Observation – Charging, Billing, Compliance and Reimbursement

Medicare rules on charging, billing, and reimbursement of observation care are often misunderstood.

A concise list of rules regarding observation billing follows:

1. **Payment for observation hours (G0378) is always "packaged" under Medicare OPPS to another payable procedure**. For example, 8 or more hours of observation care G0378 may "bump" Medicare's OPPS payment for an ED visit code 99285 from APC 5025 ($486.04) to a higher-paying APC 8011 -- Comprehensive Observation Services ($2,174.14.) The remittance will not indicate additional payment on the G0378 line, but higher payment on the 99285 line.
2. **Observation begins on the date and time of the physician order**. There must be a Physician order for referring the patient to observation, and the service must be reasonable and medically necessary.
3. **Observation care is reported on the claim with an hourly charge billed using HCPCS G0378**. At least 8 hours is required to meet Medicare's requirement for payment of APC. Less than 8 hours of observation will not "bump" any payable service.
4. **Observation hours must be billed together with an outpatient visit to qualify for reimbursement under OPPS APC 8011 -- Comprehensive Observation Services.** Typically a patient is referred to observation following a hospital emergency department visit. If the patient is referred directly from a community physician, the hospital may bill HCPCS code G0379 - Direct Admission of Patient for Hospital Observation Care; this is necessary to qualify for the observation APC payment.
5. **Medicare has not established a maximum number of hours** a patient may remain in observation status, but the Medicare Claims Processing Manual states that "…In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours." There is no incremental reimbursement for observation hours after the minimum requirement (8) is met.
6. **Observation time must not accrue during a period when the patient is closely monitored for another payable service.** Separately reimbursed services which include "significant monitoring" should not be billed concurrent with observation care. (See Concurrent Procedures section below.)
7. **Reimbursement for observation care under APC 8011 is not payable** when billed on the same day or the day following a surgical APC status T procedure.
8. **Observation should not be routinely charged following surgical procedures**. Patients should not be placed in observation status following an outpatient procedure based on (a) a standing order, (b) an order given prior to the procedure, or (c) an order that does not articulate patient-specific physician findings indicating the need for observation services. It is not appropriate to categorize extended recovery as observation care.
9. **Observation hours may not be charged retroactively.** If the physician changes the patient status from inpatient to observation prior to discharge, the hospital may not add observation hours in lieu of the room rate; documentation must support the beginning of observation concurrent with the order for observation care.
10. **An inpatient stay which does not meet criteria for inpatient billing cannot be changed to observation care after the patient is discharged.** In this instance, the hospital may elect to bill Part B services only on bill type 012X.

Observation – Charging, Billing, Compliance and Reimbursement

Observation Defined -- Both the Medicare Benefits Policy Manual (Chapter 6, section 20.6) and the Medicare Claims Processing Manual (chapter 4, section 290) offer the following 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 are able to 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. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services."

Visit codes listed below, when billed with at least 8 hours of observation (G0378) and no other surgical status T procedure, qualify for APC 8011 (Comprehensive Observation Services) payment under OPPS:

HCPCS / CPT®
99281 - Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282 - Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283 - Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284 - Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285 - Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Observation – Charging, Billing, Compliance and Reimbursement

Visit Codes (continued):

HCPCS / CPT®
99291 - Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
G0379 - Direct Admission Of Patient For Hospital Observation Care
G0380 - Level 1 hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0381 - Level 2 hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0382 - Level 3 hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0383 - Level 4 hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 cfr 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0384 - Level 5 hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 cfr 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0463 - Hospital outpatient clinic visit for assessment and management of a patient

Under Medicare's OPPS system, reimbursement for covered observation care is always packaged into another payable service. The "payable" service is the qualifying visit code, provided there is no other APC status T procedure on the claim. If a status T procedure is billed, no additional reimbursement is provided for observation care, regardless of the number of observation hours billed.

