

OUTPATIENT OBSERVATION SERVICES FOR MEDICARE PATIENTS Reporting Guidelines – 2009

Disclaimer:

This material is a compilation of information from sources listed in the "Reference" section. While every effort has been made to ensure the accuracy of the information provided according to the most current Medicare Transmittals and Palmetto GBA advices pertaining to the subject, periodic change to policies, rules, and coverage may occur.

Detailed and current policies, regulations, and updates are available thru the CMS website: <http://www.cms.hhs.gov>.

Effective Date: July 01, 2009

Implementation Date: July 06, 2009

Definition of Observation Care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they can be discharged from the hospital. Observation **services** are commonly **ordered for** patients who present to the Emergency Department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Purpose of Outpatient Observation Care:

Outpatient observation **services** is for:

1. Evaluating a patient for possible inpatient admission.
2. Treating patients expected to be stabilized and released in 24 hours (with appropriate documentation, patients can stay in observation more than 24 hours).
3. Extended recovery following a complication of an outpatient procedure, for example:
 - poor pain control
 - intractable vomiting
 - delayed recovery from anesthesia
 - abnormal postoperative bleeding

Outpatient observation **services** is **not**:

1. A substitute for inpatient admission.
2. For continuous monitoring.
3. For medically stable patients who need diagnostic testing or outpatient procedures.
4. For patients who need therapeutic procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting.
5. Patient awaiting nursing home placement.
6. To be used as a convenience to the patient, his or her family, the hospital, or the attending physician.
7. For routine prep or recovery prior to or following diagnostic or surgical services.
8. A routine "stop" between the Emergency Department and an inpatient admission.

Coverage of Outpatient Observation Services

Observation **services** are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff by laws to admit patients to the hospital or **to order outpatient services**.

Observation **services** must also be reasonable and necessary to be covered by Medicare.

Services That Are Not Covered as Outpatient Observation

The following type of services are not covered as **outpatient observation services**:

- Services that are not reasonable or necessary for the diagnosis or treatment of the patient.
- Services that are provided for the convenience of the patient, the patient's family, or a physician, (e.g., following an uncomplicated treatment or a procedure, physician busy when patient is physically ready for discharge, patient awaiting placement in a long term care facility).
- Services that are covered under Part A, such as a medically appropriate inpatient admission, or
- General standing orders for observation **services** following **all** outpatient surgery are not recognized. **Hospitals should not report as observation care**, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours) which should be billed as recovery room services.
- In the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services.
- Observation should not be billed concurrently with therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).

Observation Time:

Start time:

Observation **services** begins at the clock time documented in the medical record, which match the time **that observation care is initiated in accordance with the physician's order**.

End time:

A patient's time in observation ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

Note: Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home.

Counting Observation Time:

Hospitals should round to the nearest hour.

Example

Start time: 3:03 p.m. = 3:00

End time: 9:45 p.m. = 10:00

Total observation time = 7 hours

Duration of Observation Services

- The decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

UB Reporting:

- All of the hours for the entire period of observation must be reported in a single line and the date of service for that line is the date that observation care begins (if a period of observation spans more than 1 calendar day).

HCPCS CODES FOR REPORTING OBSERVATION SERVICES:

CODE	DESCRIPTION	APC - STATUS INDICATOR	OPPS Payment Status
G0378	Hospital observation service, per hour	N	Paid under OPPS; payment is <u>packaged</u> into payment for other services, including outliers. Therefore, <u>there is no separate APC payment.</u>
G0379	Direct admission of patient for hospital observation care	Q3	Paid under OPPS: Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service.

Classification of Observation Services According to Payment:

- I. Observation **services** as integral part of Composite APC (8002 or 8003) payment
- II. Direct admission to observation **services**:
 - 1) Separate payment as a low level hospital clinic visit under APC 0604
 - 2) Packaged into payment for Composite APC 8002
 - 3) Packaged into the payment for other separately payable services provided in the same encounter.
- III. Packaged payment for observation **services**

I

Composite APC Payment For Observation Services:

- ❖ In certain circumstances when observation care is provided as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of 2 composite APCs (APC 8002 and APC 8003) when certain criteria are met:

Composite APC	Composite APC Title	Criteria for Composite Payment
8002	Level I Extended Assessment and Management Composite	1) 8 or more of units of HCPCS code G0378 are billed— <ul style="list-style-type: none"> • On the same day as HCPCS code G0379; or • On the same day or the day after CPT codes 99205 or 99215 (level 5 clinic visit); and 2) There is no service with SI = T on the claim the same date of service or 1 day earlier than G0378. Note: <i><u>There is no limitation on diagnosis for payment of this composite APC.</u></i>
Composite APC	Composite APC Title	Criteria for Composite Payment
8003	Level II Extended Assessment and Management	1) 8 or more units of HCPCS code G0378 are billed on the same date of service or the date of service after (level 4 or 5 ER visit) 99284, 99285 or (critical care service) 99291 and; 2) There is no service with SI = T on the claim on the same date of service or 1 day earlier than G0378. Note: <i><u>There is no limitation on diagnosis for payment of this composite APC.</u></i>

