



IMA INSIGHTS

MEDICARE OBSERVATION STATUS - HIGH ON THE RAC'S RADAR

To our Healthcare Clients and Friends:

In this edition of *IMA Insights* we will discuss an issue that, while not new, will likely become a major compliance and revenue integrity issue again this year - the appropriate use of '**Observation Services**'. This edition of *IMA Insights* is the first of two editions that will focus on observation services over the next few months. This issue continues to be very complex and the related rules and regulations surrounding it are often unclear and confusing. Couple this confusion with the roll-out of the Recovery Audit Contractor Program (RAC) on a national scale, (the 'bounty hunters' who are paid on a contingency fee basis to recover monies from providers), and protecting your revenue will become a major issue for Hospital providers.

If you take into consideration the fact that, for every patient who is misclassified as 'Observation Status' vs. 'Inpatient Status', a hospital could lose approximately \$4,400 - \$5,000 per case. This issue could cost your facility hundreds of thousands of dollars. This edition of *IMA Insights* focuses on the 'basics' of the observation rules by defining observation, reviewing the documentation and billing requirements, discussing recent changes from The Centers for Medicare and Medicaid Services (CMS), and outlining just how big this issue may become now that the RACs have it on their radar.

A future edition of *IMA Insights* will begin to discuss the numerous pitfalls that face providers, provide detailed scenarios for our readers, and provide insights on how to remain compliant and protect your revenue.

BACKGROUND

CMS reimburses hospitals for services that are determined to be medically necessary. CMS defines medical necessity as the provision of services or supplies that are needed for the diagnosis or treatment of the patient's medical condition. Medically necessary services are those that meet the standards of good medical practice and are not provided for the convenience of the patient or the physician. CMS only provides reimbursement to providers if the service is deemed to be medically necessary for the treatment of the patient's medical condition.

The Medicare Claims Processing Manual Section 290.1 defines observation services 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.

Observation is considered a patient status. Observation status would be appropriate for patients whose medical outcome cannot be determined at the time the decision is made to keep the patient in the hospital. Physicians should consider if it is appropriate to admit the patient to the hospital, if it is medically safe to discharge the patient and if the patient can be discharged and receive further treatment as an outpatient. Situations when the resolution of the patient's condition is unstable or unknown may appropriately be treated as observation status.

Provision of observation services need not be in one specific area of the hospital. Observation can be provided in the emergency department (ED), adjacent to the ED, a designated observation unit, or any hospital bed.

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DOCUMENTATION AND BILLING REQUIREMENTS

CMS reimburses hospitals for observation services either as a bundled service or as a separately payable ambulatory payment classification (APC). To receive reimbursement for a separate APC for observation, the patient must have a diagnosis of chest pain, asthma, or congestive heart failure. The requirements are as follows:

- Order for observation by a physician to admit patients to a hospital or to order outpatient services.
- Observation time must be documented in the patient's medical record. The observation time begins with the time of the nurse's observation admission note. (The time ends when all clinical or medical interventions have been completed. The end time includes any follow up care provided by hospital staff or physicians that may take place after the order for discharge or admission has been written).
- Observation time for Medicare beneficiaries must be equal to or greater than eight hours and reported with HCPCS code G0378. If the observation time spans more than one calendar day, all the hours for the observation period should be reported on a single line and the date of service should be the date the patient was admitted to observation.
- Direct admission to observation occurs when a physician refers a patient to the hospital for observation and does not utilize services in the emergency department. HCPCS code G0379 (APC 0604) should be utilized to report this service.
- One of the following services must be included with a date of service of the same day or of the day before the observation service:
 - Emergency Room visit (APC 0610, 0611, or 0612)
 - Clinic Visit (APC 0600, 0601, or 0602)
 - Critical Care (APC 0620)
 - Direct admission to observation reported with HCPCS code G0379 (APC 0604)
- No procedure with a 'T' status indicator can be reported on the same day or day before observation care is provided. (Status indicator 'T' is defined as a significant procedure that is paid under the hospital APC rate that has a multiple rate reduction). If a 'T' status procedure has been performed on the same day of or the day prior to observation services, CMS will not reimburse separately for observation status. The observation services will be considered packaged into the procedure APC.
- The patient must be under the care of a physician during the period of observation as evidenced by documentation in the patient's medical record by admission, discharge, and other progress notes that are timed, written, and signed by the physician. The physician note must state the assessed patient risk to determine that the patient would benefit from observation care.

