Medicare Observation Service Reference

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APPROPRIATE USE OF OBSERVATION SERVICES

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APPROPRIATE OBSERVATION SERVICES:

- Short term treatment, assessment and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or if they can be discharged with outpatient follow-up.
- Brief stays (less than overnight) following a procedure needed to manage a complication.

OBSERVATION SERVICES ARE NOT APPROPRIATE FOR:

- Care that can only be provided in the inpatient setting and is expected to require more than 24 hours. Admit as inpatient.
- Services provided for the convenience of the patient, patient's family or a physician.
- Routine recovery following an outpatient procedure or test.

Outpatient services are covered only when provided by the order of physician or another individual authorized by state licensure law and hospital staff by-laws to admit patients to the hospital or to order outpatient tests.

For most patient the decision can be made in less than 24 hours. In rare circumstances, patients may require up to 48 hours. All medically necessary hours of observation are covered by Medicare.

If you have any questions about specific patient situations, contact the Utilization or Case Manager.

CMS INSTRUCTIONS FOR USE OF OBSERVATION

In 1996, the Centers for Medicare and Medicaid Services, (HCFA), implemented regulations regarding the appropriate use of observation services. Instructions are now published in the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual. Although the method for reimbursing hospitals for observation services continually change, the instructions for appropriate use of observation have not substantially changed. The following excerpts are taken from those regulations and more recent instructions from Transmittals and Part A Newsletters.

- Observation services are those furnished on the hospital premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an in-patient.

- Observation services usually do not exceed one day. Some patients, however, may require a second day of outpatient observation services.

- If a hospital bills for observation services that span more than 48 hours, the Fiscal Intermediary or Medicare Administrative Contractor will request the record and determine whether the extended time was reasonable and necessary. (Effective 4-01-05 Transmittal 120)

- The following services are not covered as out-patient observation services:

  Services that are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient, the patient's family, or a physician.

  Services that are covered under Part A, such as a medically appropriate inpatient admission or as part of another part B service such as post operative monitoring during a standard recovery period (e.g. 4-6 hours).

  Standing orders for observation following out-patient surgery or routine pre-op prep.

  Services that were ordered as inpatient services by the admitting physician but billed as Observation by the billing office.

Medicare Part A Newsletter Excerpts (Trailblazer 03-31-04)

<u>Example</u>: A patient comes to the emergency room complaining of difficulty in breathing. The physician on duty orders lab tests, including a blood gas analysis, and an injection to help the patient breath more easily. The physician's diagnosis is asthma. He writes an order to refer the patient for observation services to assess and reassess the signs and symptoms, and for the implementation of interventions to promote and produce effective breathing. When the physician sees the patient again approximately 8 hours later, he determines from the patient's chart and his own observation that the patient's vital signs are normal. The patient has resumed a normal breathing pattern and appears stable. He discharges the patient from observation services to home. In this clearly documented scenario, the patient's stay would be presumed to be a covered and payable observation stay.

Effective January 1, 2009, CMS has provided new composite APCs (CAPC) that reimburse hospitals for **<u>any diagnosis</u>** requiring 8 or more hours of observation provided certain conditions are met. The payment amount is based upon the point of entry:

CAPC 8002—Direct Admit, Physicians Office. National Payment $375.70

CAPC 8003 ED Level 4-5, Critical Care or Type B ED, Level 5. National Payment $674.73 *(observation and ED payments are combined)*

DECISION TO ADMIT AS INPATIENT

INPATIENT ADMISSION

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. The physician should use a 24-hour period as a benchmark, i.e., he or she should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient observation basis. However the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including:

- ♦ The patient's medical history and the severity of the signs and symptoms which impact the medical needs of the patient and influence the expected length of stay;
- ♦ The medical predictability of something adverse happening to the patient.
- ♦ The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospitals for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- ♦ The availability of diagnostic procedures at the time when and at the location where the patient presents.

"Generally a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight".

Source: Medicare Benefit Policy Manual, Chapter 1.

In assessing the necessity for an admission, the auditor must consider only the medical evidence which was available to the physician at the time an admission decision had to be made, and does not take into account the information (e.g., test results) which became available only after admission, except in cases which considering the post admission information would support a finding that an admission was medically necessary.