Reimbursement under APC 8011: Medicare OPPS reimburses facilities for observation services through APC 8011 -- Comprehensive Observation Services. This composite APC payment, which is reimbursed at a national rate of $2,174.14 in 2016, represents payment for the entire extended care encounter, including expensive status K drugs like TNKase and activase, when the following criteria are met:

- Eight or more units (hours) of HCPCS code G0378 are billed
  - on the same day as HCPCS code G0379; or
  - on the same day or the day after HCPCS code G0463 or CPT® codes 99281, 99282, 99283, 99284, 99285, G0380, G0381, G0382, G0383, G0384, or 99291;
- And there is no surgical service assigned to APC status indicator T on the claim on the same date of service or 1 day earlier than HCPCS code G0378.

Direct referral to Observation (HCPCS code G0379) is billed in lieu of a visit code for patients who are referred to observation by a community physician. This code represents the nursing resources required in a facility-based outpatient evaluation service. G0379 is reimbursed at a lower APC 5013 ($480.69) when less than 8 hours of G0378 are reported and no APC Status T procedure is payable.

It is important for hospitals to ensure that direct referrals to observation are reported with G0379, as this may trigger reimbursement whether or not the requirements for APC 8011 are met, or APC 5013 **if** less than 8 hours of observation are reported. Of course, if G0379 is billed with a surgical status T service, payment for G0379 will be packaged to the surgical APC.

Use of Observation as Extended Recovery Time -- Many hospitals and physicians struggle with whether observation status is appropriate when a patient requires an extended recovery of more than 4 to 6 hours after outpatient surgery. The following Medicare claims processing manual excerpt is commonly cited:

> Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)
>
> http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
>
> 290.2.2 - Reporting Hours of Observation
>
> "…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. Similarly, 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 payments for those diagnostic services."

Noridian, a Medicare Administrative Contractor in the western US, provides clarification in the record of its December, 2009 Outpatient Observation Presentation Q&A session:

https://www.noridianmedicare.com/provider/updates/docs/ObservationQAs.pdf

Q15. When does observation start, after six hours of recovery care or when the patient is admitted to the inpatient floor?

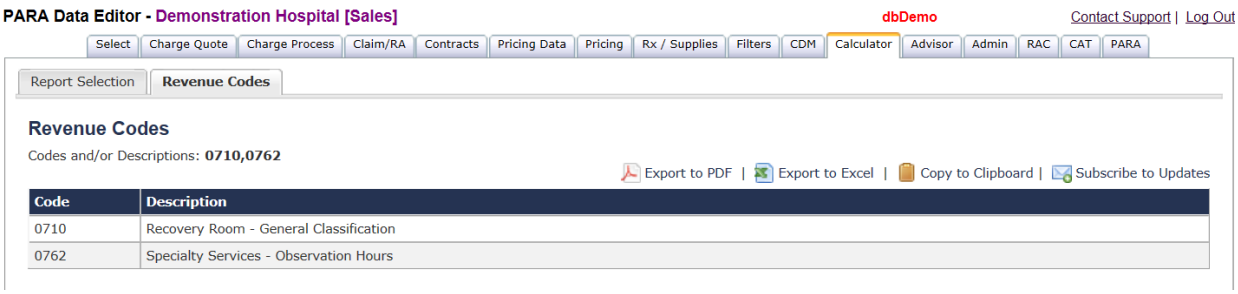
A15. Observation time does not include recovery time from surgery. Observation starts when the physician orders observation care and the patient is placed in the observation bed.

…

Q30. We have standing orders for observation after surgery; we do not have the patient sign an ABN but bill observation hours knowing that Medicare will not pay, is this accurate?

