Observation – Charging, Billing, Compliance and Reimbursement

Observation services are one of the major categories of hospital care, the Medicare rules on the charging, billing, compliance and reimbursement of observation are many and difficult to implement.

This work-paper is developed to assist in understand and implementing the rules.

Basic Rules of Observation:

1. Observation care is billed hourly, a minimum of 8 hours is required and a max of 48 hours.
2. Observation time must stop being charged when the Patient is receiving a separately billable Nursing procedure or the Patient leaves the unit for a diagnostic or therapeutic procedure
3. There must be a outpatient clinic or ED evaluation and management charge (99205, 99215, 99284, 99285, 99291, G0384) code on the claim
4. There can be a "direct referral to observation" charge on the claim (G0379) instead of a clinic or ED evaluation and management charge
5. A Patient cannot have a surgical status T procedure on the claim, observation will not be paid the day of or the day after the status T procedure
6. There must be a Physician order for "observation services"
7. Observation is billed using the G0378 HCPCS code, under the 0762 revenue code

The PARA Data Editor – RAC Tab is useful in auditing observation claims and payment:

Select | Quote A Price | Charge Maintenance | Contracts | Pricing Data | Pricing | Rx / Supplies | Filters | CDM | Calculator | Advisor | Administration | RAC | PARA

Outpatient Search Criteria

IP OP

HCPCS Group 1	HCPCS Group 2	Modifiers Group
G0378	99285	

Select Year 2009

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

Claim Headers

	Claim 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
1	1860558	$687.17	$4,489.68	7245	Backache NOS						
2	2563491	$1,394.75	$14,186.83	78659	Chest pain NEC	34690	4019				
3	2859491	$947.58	$11,446.70	4359	Trans cereb ischemia NOS	1101					
4	2935664	$1,514.88	$13,052.25	78650	Chest pain NOS	78605					
5	3062082	$2,271.25	$29,180.96	29282	Drug persisting dementia	1508	4019	2724			

Claim Details

	Claim ID	Rev Code	HCPCS	Mod 1	Mod 2	Units	Payment	Charges
1	1860558	0250				16		$190.63
2	1860558	0250				7		$64.62
3	1860558	0250				3		$29.57
4	1860558	0250				1		$13.97
5	1860558	0301	81001			1	$4.63	$78.00
6	1860558	0306	87086			1	$11.79	$108.00
7	1860558	0306	87088			1	$9.56	$60.00

Reimbursement Considerations

1. **Medicare Reimbursement will be packaged into the APC:** Most commonly, observation services are provided after an emergency department evaluation (99284/99285). When observation (G0378) is billed with an E/M code from the Emergency Department, Medicare will pay the higher APC (provided no status T HCPCS procedure was provided on the same day or the day prior to observation services.) Since G0378 is considered packaged into the APC, the higher payment appears on the remit next to the E/M code line item, not the G0378 line.

2. **Change from Observation to Inpatient Status:** Whenever possible, Utilization Review staff should evaluate every patient in observation status prior to discharge to determine whether the patient meets the hospital criteria for inpatient status assignment. If the patient meets criteria, the Utilization Review staff should confer with the physician to consider changing the patient to inpatient status. Any change in status must be accomplished prior to discharge and supported by an appropriate physician order. Inpatient payment under Medicare IPPS DRG's 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.)

3. **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 Publication 100-04, Transmittal 299, "Use of Condition Code 44" at

   http://www.saem.org/sites/default/files/Handouts_R299CP-code44.pdf

4. **Monitor PEPPER Reports:** Hospitals should download and review data from Medicare's Program for Evaluating Payment Patterns Electronic Report ("PEPPER") to determine if the facility is within the normal range for short stays within DRG's. Those that have a higher rate of short-stays than normal within a given DRG are more likely to be audited for medical necessity by RAC auditors. Those hospitals which may be unusually low in short stays may find the report reveals overuse of observation status and an opportunity to improve revenue by reviewing cases which may meet inpatient criteria to assign the correct patient status prior to discharge.

   http://www.pepperresources.org/Home.aspx

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.

290.2.1 - 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.

290.2.2 - Reporting Hours of Observation

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

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 would 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). 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.

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

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

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. In certain circumstances when observation care is 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 may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met. For information about payment for extended assessment and management composite APCs, see §10.2.1 (Composite APCs) of this chapter.

APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct referral for observation in conjunction with observation services of substantial duration (8 or more hours). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. Beginning January 1, 2009, APC 8003 also includes high level (Level 5) Type B emergency department visits. There is no limitation on diagnosis for payment of these composite APCs; 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.

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

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

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.
   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.

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 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 (CPT code 99205 or 99215); or

      Critical care (CPT code 99291); or

   Direct referral for observation care reported with HCPCS code G0379 (APC 0604) 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.

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

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

3. 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.