II

Direct Admission to Observation Services:

- ❖ Observation **services** because of a direct **referral** after being seen by a physician in the community without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation care.
- ❖ Report HCPCS code **G0379** for direct admission to observation care.
- ❖ Payment for direct admission to observation will be made either:
 - 1) Separately as a low level hospital clinic visit under APC 0604
 - 2) Packaged into payment for Composite APC 8002 (level I Extended Assessment and Management Composite)
 - 3) Packaged into the payment for other separately payable services provided in the same encounter.

Criteria for payment of G0379 under either APC 604 or APC 8002:

- Both HCPCS codes G0378 and G0379 are reported with the same date of service.
- No service with a status indicator of **T** or **V** or **Critical Care** (APC 0617) is provided on the same day of service as code G0379.

Packaged Payment for G0379, Direct Admission to Observation Services:

- If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator **N** and will be packaged into payment for other separately payable services provided in the same encounter.

III

Packaged Payment for Observation Services:

- ❖ Observation **services** reported with HCPCS code **G0378** (Hospital observation service, per hour).
- ❖ Effective for date of service on or after January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator **N**, signifying that its payment is always packaged.
- ❖ APC 0339 is deleted as of January 1, 2008.

Logic: In most circumstances, observation services are supportive and ancillary to the other services provided to a patient.

Requirements to Received Payment for the Composite APC:

All of the following requirements must be met in order for a hospital to receive an APC payment for the extended assessment and management composite APCs:

1. Observation Time

- Observation time must be documented in the medical record.
- The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

2. Additional Hospital Services

- a) The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or before the date reported for observation:
- ER level 4 (99284) or level 5 (99285), or
 - Clinic visit level 5 (99205 or 99215), or
 - Critical care (99291), or
 - Direct admission to observation (G0379), must be reported on the same date of service as the date reported for observation services.
- b) No procedure with a "T" APC SI can be reported on the same day or day before observation care is provided.

3. Medical Records Documentation

- a) The patient must be in the care of a physician during the period of observation, as

documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

- b) The medical record must include documentation that the physician explicitly assessed patient risk to determine that the patient would benefit from observation care.

4. Revenue Code Reporting

Hospitals are required to report observation charges under the following revenue codes:

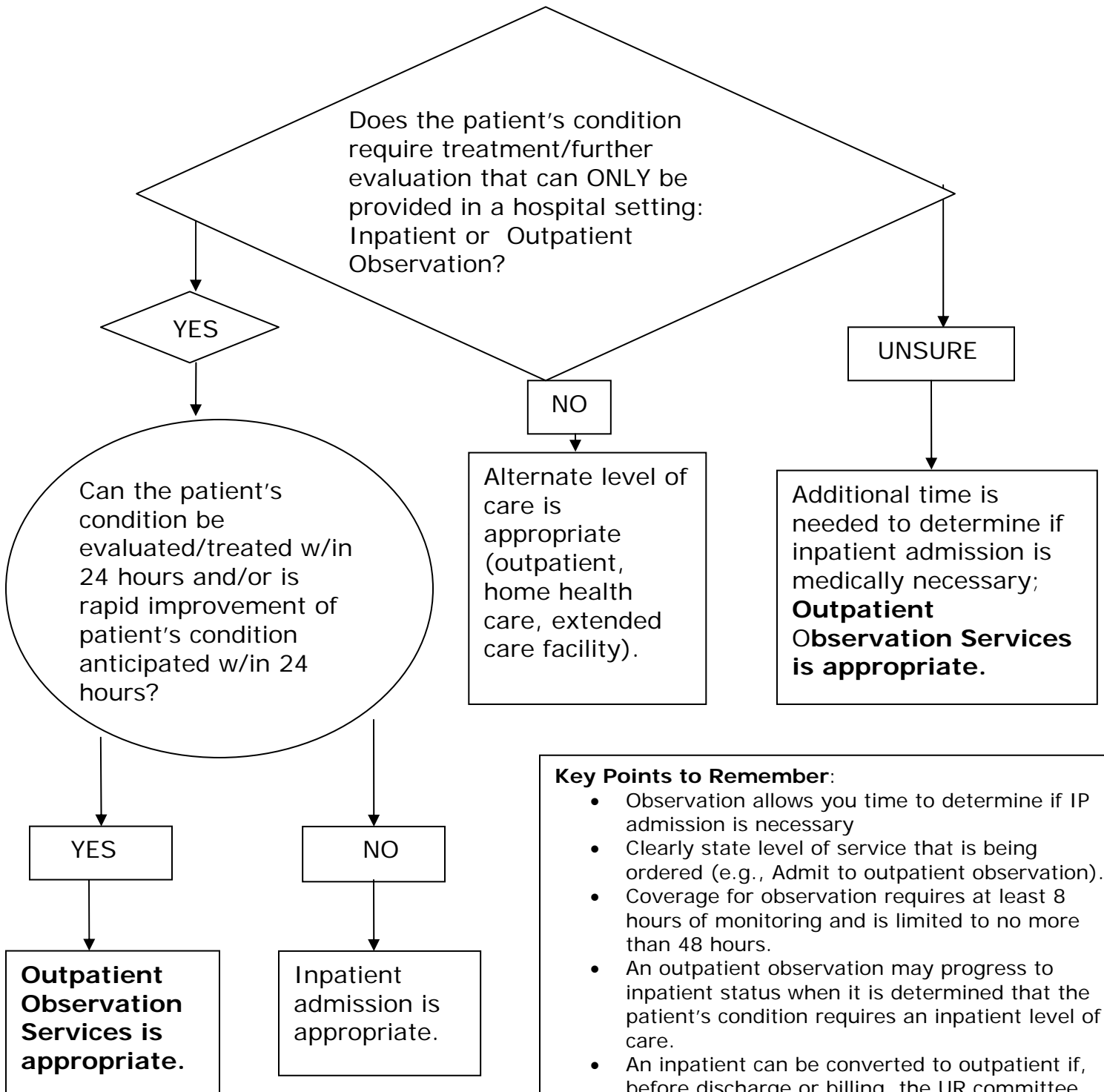
<u>Revenue Code</u>	<u>Subcategory</u>
760	General classification category
762	Observation room