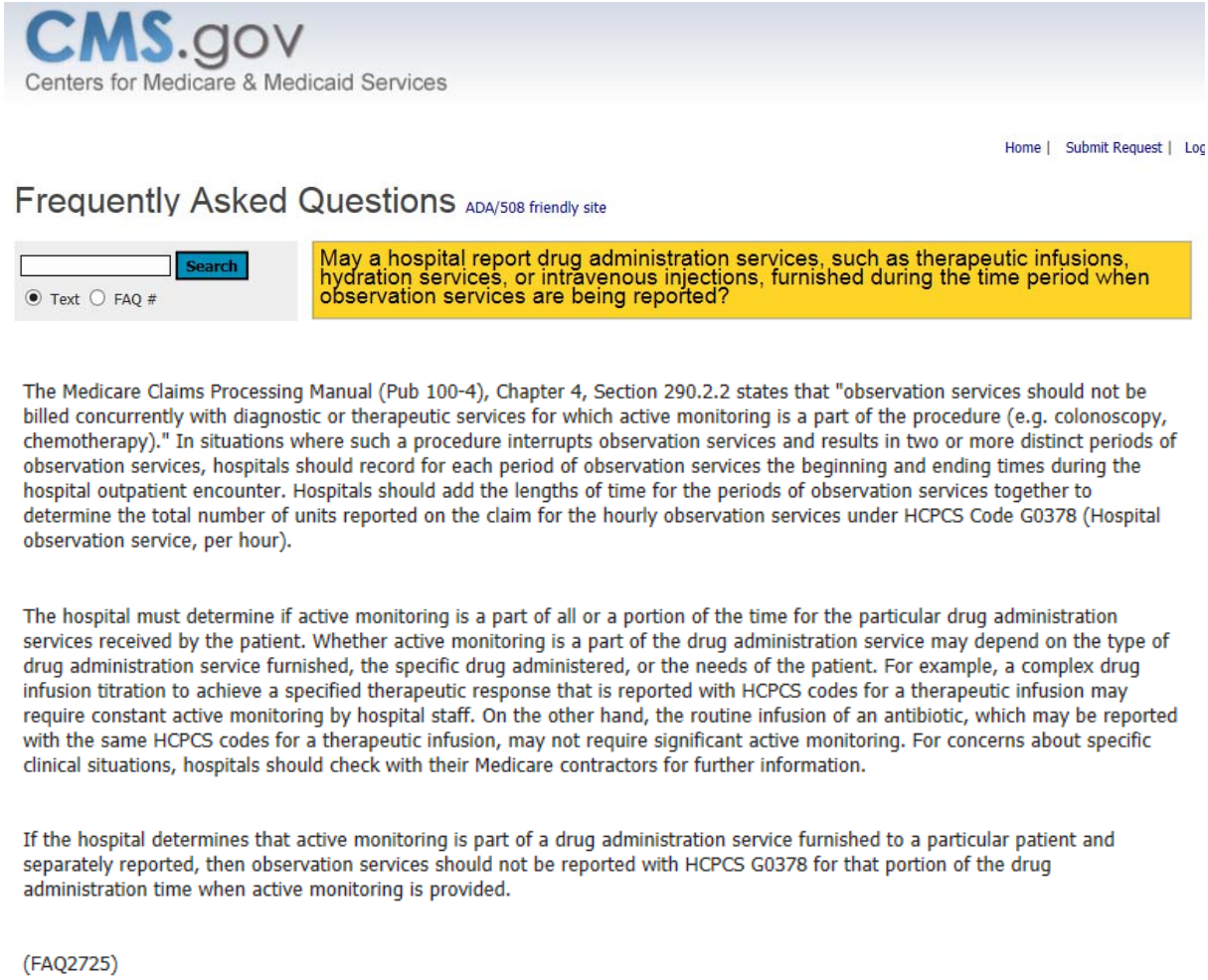
A30. Per IOM 100-04, Chapter 4 Section 290.2.2: "General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services." If a patient needs observation beyond the standard recovery period because of patient status or a complication, a specific order for observation must be written at that time. If no specific order was written, any observation hours on the claim must be billed in non-covered.

PARA recommends that hospitals bill outpatient recovery services as recovery room charges under revenue code 0710, whether or not the patient's recovery time exceeds the "4 to 6 hours" example. Following outpatient surgery, a change to observation status may be appropriate if the patient's condition deteriorates or a complication from surgery has developed which calls into question whether the patient may be safely discharged or may require inpatient care.