(Quality Improvement Organization, Chapter 4 Case Review 4110)

INPATIENT SERVICES DEFINED:

Admissions are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.

In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules.

Minor Surgery or Other Treatment

When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of ; the hour they came to the hospital, whether they used a bed and whether they remained in the hospital past midnight.

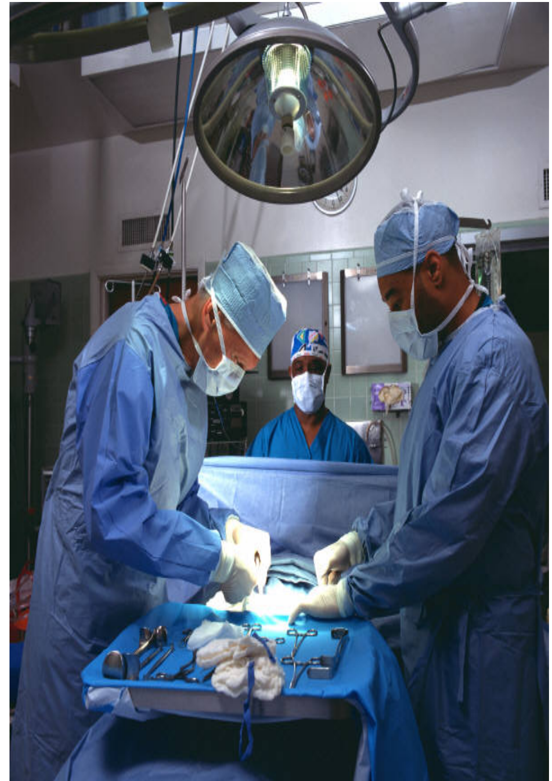
Renal Dialysis

Renal dialysis treatments are usually covered only as outpatient services but may under certain circumstances be covered as inpatient services depending on the patient's condition. Inpatient admission is not warranted solely because the patient missed a scheduled dialysis treatment and the hospital does not provide routine outpatient dialysis.

SURGERY INPATIENT VS. OUTPATIENT

Determination of the level of care (inpatient or outpatient) is dependent on medical judgment of the admitting physician. The April 7, 2000 Final Rules for OPPS (APCs) include the following instructions:

"And regardless of how a procedure is classified for purposes of payment, we expect, as we stated in our proposed rule, that in every case the surgeon and the hospital will assess the risk of a procedure or service to the individual patient, taking site of service into account, and will act in that patient's best interests."



"When a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him in the hospital only a few hours less than 24), he is considered an outpatient for coverage purposes regardless of: the hour he came to the hospital; whether he used a bed; and whether he remained in the hospital past midnight. (Benefit Policy Manual, Chapter 1) Note that this initial status is based on the morbidity associated with the procedure and the result and expectation of the physician that the stay will be brief.

Conversely, a patient should be admitted for a procedure when either the morbidity associated with the procedure or a comorbidity associated with a particular patient suggests that a 24 hour stay will be required. Note that again the key element is physician expectation at the time of admission, as long as the expectation of a prolonged stay is based on generally accepted medical grounds rather than personal idiosyncrasy or matters of convenience (i.e. the expected stay is medically reasonable and necessary)."

Generally a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight."

Medicare Benefit Policy Manual, Chapter 1

OP SURGERY FOLLOWED BY OBSERVATION

The Hospital Manual provided the following example of appropriate use of observation services following an outpatient surgery:

> *"A patient comes to a hospital's outpatient department to undergo a scheduled surgical procedure. After surgery, the patient is taken to the recovery room, where the patient exhibits difficulty in awakening form anesthesia and an elevated blood pressure. These conditions persist throughout the usual recovery period (4-6 hours) and the patient is seen by a physician, who orders observation services. The physician leaves an order for the nursing staff to monitor the patient's condition and note any continued abnormalities that could indicate a drug reaction or other post-surgical complication. After a few hours in observation, the patient no longer is lethargic, has normal blood pressure and shows no other signs of post-surgical complications. The physician, upon being advised of these conditions, orders the patient released from the hospital."*

Riverbend Government Benefits Administrator (Blue Cross-Blue Shield of Tennessee) Local Coverage Determination effective for services after 11/07/2004 provides the following clarification:

"In the appropriate conversion of an outpatient procedure to an observation service, there should be an event which heralds a time period during which is unclear whether the patient will be able to go home or will need to be fully admitted.... Claims for outpatient procedures that include observation hours will be expected to demonstrate a medical necessity for observation beyond the usual and customary recovery period associated with that procedure...

