

A Refresher: Observation Services

When tracking patients' admissions status, identifying services rendered, calculating the number of observation hours, and ensuring accuracy and completeness of medical documentation, billing for observation services can be a complex and arduous task. Hospitals are faced with the daunting responsibility of shifting through an enormous amount of documents to extract relevant information required to submit accurate observation service claims. This, in combination with the Centers for Medicare & Medicaid Services' (CMS') somewhat "tricky" billing requirements and the implementation of the new CMS contractors (i.e. Recovery Audit Contractors, Medicare Audit Contractors (MACs), etc.), burdens hospitals with not only the difficulty in comprehending how to code and bill observation services correctly, but also the increased pressure of being identified as non-compliant. Accordingly, hospitals should review coding and billing regulations for observation services to facilitate compliance. This article is meant to provide an overview on observation services and assist hospitals in avoiding common pitfalls associated with observation services.

What are observation services?

CMS defines observation care as 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 are able to be discharged from the hospital."¹ Patients that are admitted into observation care are considered outpatient. Thus, payment for observation services is through the Outpatient Prospective Payment System (OPPS). Medicare will reimburse hospitals for observation services if all of the following requirements are met:

1. **Medical necessity requirements:** all observation services are reasonable and necessary. The decision to admit or discharge a patient is usually less than forty-eight (48) hours (often twenty-four hours). However, in "rare and exceptional cases reasonable and necessary outpatient observation [can] span more than 48 hours."²
2. **Physician's order requirements:** all orders for observation services are administered by "a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient test."³
3. **Documentation requirements:** the beneficiary's observation services are administered by a physician and appropriately documented in the medical records by "admission, discharge and progress notes that are timed, written, and signed by the physician."⁴ Furthermore, the medical record includes an assessment of the "patient risk to determine that the beneficiary would benefit from observation care" by the physician.⁵
4. **Observation time requirements:** all observation services commence when the beneficiary is admitted to an observation bed and ends when all appropriate clinical and medical assessments and treatments have been completed. This includes follow-up care rendered by hospital staff and

¹ CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 4, sec. 290.1, Observation Services Overview.

² Ibid.

³ Ibid.

⁴ CMS, Medicare Claims Processing Manual; January 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 1657, CR 6320 (December 31, 2008).

⁵ Ibid.

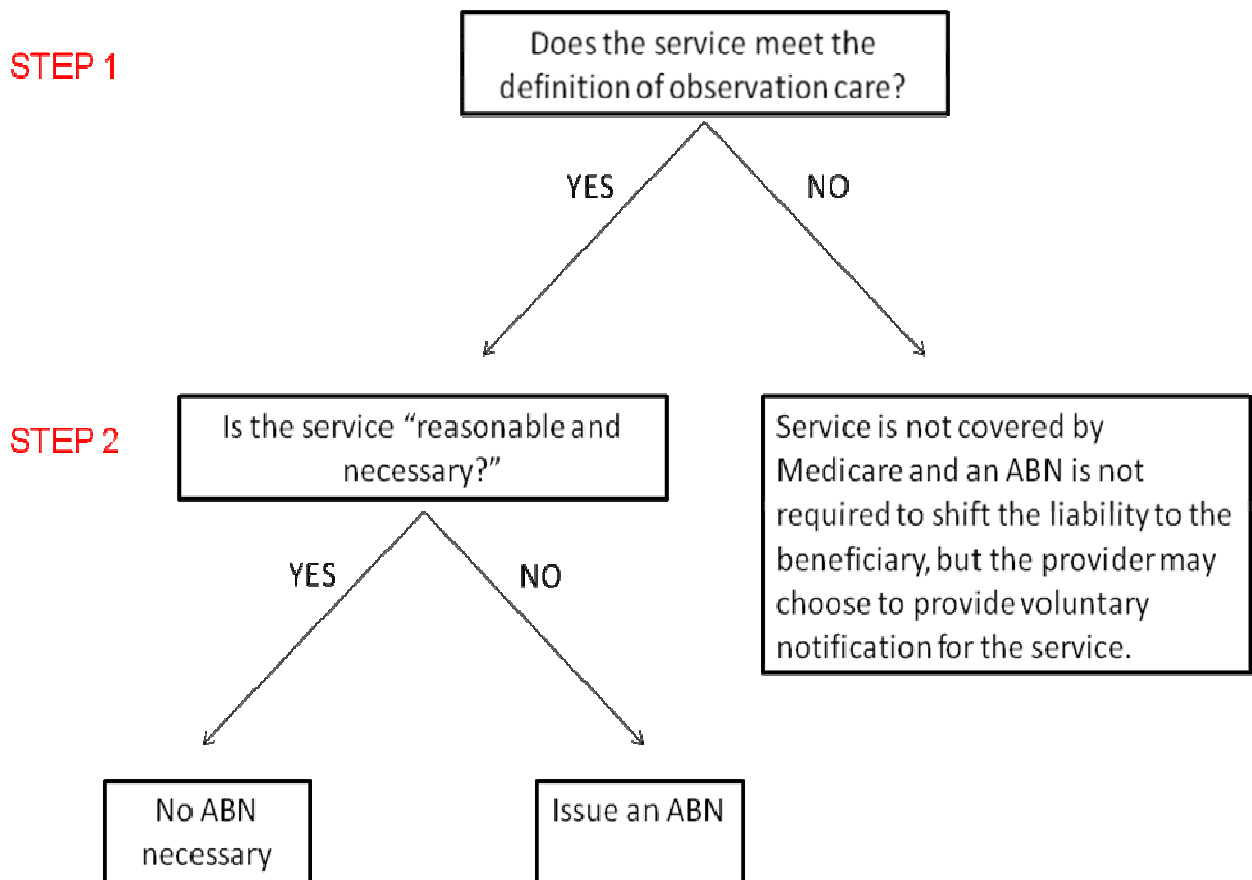
physicians. Additionally, hospitals are required to round to the nearest hours (e.g. 9:45 pm. rounds up to 10 p.m. and 3:03 pm. rounds down to 3 p.m.)