If these criteria are not met, payment for any separately payable services would be made through the usual associated APCs. Reimbursement for observation services is made under APC 0339 on bill type 013X (Hospital Outpatient). The number of hours assigned should be billed with Revenue Code 0762 with HCPCS code G0378. CMS states that most observation services should not exceed one day. All of the services should be billed on the same claim so that the processing logic will determine the appropriate payment.

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NEW FOR 2008

New this year is the fact that CMS has developed a process utilizing the Outpatient Code Editor (OCE) that may package your observation services when certain criteria are met. The OCE is a system that edits claims to identify services that have combinations of identified CPT codes on the same date of service and group them to a composite APC.

The 2 composite APCs specific to observation services are APC 8002 and APC 8003.

- APC 8002 is a Level I extended assessment and management composite and includes a high level (Level 5, or 99215 or 99205) clinic visit or a direct admission to observation HCPCS G0379 and G0378, billed with 8 or more hours of observation care.
- APC 8003 is a Level II extended assessment and management composite and includes Level 4 or Level 5 emergency department visit (99284 or 99285) or critical care (99291) and G0378, billed with 8 or more hours of observation care.

The OCE will evaluate the claim to identify whether reimbursement for one of these composite APCs is appropriate. If a hospital provides a service with a status indicator of 'T' on the same date or one day earlier than the observation service with G0378, the hospital will not be eligible for payment under APC 8002 or APC 80003. There are no diagnostic limitations for these composite APCs. If any of the criteria are not met, payment will be made utilizing the usual APC rate associated with each separately payable APC service, including the Clinic or Emergency Room visit.

INSIGHTS

Some examples of appropriate use of observation services include evaluating a patient for possible inpatient admission, treating patients expected to be stabilized and released, or extended recovery following a complication of an outpatient procedure. Outpatient complications may include abnormal postoperative bleeding, poor pain control, intractable vomiting, and delayed recovery from anesthesia.

When considering the use of observation services, start by monitoring your patient flow through the emergency department. Patients with chest pain, congestive heart failure, and asthma are faced with health concerns that bring them to hospitals on a daily basis. Before you admit the patient to the hospital, ask yourself the following questions:

- Is the patient's diagnosis unclear and may be determined in less than 24 hours?
- Is there an expectation that the patient can be treated and stabilized in less than 24 hours?
- Does the patient's condition require monitoring that can only be provided in an inpatient setting?
- Is there a complication of an ambulatory surgery that requires observation greater than 6 hours?

A process should be developed that includes extensive training on the selection of the appropriate patient status for the level of care provided to your patients.



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Observation services are a covered Medicare benefit that provide for the care of a patient with an unstable medical condition and a diagnosis of chest pain, asthma, or congestive heart failure. Services that do not qualify for reimbursement as observation include those services provided for the convenience of the patient, routine preparation and recovery before and after diagnostic or therapeutic procedures, and procedures designated by CMS as ‘inpatient only’ procedures.

To guarantee your facility receives the appropriate reimbursement for observation services, physician medical documentation training and coding is not only recommended, but should be considered mandatory.

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We are pleased to have had the opportunity to provide this information to you. If you have any questions regarding this issue, please do not hesitate to contact either Liz Scholz at (484) 653-9750, Sandy Newstein at (610) 742-1424, or me at (484) 832-0044.

Yours very truly,

John Manzi
Director, Finance

ANNOUNCEMENTS

Promotion: John Manzi to Director, Finance and Regulatory Practice

John is a healthcare financial advisor who excels in providing qualified and timely advice. He has over 30 years experience in the healthcare field, primarily in hospital financial management in both hospital and consulting settings. John’s expertise includes Medicare & Medicaid cost reporting reimbursement and CMS regulatory issues, expense & revenue budgeting, reimbursement software, charge setting enhancement tools, financial feasibility reviews and product line profitability management.

New Hire: Tim Clancy, Director, Operations Improvement Practice

Tim has 20 years proven success facilitating improved operations in a wide variety of organizations and industries. He has demonstrated measurable impact on bottom line margins through reduced expenses, increased volumes, market share, and net revenue, while improving clinical quality, customer satisfaction, and cycle time. Tim is an experienced and credentialed teacher, coach, and mentor of staff, managers, physicians, senior leaders, and board members.

Also joining IMA Consulting are Senior Consulting Managers: John M. Cicero RPH, CPH, MBA; Elizabeth S. Scholz, RN, CPC, CPC-H; Lucinda Rook, RN, CPC; and Helene Montini. Consulting Manager: Mike Tedesco.