Concurrent Procedures - Facilities are cautioned to be conservative in charging observation hours when also charging for diagnostic or therapeutic procedures which require the patient to leave the unit for services, such as radiology or cardiology testing. Further, CMS requires that observation hours should be reduced for procedures which require "active monitoring". The following CMS FAQ provides guidance for hospitals in determining which procedures include "active monitoring":

https://questions.cms.gov/faq.php?id=5005&faqId=2725



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Text FAQ #

May a hospital report drug administration services, such as therapeutic infusions, hydration services, or intravenous injections, furnished during the time period when observation services are being reported?

The Medicare Claims Processing Manual (Pub 100-4), Chapter 4, Section 290.2.2 states that "observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g. colonoscopy, chemotherapy)." In situations where such a procedure interrupts observation services and results in two or more distinct periods of observation services, hospitals should record for each period of observation services the beginning and ending times during the hospital outpatient encounter. Hospitals should add the lengths of time for the periods of observation services together to determine the total number of units reported on the claim for the hourly observation services under HCPCS Code G0378 (Hospital observation service, per hour).

The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.

If the hospital determines that active monitoring is part of a drug administration service furnished to a particular patient and separately reported, then observation services should not be reported with HCPCS G0378 for that portion of the drug administration time when active monitoring is provided.

(FAQ2725)

In addition, facilities should avoid billing observation hours concurrently with other billable services which require "direct" or "personal" physician supervision. There is no additional guidance as to the specific list of billable services which duplicate the care required for observation. Hospitals should be particularly careful not to bill observation time which services are rendered away from the medical unit, for instance an imaging study which requires transferring the patient to a radiology suite.

Medicare published a list of extended duration services which are "nonsurgical therapeutic services that have a tendency to last for a long period of time, that largely consist of monitoring…" While the purpose of this list is to allow a relaxed physician supervision requirement, it may also serve as a reference list of those services which may require supervision that duplicates observation care.

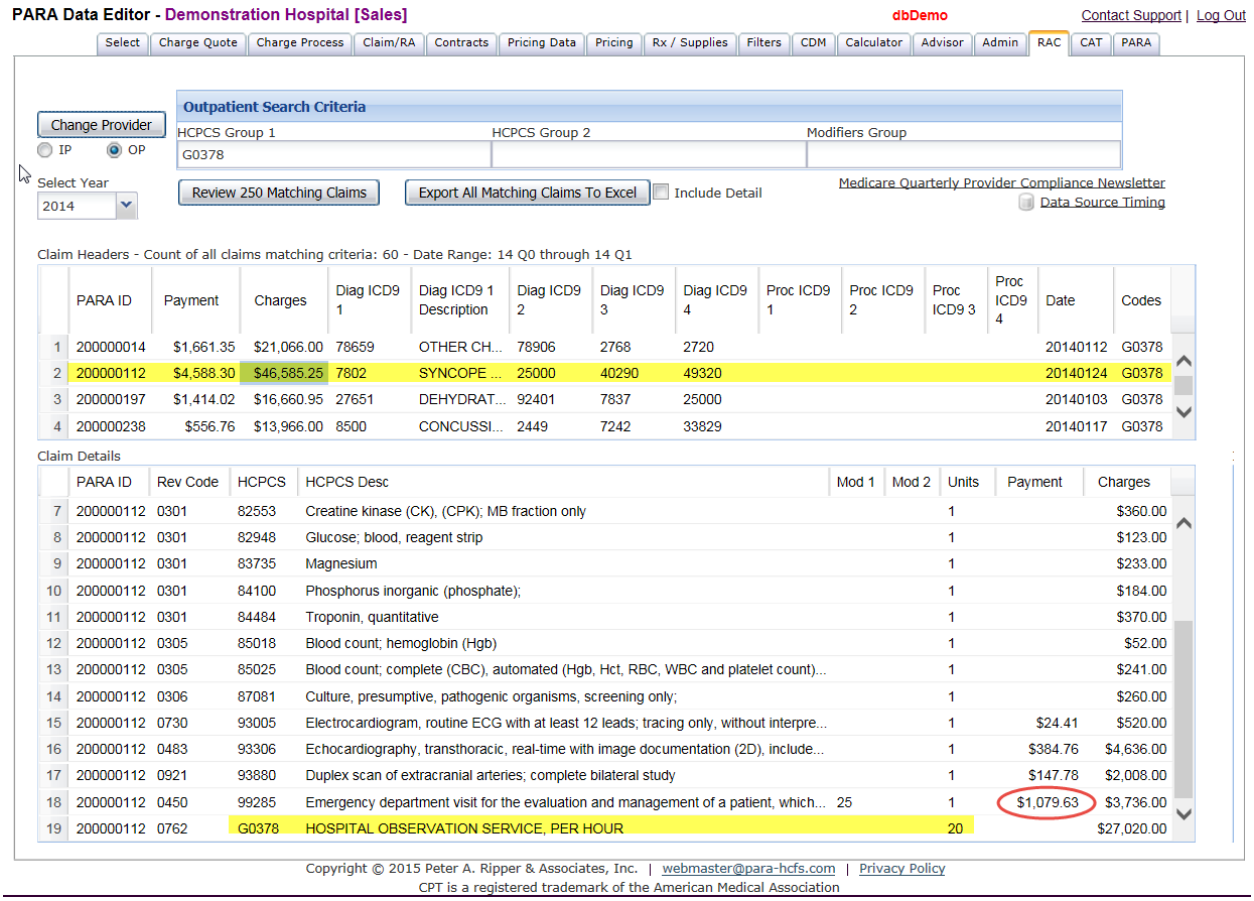
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1525-FC_FINAL_2012_Extended_Duration_Services.pdf