Other ancillary services performed while the patient receives observation **services** are reported using appropriate revenue codes and HCPCS codes as applicable.

Hospitals must not bill patients directly for reasonable and necessary observation services for which OPPS packages payment for observation as part of the payment for the separately payable services provided in the same encounter.

Hospitals should not confuse packaged payment with non-coverage or nonpayment.

MEDICARE PATIENTS Outpatient Observation **Services** or Inpatient Admission Decision Tree



Key Points to Remember:

- Observation allows you time to determine if IP admission is necessary
- Clearly state level of service that is being ordered (e.g., Admit to outpatient observation).
- Coverage for observation requires at least 8 hours of monitoring and is limited to no more than 48 hours.
- An outpatient observation may progress to inpatient status when it is determined that the patient's condition requires an inpatient level of care.
- An inpatient can be converted to outpatient if, before discharge or billing, the UR committee determines outpatient status is more appropriate and the physician concurs and documents this in the medical record.
Condition Code 44 applies.
- Observation should not be billed for monitoring during standard postoperative recovery period (e.g. 4-6 hrs.).

CONDITION CODE 44
Inpatient Admission Changed to Outpatient Status

Description:

For use on outpatient claims only, when the physician ordered a patient to be admitted to an inpatient bed, but upon reviewing the case before discharge, and before the claim is initially submitted the hospital's Utilization Review committee determines that an inpatient level of care does not meet the hospital's admission criteria.

Effective Date: April 1, 2004

Policy and Billing Instructions:

A. In cases where a Hospital Utilization Review Committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may:

- ❖ change the patient's status from inpatient to outpatient, and
- ❖ submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the patient, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission.
3. A physician concurs with the Utilization Review Committee's decision; and
4. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

B. When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

C. When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 in one of Form Locator 24-30, or in the ANSIX12N 837 I in Loop 2300, HI segment with qualifier BG, on the outpatient claim.

Billing If Criteria for Using Condition Code 44 are Not Met:

- ❖ If the conditions for use of Condition Code 44 are not met, the hospital should submit a bill using Type of Bill 12x for covered Part B only services that were furnished to the inpatient.
- ❖ Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary

Covered Part B Only Services Furnished to an Inpatient:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests; x-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech pathology services, and outpatient occupational therapy;
- Screening mammography services;
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self-management;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO).

UCLA HEALTH SYSTEM
Hospital Compliance

References:

Medicare Claims Processing Manual, Chapter 4-Part B Hospital, Rev. 07-30-09
CMS Transmittal 1760, CR 6492
HCPCS Level II 2009
MLN Matters 5946, January 2008
CMS Transmittal No. 1417, CR 5912, January 18, 2008
CMS Transmittal No. 82, CR 5946, February 8, 2008
CMS Transmittal No. 1445, CR 5946, February 8, 2008
Medicare Claims Processing Manual, Chapter 4, Section 240.1
Medicare Claims Processing Manual, Chapter 4, Section 290
Medicare Claims Processing Manual, Chapter 4, Section 50.3
OCE Observation Criteria, specifications V9.1
APC 2008
NGS, Power Point Presentation-Observation Services 2008
www.cms.gov
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www.tmf.org/hpmp.obs