Medicare will not cover the following as observation services:

1. Non-reasonable and necessary services;
2. Services administered after termination of observation care (e.g. beneficiary awaiting transportation);
3. Services that are reimbursed under another Part B service, i.e. postoperative monitoring, routine preparation for diagnostic tests (e.g. colonoscopy), or routine recovery for diagnostic tests;
4. Observation services rendered with therapeutic services (e.g. chemotherapy); and
5. Standing orders subsequent to outpatient surgery.

A common concern that arises with non-covered observation services is when to shift financial liability to the beneficiary. When determining if an Advanced Beneficiary Notice (ABN) should be issued to the patient, hospitals should follow a two-step process as illustrated in the Figure 1.

Figure 1: The Issuance of an Advance Beneficiary Notice (ABN)



How are observation services processed?

Given that observation services are reimbursed under the OPSS, claims will be processed by the provider's respective fiscal intermediary or A/B MAC through the Integrated Outpatient Code Editor (I/OCE). The I/OCE has three major functions:

1. Edits data to identify errors.
2. Assigns an APC number to each service under OPSS (and returns this information to OPSS Pricer program for further processing).
3. Assigns an Ambulatory Surgical Center payment group to claims when applicable.

The I/OCE can only operate on a single claim and does not have the capabilities to work with multiple ("cross") claims. Thus, hospitals must report all related services in a single claim record. More specifically, when observation services are furnished in conjunction with other hospital services, all relevant codes must be reported on the same claim. In addition, the I/OCE is directed by the HCPCS and ICD-9 CM diagnosis codes. Consequently, hospitals must confirm that the HCPCS codes reported in the claim accurately reflect the services rendered.

How are observation services coded and billed?

Two Healthcare Common Procedure Coding System (HCPCS) codes are used to bill for observation services, G0378 (hospital observation services, per hour) and G0379 (direct admission of patient for hospital observation care).⁶ Observation services may be reimbursed by the following three payment methods:

1. Observation services paid as a packaged;
2. Services paid as a component of the Extended Assessment and Management Composite Ambulatory Payment Classification (composite APC); or
3. Observation services paid as a separate clinic visit:

The majority of reimbursements for observation services are packaged into a payment for other separately payable services that have been provided during the same encounter. The status indicator N is assigned to the HCPCS code G0378 to represent that the observation service will not be paid separately and payment will be packaged in other payable services on the same day.

Under certain circumstances, observation services can be paid separately. Specific codes that are grouped together may be reimbursed as a composite APC when the composite criteria are met. There are two composite APC used for observation services—composite APC code 8002 (Level I Extended Assessment and Management Composite Code) and composite APC code 8003 (Level II Extended Assessment and Management Composite Code). The composite APC code 8002 is assigned by the I/OCE when observation services are administered in conjunction with a high level clinic visit or a direct admission of patients for hospital observation care. Moreover, the I/OCE assigns the composite APC code 8003 for observation care associated with a high level emergency department visit or a critical care encounter. Hospitals may receive a separate payment for observation services if the following criteria are met:

⁶ Note: Hospitals are permitted to submit claims for patients that are directly admitted to the hospital for observation services subsequent to a referral from a physician in the community (i.e. direct admission).

