

OR

II. Somatic dysfunction

04. Somatic dysfunction which significantly impairs the individual's efficiency of performance (e.g., spasticity, incoordination, paresis, bowel and bladder dysfunction, gait disturbance, dysarthria, dyskinesia)

AND

III. Comprehensive rehabilitation status (any one of)

05. Has had no previous comprehensive rehabilitation effort, or previous rehabilitative efforts for the same condition showed little or no improvement, but because of an intervening circumstance rehabilitation is now considered reasonable
06. Previously has been unable to attain rehabilitation goals which are currently considered attainable because of techniques or technology not previously available to the patient--this may include previous trial of outpatient therapy with unsatisfactory response
07. Has lost previous level of attained functional independence due to complication(s) or intercurrent illness and reattainment of functional independence currently is feasible
08. The patient is medically stable but has complications which require special care during rehabilitation goals or attainment of goals
09. Documented objective evidence of a significant change in the patient's function requiring a planned evaluation of re-evaluation of rehabilitation goals or attainment of goals

S. PHYSICAL REHABILITATION
Treatment

Physical

Rehabilitation program must include medical management by a physician and a rehabilitation nurse plus the provision of at least one of the following services for minimum of three hours per day and no less than five days a week:

51. Occupational therapy
52. Physical therapy
53. Speech/language pathology services and/or prosthetic/orthotic services (must be a combination of these two services or one in conjunction with OT or PT)

AND Evidence of periodic multidisciplinary rehabilitation team review at least every two weeks with documentation of progress and recommendation for continuing rehabilitation program

Discharge Screens

100. Maximum functional achievement through inpatient comprehensive rehabilitation as determined by rehabilitation team (patient has met current assessed goals)
101. Failure after adequate trial (documented by at least two consecutive rehabilitation team reviews, or after two weeks, whichever is shorter) to make progress toward remaining treatment goals
102. Development of serious complication(s), persisting longer than three days, requiring another level of care
103. Services being provided can be provided on an outpatient basis or at a lower level of care.

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GENERIC QUALITY SCREENS

CMS: ACUTE CARE/HOSPITAL INPATIENT

1. Adequacy of discharge planning—No documentation of discharge planning or appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge.
2. Medical stability of the patient
   - a.* Blood pressure (BP) within 24 hours of discharge (systolic less than 85 mmHg or > 180; diastolic < 50 mmHg or > 110 mmHg)
   - b.* Temperature within 24 hours of discharge > 101° F (38.3° C) oral, > 102 ° F (38.9° C) rectal
   - c.* Pulse < 50 (or 45 if the patient is on a beta blocker), or > 120 within 24 hours of discharge
   - d. Abnormal diagnostic findings which are not addressed and resolved or where the record does not explain why they are not resolved
   - e.* IV fluids or drugs after 12 midnight on day of discharge
   - f.* Purulent or bloody drainage of wound or open area within 24 hours prior to discharge
3. Deaths
   - a. During or following any surgery performed during the current admission
   - b. Following return to intensive care unit, coronary care or other special care unit within 24 hours of being transferred out
   - c. Other unexpected death
4.* Bacteremia confirmed by positive blood culture
5.* Unscheduled return to surgery—Within same admission for same condition as previous surgery or to correct operative problem
6. Trauma suffered in hospital
   - a. Unplanned surgery which includes, but is not limited to, removal or repair of a normal organ or body part (i.e., surgery not addressed specifically in the operative consent)
   - b. Fall
   - c. Serious complications of anesthesia
   - d. Any transfusion error or serious transfusion reaction
   - e. Hospital acquired decubitus ulcer and/or deterioration of an existing decubitus
   - f. Medication error or adverse drug reaction: (1) with serious potential for harm or (2) resulting in measures to correct
   - g. Care or lack of care which resulted, or could have resulted in a potentially serious complication
7. Medication or treatment changes (including discontinuation) within 24 hours of discharge without adequate observation

NOTE: See CMS Generic Quality Screens—Acute Care/Hospital Inpatient Care Guidelines for application of the screens.

* Indicates screens that are also applicable for psychiatric and long-term facility review