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

Direct referral for observation is reported using HCPCS code G0379 (Direct referral for hospital observation care). Note: 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 0604 or packaged into payment for composite APC 8002 (Level I Prolonged 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 0604 or APC 8002 include:

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.

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.

EXAMPLE #1

INPATIENT VS. OBSERVATION STATUS REIMBURSEMENT COMPARISON

TOTAL CHARGES: 9,797.30

STATUS	METHOD	REIMBURSEMENT FACTORS	REIMBURSEMENT
Inpatient	IPPS	DRG 69 @ RW 0.7347 X $6000 Blended Rate	4,408.20
Outpatient	OPPS	APC & FEE SCHEDULES	952.57

DRG	MDC	Type	RW	GMLOS	ALOS
69 - TRANSIENT ISCHEMIA	01 -Dis & Disord Nervous System.	MED	0.7347	2.2	2.7

Diag ICD9 1	Diag ICD9 2	Diag ICD9 3	Diag ICD9 4	Diag ICD9 5	Diag ICD9 6	Diag ICD9 7	Diag ICD9 8
4371	3319	4019	78079	3310	7862	V4501	41401

APC/FEE SCHEDULE REIMBURSEMENT DETAILS (ACTUAL CLAIM)

Rev Code	HCPCS	Abbreviated HCPCS Desc	Units	Charges	Payment	Status/Method
0250		(blank)	1	33.40	0.00	
0258		(blank)	1	53.40	0.00	
0259		(blank)	5	55.80	0.00	
0259		(blank)	6	51.70	0.00	
0259		(blank)	9	84.50	0.00	
0259		(blank)	10	99.90	0.00	
0271		(blank)	2	193.60	0.00	
0300	36415	Collection of venous blood by venipunctu	1	33.00	3.00	A/FEE SCHED
0300	80048	Basic metabolic panel (Calcium, total) T	1	300.00	7.02	A/FEE SCHED
0300	80076	Hepatic function panel This panel must i	1	250.00	11.70	A/FEE SCHED
0300	81003	Urinalysis, by dip stick or tablet reage	1	92.00	3.22	A/FEE SCHED
0300	82140	Ammonia	1	227.00	20.87	A/FEE SCHED
0300	82550	Creatine kinase (CK), (CPK); total	1	39.00	5.41	A/FEE SCHED
0300	82553	Creatine kinase (CK), (CPK); MB fraction	1	195.00	13.33	A/FEE SCHED
0300	82607	Cyanocobalamin (Vitamin B-12);	1	111.00	21.59	A/FEE SCHED
0300	82746	Folic acid; serum	1	111.00	21.06	A/FEE SCHED
0300	84436	Thyroxine; total	1	97.00	9.84	A/FEE SCHED
0300	84443	Thyroid stimulating hormone (TSH)	1	230.00	48.12	A/FEE SCHED
0300	84480	Triiodothyronine T3; total (TT-3)	1	96.00	20.31	A/FEE SCHED
0300	84484	Troponin, quantitative	1	229.00	0.00	A/FEE SCHED
0300	85610	Prothrombin time;	1	92.00	5.62	A/FEE SCHED
0300	85652	Sedimentation rate, erythrocyte; automat	1	77.00	3.87	A/FEE SCHED
0300	85730	Thromboplastin time, partial (PTT); plas	1	113.00	0.00	A/FEE SCHED
0300	86592	Syphilis test, non-treponemal antibody;	1	71.00	6.11	A/FEE SCHED
0305	85025	Blood count; complete (CBC), automated (	1	172.00	11.14	A/FEE SCHED
0324	71010	Radiologic examination, chest; single vi	1	452.00	35.89	Q/APC
0351	70450	Computed tomography, head or brain; with	1	2,744.00	119.54	Q/APC
0450	99284	Emergency department visit for the evalu	1	1,517.00	563.71	Q/APC
0730	93005	Electrocardiogram, routine ECG with at l	1	321.00	21.22	S/APC
0762	G0378	HOSPITAL OBSERVATION SERVICE, PER HOUR	23	1,656.00	0.00	N/APC
				9,797.30	952.57	

EXAMPLE #2

INPATIENT VS. OBSERVATION STATUS REIMBURSEMENT COMPARISON

TOTAL CHARGES: 11,379.61

STATUS	METHOD	REIMBURSEMENT FACTORS	REIMBURSEMENT
Inpatient	IPPS	DRG 914 @ .7097 RW X $6,000 BLENDED RATE	4,258.20
Outpatient	OPPS	APC & FEE SCHEDULES	857.53

DRG	MDC	Type	RW	GMLOS	ALOS
914 - TRAUMATIC INJURY W/O MCC	21 - Inj., Pois., Toxic Eff Drugs.	MED	0.7097	2.5	3.2

Diag ICD9 1	Diag ICD9 2	Diag ICD9 3	Diag ICD9 4	Diag ICD9 5	Diag ICD9 6	Diag ICD9 7	Diag ICD9 8
9593	95901	25000	3320	3314	2989	7802	70703