Level I Extended Assessment and Management Composite (composite APC 8002):

1. Observation time is documented in the medical record (refer to “Observation time requirement” above);
2. The beneficiary is under the care of a physician during the observation period and appropriate medical documentation is evident (admission, discharge, and progress notes are timed, written, and signed by the physician as well as documentation of patient’s assessment for observation care);
3. The observation services are billed on a 13X bill type
4. The number of hours reported with the HCPCS code G0378 is at least eight hours and is billed:
 - 4.1. On the same day as HCPCS code G0379 (direct admission of patient for hospital observation care) or
 - 4.2. On the same day or the day after CPT codes 99205 (Office/Outpatient visit, new) or 99215 (Office/Outpatient visit, established); and
5. The status indicator T is not reported on the same day or a day prior to HCPCS code G0378.

Level II Extended Assessment and Management Composite (composite APC 8003):

1. Observation time is documented in the medical record (refer to “Observation time requirement” above);
2. The beneficiary is under the care of a physician during the observation period and appropriate medical documentation is evident (admission, discharge, and progress notes are timed, written, and signed by the physician as well as documentation of patient’s assessment for observation care);
3. The observation services are billed on a 13X bill type
4. The number of hours reported with the HCPCS code G0378 is at least eight hours and is billed:
 - 4.1. On the same day or the day after CPT codes 99291 (Critical Care), 99285 (Level 5 Type A emergency department visit), 99284 (Level 4 Type A emergency department visit), or HCPCS code G0384 (Level 5 Type B emergency department visit); and
5. The status indicator T is not reported on the same day or a day prior to HCPCS code G0378.

If the above criteria are met, the I/OCE will assign the primary code on the claim a composite APC (8002 or 8003) and a status indicator (Q3). The remaining related codes displayed on the claim will be assigned a status indicator N and payment will be packaged into the composite APC. If the composite criteria are not fulfilled, each code will be assigned its appropriate status indicator and/or APC for reimbursement purposes.

As noted above, observation services may be reimbursed as a separate clinic visit. More specifically, if a patient is directly admitted to a hospital for observation care and the request is from a physician within the community (i.e. direct admission of patient for hospital observation services), the observation services administered may be reimbursed under APC code 0604 (Level 1 Hospital Clinic Visit). To receive payment under APC code 0604, the following requirements must be met:

1. Observation time is documented in the medical record (refer to “Observation time requirement” above);
2. The beneficiary is under the care of a physician during the observation period and appropriate medical documentation is evident (admission, discharge, and progress notes are timed, written, and signed by the physician as well as documentation of patient’s assessment for observation care);
3. The observation services are billed on a 13X bill type

4. Both HCPCS codes G0378 and G0379 with the same date of service are reported on the same claim; and
5. No services with a status indicator T or V or Critical Care APC code 0617 were provided the same day of service as HCPCS code G0379.

Uncertainties may arise when billing for observation services affiliated with direct admission. Hospitals must keep in mind that observation services due to a direct admission from a physician's office may be reimbursed with the following payment methods:

1. A component of the Level I Extended Assessment Management Composite APC (APC 8002);
2. Packaged into T,V, or critical care service procedure; or
3. Processed as a clinic visit (APC 0604).

Therefore, as a general rule of thumb, if the composite APC is not applicable, observation services may be reimbursed under APC 0604. This usually occurs if the hours of observation reported with HCPCS code G0378 are less than eight and the status indicators T and V, as well as the critical care APC code 0617 are not reported on the same day of service as HCPCS code G0379. Lastly, if the criteria for composite APC and APC 0604 are not met, observation services will be packaged into other payable services rendered on the same day.

Table 1 is a checklist hospitals may utilize to facilitate accurate coding and billing for observation services.

How to calculate observation hours?

Hospitals must ensure that submitted claims accurately reflect the number of observation hours administered. Failure to report accurate observation hours will result in improper payment. According to CMS billing regulations, hospitals are not permitted to include diagnostic and therapeutic service hours in the total observation hours. Rather, diagnostic and therapeutic service hours are to be deducted from the total observation hours prior to submitting the bill. For example, if a beneficiary was in observation care for nine hours and two hours were attributed to laboratory testing, the two hours for diagnostic services must be subtracted, resulting in seven hours of observation services.

The total number of observation hours is also important in determining whether the observation services will be packaged into other separate payable services, reimbursed under APC 0604 or paid as a component of the composite APC. For instance, if a patient was admitted into the emergency department (CPT 99284) and received observation care for twenty hours and five hours were utilized for diagnostic and therapeutic services, the total number of observation hours is fifteen. Fifteen hours exceeds the minimum eight hour criteria to receive a separate payment for observation services and thus, the hospital will be reimbursed via the composite APC provided all additional requirements are fulfilled. In contrast, if a beneficiary was admitted into the emergency department (CPT 99284) and received observation services for eight hours and two hours were used for therapeutic services, the total hours of observation services furnished is six. As a result, the hospital will not receive reimbursement under the composite APC. Instead, the hospital will receive payment via APC 0604 or payment will be packaged into other payable services. Hospitals must ensure the appropriate protocols with regards to accurate documentation of observation hours are developed and implemented to remain in compliance with CMS' regulations.