The following table provides the list of services that are designated as non-surgical extended duration therapeutic services (extended duration services) for calendar year (CY) 2012. See 42 CFR 410.27 and the Medicare Benefit Policy Manual (IOM Pub. 100-02) Chapter 6 Section 20.7 for the definition of physician supervision for these services.

Nonsurgical Extended Duration Therapeutic Services, CY 2012	
HCPCS Code	**Long Description**
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump
G0378	Hospital observation services, per hour
G0379	Direct admission of patient for hospital observation care
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)

Observation – Charging, Billing, Compliance and Reimbursement

The PARA Data Editor – RAC Tab is useful in auditing observation claims and payment: The following 2014 claim was paid at the higher APC – over 8 hours of observation were billed with a high level ED visit. Without the 8 hours of observation, the visit code 99285 would have been reimbursed at $455.93. In this case, the 99285 was paid at the higher "composite" 2014 APC rate of $1,198.91 less patient coinsurance and deductible:



PARA Data Editor - Demonstration Hospital [Sales] dbDemo Contact Support | Log Out

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx / Supplies | Filters | CDM | Calculator | Advisor | Admin | RAC | CAT | PARA

Change Provider

IP OP

Select Year 2014

Outpatient Search Criteria

HCPCS Group 1: G0378 | HCPCS Group 2 | Modifiers Group

Review 250 Matching Claims | Export All Matching Claims To Excel | Include Detail

Medicare Quarterly Provider Compliance Newsletter

Data Source Timing

Claim Headers - Count of all claims matching criteria: 60 - Date Range: 14 Q0 through 14 Q1

	PARA ID	Payment	Charges	Diag ICD9 1	Diag ICD9 1 Description	Diag ICD9 2	Diag ICD9 3	Diag ICD9 4	Proc ICD9 1	Proc ICD9 2	Proc ICD9 3	Proc ICD9 4	Date	Codes
1	200000014	$1,661.35	$21,066.00	78659	OTHER CH...	78906	2768	2720					20140112	G0378
2	200000112	$4,588.30	$46,585.25	7802	SYNCOPE ...	25000	40290	49320					20140124	G0378
3	200000197	$1,414.02	$16,660.95	27651	DEHYDRAT...	92401	7837	25000					20140103	G0378
4	200000238	$556.76	$13,966.00	8500	CONCUSSI...	2449	7242	33829					20140117	G0378