APC/FEE SCHEDULE REIMBURSEMENT DETAILS (ACTUAL CLAIM)

Rev Code	HCPCS	Abbreviated HCPCS Desc	Units	Charges	Payment	Status/Method
0250		(blank)	10	441.00	0.00	
0259		(blank)	20	167.60	0.00	
0272		(blank)	4	617.01	0.00	
0300	36415	Collection of venous blood by venipunctu	1	33.00	3.00	A/FEE SCHED
0300	80048	Basic metabolic panel (Calcium, total) T	1	600.00	24.24	A/FEE SCHED
0300	85652	Sedimentation rate, erythrocyte; automat	1	154.00	0.00	A/FEE SCHED
0300	86141	C-reactive protein; high sensitivity (hs	1	95.00	18.54	A/FEE SCHED
0305	85025	Blood count; complete (CBC), automated (	1	516.00	33.42	A/FEE SCHED
0320	73080	Radiologic examination, elbow; complete,	1	552.00	35.98	X/APC
0324	71010	Radiologic examination, chest; single vi	1	452.00	35.98	Q/APC
0351	70450	Computed tomography, head or brain; with	1	2,744.00	120.01	Q/APC
0450	99284	Emergency department visit for the evalu	1	1,517.00	565.09	Q/APC
0460	94760	Noninvasive ear or pulse oximetry for ox	1	74.00	0.00	N/APC
0730	93005	Electrocardiogram, routine ECG with at l	1	321.00	21.27	S/APC
0762	G0378	HOSPITAL OBSERVATION SERVICE, PER HOUR	43	3,096.00	0.00	N/APC
				11,379.61	857.53	

EXAMPLE #3
INPATIENT VS. OBSERVATION STATUS REIMBURSEMENT COMPARISON
TOTAL CHARGES: 7,929.21

STATUS	METHOD	REIMBURSEMENT FACTORS	REIMBURSEMENT
Inpatient	IPPS	DRG 125 @ RW .6918 x $6000 BLENDED RATE	4,150.80
Outpatient	OPPS	APC & FEE SCHEDULES	690.28

DRG	MDC	Type	RW	GMLOS	ALOS
125 - OTHER DISORDERS OF THE EYE	02 - Dis and Disord of Eye	MED	0.6918	2.5	3.2

Diag ICD9 1	Diag ICD9 2	Diag ICD9 3	Diag ICD9 4	Diag ICD9 5	Diag ICD9 6	Diag ICD9 7	Diag ICD9 8
05321	05449	25000	4019	2724	41401	V851	(blank)

APC/FEE SCHEDULE REIMBURSEMENT DETAILS (ACTUAL CLAIM)

Rev Code	HCPCS	Abbreviated HCPCS Desc	Units	Charges	Payment	Status/Method
0250		(blank)	6	243.00	0.00	
0250	J1956	INJECTION, LEVOFLOXACIN, 250 MG	2	136.00	0.00	N/APC
0250	J2175	INJECTION, MEPERIDINE HYDROCHLORIDE, PER	3	39.00	0.00	N/APC
0258		(blank)	7	452.00	0.00	
0259		(blank)	60	619.00	0.00	
0271		(blank)	5	97.58	0.00	
0272		(blank)	2	195.12	0.00	
0300	36415	Collection of venous blood by venipunctu	1	28.00	3.00	A/FEE SCHED
0300	80048	Basic metabolic panel (Calcium, total) T	1	300.00	7.70	A/FEE SCHED
0300	80076	Hepatic function panel This panel must i	1	250.00	7.44	A/FEE SCHED
0300	80162	Digoxin	2	274.00	0.00	A/FEE SCHED
0300	81003	Urinalysis, by dip stick or tablet reage	1	92.00	3.22	A/FEE SCHED
0300	83036	Hemoglobin; glycosylated (A1C)	1	41.00	13.90	A/FEE SCHED
0300	84436	Thyroxine; total	1	97.00	9.84	A/FEE SCHED
0300	84443	Thyroid stimulating hormone (TSH)	1	115.00	24.06	A/FEE SCHED
0300	84479	Thyroid hormone (T3 or T4) uptake or thy	1	96.00	9.27	A/FEE SCHED
0300	85610	Prothrombin time;	1	92.00	5.62	A/FEE SCHED
0300	85730	Thromboplastin time, partial (PTT); plas	1	113.00	0.00	A/FEE SCHED
0305	85025	Blood count; complete (CBC), automated (	1	172.00	11.14	A/FEE SCHED
0450	99284	Emergency department visit for the evalu	1	1,517.00	565.09	Q/APC
0762	G0378	HOSPITAL OBSERVATION SERVICE, PER HOUR	39	2,808.00	0.00	N/APC
0940	96375	Therapeutic, prophylactic, or diagnostic Inj	1	145.00	30.00	S/APC
				7,929.21	690.28	