What is next for observation services?

Based on the number of changes reported in the "Medicare Program: Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Changes to the Ambulatory Surgical Center Payment

System and CY 2009 Payment Rates,” provisions related to observation services could occur in the future. Thus, hospitals should continuously review CMS’ regulations to ensure accurate coding and billing. As presented above, complying with CMS’ observation service requirements is not a straightforward task. In addition to reviewing coding and billing regulations related to observation services, hospitals must provide on-going organization-wide education. Furthermore, to ensure that ongoing education is effective, hospitals ought to conduct regular chart audits to evaluate the effectiveness of compliance education efforts.

Table 1: Checklist for Observation Services Coding and Billing

Composite APC 8002- Level 1 Extended Assessment and Management Composite		
Yes	No	Criteria
		Are the observation hours documented in the medical record?
		Is the beneficiary under the care of a physician during the observation period and appropriate medical documentation is evident (admission, discharge, and progress notes are timed, written, and signed by the physician as well as documentation of patient's assessment for observation care)?
		Are the observation services billed on a 13x bill type?
		Is the number of hours reported with HCPCS code G0378 at least eight hours and billed: <ul style="list-style-type: none"> a. On the same day as HCPCS code G0379; or b. On the same day or the day after CPT codes 99205 and 99215?
		The claim does not report services with the status indicator T on the same day or the day before HCPCS code G0378.

Composite APC 8003- Level 2 Extended Assessment and Management Composite		
Yes	No	Criteria
		Are the observation hours documented in the medical record?
		Is the beneficiary under the care of a physician during the observation period and appropriate medical documentation is evident (admission, discharge, and progress notes are timed, written, and signed by the physician as well as documentation of patient's assessment for observation care)?
		Are the observation services billed on a 13x bill type?
		Is the number of hours reported with HCPCS code G0378 at least eight hours and billed: <ul style="list-style-type: none"> a. On the same day or the day after CPT codes 99291, 99285, 99284, or HCPCS code G0384?
		The claim does not report services with the status indicator T on the same day or the day before HCPCS code G0378.

APC 0604- Level I Hospital Clinic Visit

Yes	No	Criteria
		Are the observation hours documented in the medical record?
		Is the beneficiary under the care of a physician during the observation period and appropriate medical documentation is evident (admission, discharge, and progress notes are timed, written, and signed by the physician as well as documentation of patient's assessment for observation care)?
		Are the observation services billed on a 13x bill type?
		Are HCPCS codes G0378 and G0379 reported the same day and on the same claim?
		The claim does not report services with the status indicator T or V as well as critical care services associated with APC code 0617 on the same day as HCPCS code G0379.

Packaged Payment for Observation Services

Yes	No	Criteria
		Are the observation hours documented in the medical record?
		Is the beneficiary under the care of a physician during the observation period and appropriate medical documentation is evident (admission, discharge, and progress notes are timed, written, and signed by the physician as well as documentation of patient's assessment for observation care)?
		Are the observation services billed on a 13x bill type?
		Is HCPCS codes G0378 reported with the correct number of hours?

Resources:

1. Medicare Program: Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates, 74 Fed. Reg. 223, 68922, 69380 (Nov. 18, 2008).
2. Centers for Medicare & Medicaid Services Medicare: Hospital Outpatient Prospective Payment System and CY 2008 payment rates, etc, 72 Fed. Reg. 227, 66814, 66815 (Nov. 27, 2007).
3. CMS, Medicare Claims Process Manual, January 2009 Integrated Outpatient Code Editor (I/OCE) Specification Version 10.0, Trans. 1664, CR 6315 (January 9, 2009).
4. CMS, Medicare Claims Processing Manual; January 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 1657, CR 6320 (December 31, 2008).
5. CMS, Medicare Benefit Policy Manual, January 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 100, CR 6320 (December 31, 2008).
6. CMS, Medicare Benefit Policy Manual, CMS 100-02, Ch. 6 sec. 20.6, Outpatient Observation Services.
7. CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 4, sec. 10.2.1, Composite APCs.
8. CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 4, sec. 290.1, Observation Services.
9. CMS, Medicare Claims Processing Manual, CMS 100-04, Ch.4, sec. 290.2, General Billing Requirements for Observation Services.
10. CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 4, sec. 290.5.1, Billing and Payment for Observation Services Beginning January 1, 2008.
11. CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 4, sec. 290.5.2, Billing and Payment for Direct Admission to Observation Care Beginning January 1, 2008.
12. CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 4, sec. 290.6, Services Not Covered as Observation Services.
13. "Some Hospitals are Noncompliant With CMS Rules on Counting Observation Hours." Report on Medicare Compliance Vol. 17, No. 40. 3 Nov. 2008.