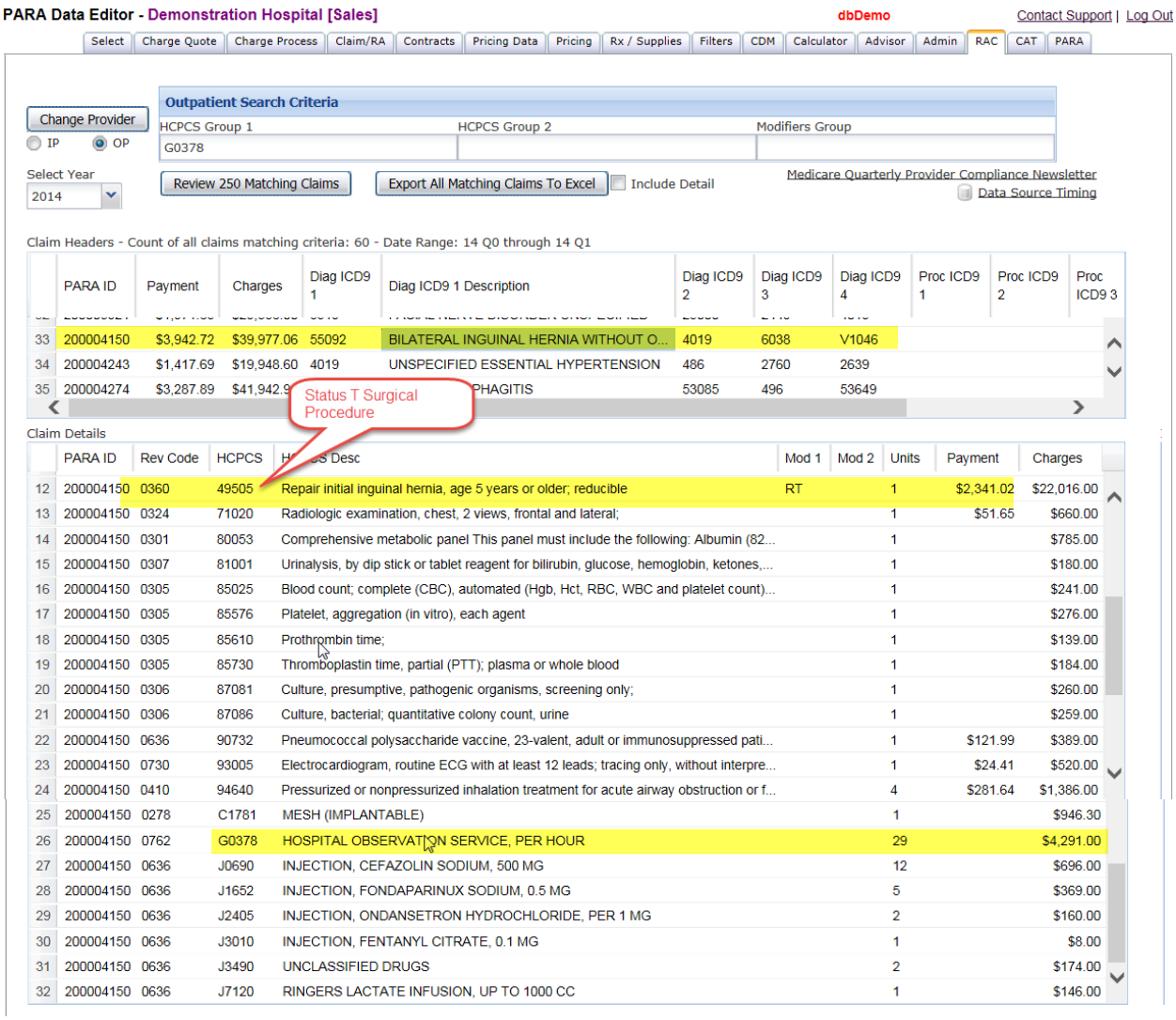
Claim Details

	PARA ID	Rev Code	HCPCS	HCPCS Desc	Mod 1	Mod 2	Units	Payment	Charges
7	200000112	0301	82553	Creatine kinase (CK), (CPK); MB fraction only			1		$360.00
8	200000112	0301	82948	Glucose; blood, reagent strip			1		$123.00
9	200000112	0301	83735	Magnesium			1		$233.00
10	200000112	0301	84100	Phosphorus inorganic (phosphate);			1		$184.00
11	200000112	0301	84484	Troponin, quantitative			1		$370.00
12	200000112	0305	85018	Blood count; hemoglobin (Hgb)			1		$52.00
13	200000112	0305	85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)...			1		$241.00
14	200000112	0306	87081	Culture, presumptive, pathogenic organisms, screening only;			1		$260.00
15	200000112	0730	93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpre...			1	$24.41	$520.00
16	200000112	0483	93306	Echocardiography, transthoracic, real-time with image documentation (2D), include...			1	$384.76	$4,636.00
17	200000112	0921	93880	Duplex scan of extracranial arteries; complete bilateral study			1	$147.78	$2,008.00
18	200000112	0450	99285	Emergency department visit for the evaluation and management of a patient, which...	25		1	$1,079.63	$3,736.00
19	200000112	0762	G0378	HOSPITAL OBSERVATION SERVICE, PER HOUR			20		$27,020.00

Changes to Packaging Rules -- In 2014, payment for lab services and observation charges were "packaged" to the Emergency Department visit code reimbursement. As you can see above, in 2014 certain non-lab HCPCS were separately reimbursed, such as the duplex artery scan 93880, the TTE 93306, and the EKG, 93005. In 2016, however, Medicare packages payment for these codes into the higher-paying composite on the ED visit charge. While the composite offers higher reimbursement than in previous years, the codes that are packaged to it are greatly increased.

Observation – Charging, Billing, Compliance and Reimbursement

Reimbursement for observation on the claim below is packaged into payment for the status T procedure:



Reimbursement Considerations

1. **Medicare Reimbursement will be packaged into another payable service:** Most commonly, observation services are provided after an emergency department evaluation (99284/99285). When observation (G0378) is billed with a clinic or ED evaluation and management code, or the direct-to-observation nursing assessment G0379, Medicare will pay the higher APC 8011 rate provided no status T HCPCS procedures are also on the claim. Since G0378 is considered packaged into the APC, the higher payment appears on the remittance advice next to the E/M code line item, not on the G0378 line.