Non-covered observation services include those services that are provided for the convenience of the patient, his family, or a physician.

Physician Documentation

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.

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

RECOVERY AUDIT CONTRACTORS DETERMINE IMPROPER PAYMENTS

The Quality Improvement Organization is no longer responsible for evaluating medical necessity of admission and correcting improper payments. Effective August 1, 2008 this responsibility was assigned to Fiscal Intermediaries, Medicare Administrative Contractors and to Recovery Audit Contractors. These organizations assumed responsibility for deciding, during retrospective review of inpatient admissions on a case-by-case basis, whether the admissions were medically necessary. These organizations are authorized by Medicare law to make these judgments, and the judgments are binding for the purpose of Medicare coverage.

Inpatient care rather than outpatient care may be determined to be medically necessary if the patient's medical condition, safety or health would be significantly and directly threatened if care were provided in a less intensive setting. Factors that may cause the patient inconvenience or that may cause the patient to worry, such as the cost of home care or travel to a doctor's office, do not justify admission to a hospital or approval of a higher-than-necessary level of care.

Medical review of hospital claims, both inpatient admission and outpatient observation, will be based upon an attempt to find documentation that supports the existence of each of the following critical elements:

An INPATIENT claim must contain:

A) A valid order to admit as inpatient (decision rests with the admitting physician)
B) Execution of the order to admit (service was actually rendered)
C) Medical necessity for an inpatient stay
D) Services were billed as rendered (bill type 111—MS-DRG coding)

An OUTPATIENT claim must contain:

A) A valid order for services such as "Refer patient for observation services" radiology and lab proce dures, etc. BUT no valid physician's order to admit to inpatient.
B) Execution of the orders consistent with their wording (services rendered as ordered)
C) Medical necessity for the services provided
D) Correct coding (services billed as rendered)

CHANGING FROM INPATIENT TO OUTPATIENT

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon reviewing the case later, it is determined that outpatient care was more appropriate. Effective October 12, 2004, hospitals may bill a "Condition Code 44" to change an inpatient admission order to an outpatient order if all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. A physician concurs with the utilization review committee's decision; and
4. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record. *See Medicare Transmittal 299 (9-10-2004), Medlearn Matters (MLM SE0622) and Transmittal 1803 effective October 1, 2009.*

CHEST PAIN CASE STUDIES

Admission should be considered when a patient has an elevated Troponin, ST elevation, MI or dynamic ST-T wave changes on EKG. Observation should be considered when the patient has no EKG or enzyme changes but the patient's story suggests the possibility of acute cardiac ischemia.

Case Study 1: A 67 year-old patient was seen in the emergency room with a gradual onset of chest pain over the last two hours. The EKG was normal and the first set of cardiac enzymes revealed an elevated Troponin level. ***Admit as inpatient or refer patient for outpatient observation services?***

Admit as inpatient.

With elevated cardiac enzymes, it could be expected that admission was needed.

Case Study 2: A 64 year-old patient was seen in the emergency room with chest pain. The EKG revealed slight ST segment elevation and the cardiac enzymes were negative. ***Admit as inpatient or refer patient for outpatient observation ?***

Place in outpatient observation.

Initial cardiac enzymes were negative, and the physician could observe serial enzymes and EKG in outpatient observation. If the physician later determines that acute inpatient level of care is necessary, he/she can always progress a patient receiving observation services to a full admission, documenting the change clearly in the physician orders. The physician should not automatically admit a patient because 24 hours have elapsed. There must be a medical need for a subsequent admission.