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTES
1. Adequacy of discharge planning—No documentation of discharge planning or appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge	Death; transfer to an acute, short-term, general hospital or swing bed status; patient left AMA; inpatient psychiatric case	Discharge planning is appropriate for all patients. Discharge planning is a generic term which covers a range of care from the simple to the complex. The plan should be developed timely, as defined by the patient's needs, and must meet these needs at time of discharge. The plan should reflect appropriate transition of care, identify additional resources needed, and provide appropriate teaching or transmission of pertinent information. Documentation must be present which addresses the following elements of a discharge plan: A needs assessment; Development of plan Initiation of appropriate arrangements and obtaining appropriate resources to ensure smooth transition to post-hospital level of care. A screen failure occurs when a discharge plan is not documented. A confirmed problem occurs when the patient had needs which were not met.
2. Medical stability of patient a. Blood pressure (BP) within 24 hours of discharge (systolic < 85 mmHg or > 180 mmHg; diastolic < 50 mmHg or > 110 mmHg)	Death; transfer to an acute, short-term, general hospital; patient left AMA	This entire category (medical stability of patient) identifies aberrant clinical data which has not been recognized or which has been inadequately treated during the hospitalization. A single abnormal vital sign or laboratory result may be in error. Therefore, serial determinations should be sought. Where serial determinations are not available, corroborating evidence of clinical instability should be identified. There should be evidence in the medical record that action was taken to address the problem prior to discharge. A screen failure is defined as more than one abnormal reading within 24 hours of discharge where a subsequent normal reading is not documented.
b. Temperature within 24 hours of discharge > 101° F (38.3°C) oral, > 102° F (38.9°C) rectal	Death; transfer to an acute, short-term, general hospital; patient left AMA	Same as 2.a.
c. Pulse < 50 (or 45 if the patient is on a beta blocker), or > 120 within 24 hours of discharge	Death; transfer to an acute, short-term, general hospital; patient left AMA	Same as 2.a.
d. Abnormal diagnostic findings which are not addressed and resolved, or where the record does not explain why they are not resolved	Inpatient psychiatric case	Abnormal findings are defined as those results which fall outside of normal or acceptable limits for the test or physical findings as defined by the laboratory or facility performing the test. Abnormal test results or physical findings would not be identified as an occurrence (screen failure) if the medical record indicated acknowledgment of the abnormal test result or physical finding and documented appropriate and timely therapeutic intervention prior to the patient's discharge. The following examples, if identified in the medical record, would not be considered a confirmed problem: 1. Medical condition or treatment for same explains abnormal values (e.g., patient with known cancer of liver has elevated SGOT). 2. Patient refuses medical treatment (e.g., Jehovah Witness) 3. Treatment begun in hospital will continue as outpatient or follow-up as outpatient. (Lab value should be within discharge screen criteria.) 4. Minimum elevated values which are not clinically significant (as with glucose, cholesterol) 5. Death before abnormal finding could be addressed 6. Patient left AMA before abnormal finding could be addressed

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTES
2.e. IV fluids or drugs after 12 midnight on day of discharge	Death; transfer to an acute, short-term, general hospital or Medicare-covered SNF; patient left AMA; KVOs; antibiotics; chemotherapy; total parenteral nutrition; heparin given to maintain a heparin lock	None
f. Purulent or bloody drainage of wound or open area within 24 hours prior to discharge	Transfer to an acute, short term, general hospital; death; patient left AMA	This element is defined as an adverse change in the healing of a wound or open area. Screen failures would include, but not be limited to, drainage that has significantly increased or decreased within 24 hours prior to discharge. A confirmed problem would be reported if it was medically inappropriate to discharge the patient with this degree of drainage.
3. Deaths a. During or following any surgery performed during the current admission	Inpatient psychiatric case	Confirmed problem would be recorded for any intraoperative or postoperative death if such death resulted from inadequate preoperative assessment, inadequate postoperative care, or improper procedures which resulted in surgical or anesthesia complications.
b. Following return to intensive care unit, coronary care, or other special care unit within 24 hours of being transferred out	Inpatient psychiatric case	None
c. Other unexpected death	Inpatient psychiatric case	Unexpected death is defined as death occurring when there had been a reasonable expectation on admission that the patient would recover (i.e., where there was no documented expectation of possible death).
4. Bacteremia confirmed by positive culture	The following organisms when isolated from a single culture: • Coagulase-negative staphylococcus • Corynebacteria • Propionibacteria • Bacillus Species • Diphtheroids Those excluded organisms can be considered clinically important (i.e., the screen would be failed) when the same organism is grown from two or more blood cultures obtained from different vascular access sites	Identify those cases where a positive blood culture is not correctly treated. The proper diagnosis of the infection should be addressed in Screen 6.g., and the diagnosis and treatment of all other infections, nosocomial or community-acquired, are to be reviewed against Screens 2.d. and 6.g. The progress notes should contain reference to the positive blood culture(s). A screen failure occurs when the patient is not receiving an antibiotic to which the organism is sensitive. A screen failure is not necessarily a confirmed problem. The drug shall be ordered within 24 hours of the time when the final sensitivity is available in the lab. Exceptions include: • When bacteremia is associated with meningitis, the antibiotic chosen would penetrate the blood-brain barrier (see Antibiotic Families) • The patient should not receive an antibiotic to which he/she is allergic. For device associated bacteremia, where the device is removed promptly, therapy may not be indicated. In both instances this decision should be documented in the patient record.
5. Unscheduled return to surgery within the same admission for the same condition as previous surgery or to correct operative problem	"Staged" procedures	"Unscheduled surgery" is defined as an unexpected return to surgery and is not limited to the procedure being performed in the operating suite. Example: Surgical repair of a wound separation performed in a patient's room is considered an unscheduled return to surgery.