2. **Change from Observation to Inpatient Status:** Utilization Review staff should evaluate every patient in observation status prior to discharge to determine whether the patient meets criteria for inpatient status assignment. Any change in status must be accomplished prior to discharge and supported by an appropriate physician order. Inpatient payment under Medicare IPPS DRGs is typically much higher than the alternative APC reimbursement as an outpatient claim (three examples at the end of this document illustrate inpatient DRG to outpatient/APC reimbursement). Under Medicare's 72-hour rule, outpatient services for conditions which are related to the inpatient admission and provided up to three days prior to the admit (including observation hours) should be billed on the inpatient claim, which is reimbursed under DRG methodology.

3. **The "Two Midnights" Rule**, which provides hospitals a measure of protection against denials for medical necessity on inpatient claims, produced a new means by which facilities can indicate time spent in outpatient services prior to an inpatient admission on the claim form. Occurrence Code 72, "First/Last Visit Dates" signifies that the entire episode of care is not represented by the From/Through service dates of Form Locator 06 (Statement Covers Period); it allows facilities to defend against medical review through indicating contiguous outpatient hospital services which preceded the inpatient admission.

4. **Change from Inpatient to Observation Status:** Prior to discharge, the attending physician or the hospital's UR Committee may document an order to change the status of an admitted inpatient to observation status if the case does not meet inpatient status criteria (intensity of service/severity of illness). In that event, the claim for observation services must indicate Condition Code 44. For more information, refer to CMS MedLearn "Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient" at:

   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0622.pdf

A link and excerpt from the Medicare Claims Processing Manual regarding Outpatient Observation Services is provided:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

290 - Outpatient Observation Services
(Rev. 1, 10-03-03)
A3-3663, A3-3112.8.D, A-01-91

290.1 - Observation Services Overview
(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)
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 are able to 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. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, 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.