(Examples reprinted with permission of Texas Medical Foundation. TMF Review and HPMP Update, December 2004)

GASTROINTESTINAL CONDITIONS

Admission should be considered when the patient has symptoms that are not associated with food ingestion and include prolonged duration of symptoms, worrisome physical findings (orthostasis, incapacitating pain, temperature, bleeding, acute abdomen), significant diagnostic data (high WBC, low Hgb/Hct, abnormal electrolytes, positive imaging studies) and/or is at higher risk (due to hypernatremia, acute abdomen, infection, comorbid illnesses, e.g., coronary artery disease). Observation should be considered when the patient has symptoms associated with food ingestion, short duration of symptoms, no signs of infection or acute abdomen, no orthostasis and/or pain that is not incapacitating.

MEDICAL NECESSITY FOCUS

Recovery Audit Contractors (RAC) identified 1.03 billion dollars in overpayments during the 3 year demonstration project in New York, Florida and California. 40% of that total was the result of medical necessity denial for inpatient admissions.

Target areas for potentially unnecessary admissions include the following diagnoses and procedures:

- Chest Pain
- CHF
- Misc. Gastrointestinal Disorders
- Misc. Nutritional—Metabolic Disorders
- Medical Back Diagnoses
- Acute Renal Failure
- Coronary Stents (Non-Urgent)
- Pacemaker Insertion (Non-Urgent)
- Defibrillator Insertion (Non-Urgent)
- 3 Day Stays with Transfer to SNF

Not all inpatient admissions in these categories are unnecessary. Each case must be evaluated applying evidenced based screening criteria and ultimately the opinion of another physician applying clinical judgment. To support medical necessity, physician documentation should include the severity of the patient's presenting signs and symptoms, any appropriate past medical history, the physician's assessment of why in-patient admission was medically necessary, the patient's medical stability for discharge.

PHYSICIAN BILLING FOR MEDICAL OBSERVATION PATIENTS

The November 1, 2000 Federal Register "redefined" professional billing for observation services and added the element of time to the definition. This ruling requires the observation stay to be at least eight (8) hours before certain CPT codes can be used.[1] As stated in this Federal Register, CMS's policy for observation care is as follows:

- For a physician to appropriately report CPT codes 99234 through 99236 for Medicare payment, the patient must be an inpatient or an observation care patient for a minimum of eight (8) hours on the same calendar date. This is an important audit point in medical records review
- The physician must satisfy the documentation requirements for both admission to and discharge from inpatient or observation care to bill CPT codes 99234, 99235, or 99236. The length of time for observation care or treatment status must also be documented.
- When the patient receives observation services for less than eight (8) hours on the same date then the physician should use CPT codes 99218 through 99220 and no discharge code should be reported. This represents a change from the current CPT4 definition and will need to be readdressed with the physicians coders. The documentation of time will need to be clearly contained in the patient's medical record.
- When patients are admitted for observation care and then discharged on a different calendar date, the physician should use CPT codes 99218 through 99220 and CPT observation discharge code 99217. This represents no change from current policy.
- When patients are admitted to inpatient hospital care and then discharged on a different calendar date, the physician should use CPT codes 99221 through 99223 and CPT hospital discharge day management codes 99238 or 99239. (This represents no change from the current policy)
- For an inpatient admission and discharge less than eight hours later on the same calendar date, CPT codes 99221 through 99223 should be used for the admission service, and the hospital discharge day management service should not be billed.

For both the hospital and the physician's billing, the timing of the physician's entries in the medical record will become increasingly important. This will also need to become an audit checkpoint for those conducting coding and billing reviews.

Summary:

The differentiation of an inpatient admission from outpatient observation services has continued to be a problem for providers nationwide. There are many reasons for this. First, there is a misunderstanding of the relative roles of physicians and facilities in determining patient level of care. Second there is general confusion over the actual Medicare rules that guide the appropriate level of care selection. Third, the distinction between inpatient and outpatient observation represents a difference in billing, not a difference in medical treatment. The distinction is medically irrelevant to the ordering physician, and therefore is frequently not addressed explicitly. Finally, unique requirements imposed by the two benefit categories make it difficult to correct errors after the fact.

If you have any questions or would like to schedule an observation use and/or billing assessment in your facility please contact:

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