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTES
6. Trauma suffered in hospital a. Unplanned surgery which includes, but is not limited to, removal or repair of a normal organ or body part (i.e., surgery not addressed specifically in the operative consent)	None	None
b. Fall	Inpatient psychiatric case	"Falls" are the key to failing the screen, not the degree of injury. A fall with or without injury is a quality concern. The concern may be due to the hospital's negligence or to the injury incurred by the patient. A screen failure exists if a fall occurred. A confirmed problem exists if the fall was avoidable. A confirmed problem also exists if the fall was not properly followed up whether or not the fall was avoidable.
c. Serious complications of anesthesia	None	This is defined as complications related only to anesthesia. (This would not include problems resulting from the surgical procedure). Serious complications would include any condition which increases the patient's morbidity or possibility of mortality, or results in an increased length of stay or the use of special equipment to support the patient during recovery from the complication. Anesthesia complications would include but are not limited to: General anesthesia: • Anoxia • Laryngospasm • Anaphylaxis • Aspiration with pulmonary complications • Unplanned retained foreign body • Reintubation within 24 hours of extubation • Seizures occurring intra-operatively or within 24 hours post-op Spinal anesthesia: • Indications of paralysis or paresis present at discharge
d. Any transfusion error or serious transfusion reaction	None	Transfusion error or serious reaction would include administration of incompatible blood products or any reaction that was unrecognized and untreated which, for example, resulted in signs or symptoms of hemolysis, severe circulatory overload, anaphylactic reactions, coagulation complications, hepatitis, renal failure, or cardiac arrest.
e. Hospital acquired decubitus ulcer or deterioration of an existing decubitus	Readmission for treatment of decubitus ulcer acquired previously.	Decubitus ulcer is defined as a break in the skin, regardless of the size and depth, caused by prolonged pressure over a pressure point.
f. Medication error or adverse drug reaction with serious potential for harm or resulting in measures to correct	Inpatient psychiatric case	Examine the process as well as the outcome. The following are examples of errors which may have a potential for harm or result in actual harm: • Incorrect antibiotic ordered by the physician (e.g., inconsistent with diagnostic studies or the patient's history of drug allergy)

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTES
6.f. (continued)		• No diagnostic studies to confirm which drug is correct to administer (e.g., culture and sensitivity; C&S) • Serum drug levels not performed as needed • Diagnostic studies or other measures for side effects not performed as needed (e.g., renal function tests and intake and output; I&O; for patients on aminoglycosides) • Measures to correct include, but are not limited to, intubation, cardiopulmonary resuscitation, gastric lavage, dialysis, or medications.
g. Care or lack of care which resulted in or could have resulted in a potentially serious complication	Inpatient psychiatric case	Care or lack of care is defined as inappropriate or untimely assessment, intervention, and/or management.
7. Medication or treatment changes (including discontinuation) within 24 hours of discharge without adequate observation	None	None

ANTIBIOTIC FAMILIES* (Applies to Screen 4 in the CMS: Generic Quality Screens—Acute Care/Hospital Guidelines)			
PARENT PARENTERAL DRUG		**RELATED PARENTERAL DRUGS**	
Generic Name	Trade Name	Generic Name	Trade Name
Methicillin	Staphcillin	Oxacillin	Prostaphlin Nafcil Unipen
Ampicillin	Amcil Omnipen Polycillin Principen	Ampicillin+ sulbactam	Unasyn
Carbenicillin	Geopen	Ticarcillin Ticarcillin+ clavulanate	Ticar Timetin
Mezlocillin	Mezlin	Pipercillin Azlocillin	Pipracil Azlin
Cefazolin	Ancef Kefzol Zolicef	Cephapirin Cephradine	Cefadyl Anspor Velosef
Cefuroxime	Zinacef Kefurox	Cefamandole Ceforanide Cefonicid	Mandol Precef Monocid
Cefoxitin	Mefoxin	Cefotetan Cefmetazole	Cefotan Zefazone
Ceftriaxone	Rocephin	Cefotaxime Ceftizoxime	Claforan Cefizox
Ceftazidime	Fortaz Tazidime Tazicef	Cefoperazone	Cefobid
Gentamicin	Garamycin	Tobramycin Amikacin Netilmicin	Nebcin Amikin Netromycin
Tetracycline	Achromycin	Oxytetracycline Doxycycline Minocycline	Terramycin Vibramycin Minocin
*Other antibiotics are appropriate for use when the organism is found to be susceptible to them. Examples of these drugs are: vancomycin, erythromycin, chloramphenicol, metronidazole, trimethoprim/sulfamethoxazole, clindamycin, impipenen, aztreonam, ciprofloxacin IV, kanamycin, and streptomycin			