290.2 - General Billing Requirements for Observation Services
(Rev. 787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

290.2.1 - Revenue Code Reporting
(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

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

Revenue Code	Subcategory
0760	General Classification category
0762	Observation Room

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

Medicare Claims Processing Manual, Chapter 4 – continued

290.2.2 - Reporting Hours of Observation

(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.
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. Similarly, 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 payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

290.3 - Reserved

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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290.5 - Billing and Payment for Observation Services Furnished on or After January 1, 2008

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

290.5.1 - Billing and Payment for Observation Services Beginning January 1, 2008

(Rev. 2903, Issued: 03-11-14, Effective: 04-01-14, Implementation: 04-07-14)

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. *Beginning January 1, 2014, in* certain circumstances when observation care is billed in conjunction with a clinic visit, high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through *APC 8009 (Extended Assessment and Management Composite*)

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when certain criteria are met. *Prior to January 1, 2014, in certain circumstances when observation care was billed in conjunction with a high level clinic visit (Level 5), high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment could be made for the entire extended care encounter through one of two composite APCs (APCs 8002 and 8003) when certain criteria were met. APCs 8002 and 8003 are deleted as of January 1, 2014.* For information about payment for extended assessment and management composite APC, see §10.2.1 (Composite APCs) of this chapter.

There is no limitation on diagnosis for payment of *APC 8009*; however, composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

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

1. Observation Time
    a. Observation time must be documented in the medical record.

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b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
c. A beneficiary's time receiving observation services (and hospital billing) 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.
d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services
   b. 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 the day before the date reported for observation:
      - A Type A or B emergency department visit (CPT codes 99284 or 99285 or HCPCS code G0384); or
      - A clinic visit (*HCPCS code G0463 beginning January 1, 2014;* CPT code 99205 or 99215 *prior to January 1, 2014*); or
      - Critical care (CPT code 99291); or
      - Direct referral for observation care reported with HCPCS code G0379 (APC *0633*) must be reported on the same date of service as the date reported for observation services.
   b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation
   a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, 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 beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that the criteria will be met for payment of the extended encounter through extended assessment and management composite payment.

Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a composite APC payment.

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Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5.2 - Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008

(Rev. 2903, Issued: 03-11-14, Effective: 04-01-14, Implementation: 04-07-14)

Direct referral for observation is reported using HCPCS code G0379 (Direct referral for hospital observation care). : Prior to January 1, 2010, the code descriptor for HCPCS code G0379 was (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation

services. Hospitals should only report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Payment for direct referral for observation care will be made either separately as a low level hospital clinic visit under APC 0633 *(Level 3 Examinations & Related Services)* or packaged into payment for composite APC *8009 (Extended Assessment and Management Composite)* or packaged into the payment for other separately payable services provided in the same encounter. For information about payment for extended assessment and management composite APCs, see, §10.2.1 (Composite APCs) of this chapter.

The criteria for payment of HCPCS code G0379 under either APC *0633* or APC *8009* include:

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1. Both HCPCS codes G0378 (Hospital observation services, per hr.) and G0379 (Direct referral for hospital observation care) are reported with the same date of service.
2. No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.

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.

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Only a direct referral for observation services billed on a 13X bill type may be considered for a composite APC payment.

290.6 - Services Not Covered as Observation Services

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Hospitals must not bill beneficiaries directly for reasonable and necessary observation services for which the OPPS packages payment for observation as part of the payment for the separately payable items and services on the claim. Hospitals should not confuse packaged payment with non-coverage or nonpayment. See the Medicare Benefit Policy Manual, Pub 100-02, chapter 6, section 20.6 for further explanation of non-covered services and notification of the beneficiary in relation to observation care.