Observation Coding and Billing Compliance

Montana Hospital Association

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IP versus Observation considerations

- Severity of patient's signs and symptoms
- Medical predictability of something adverse happening to the patient
- Need for diagnostic studies to aid in decision to admit
- Inpatient procedure in OR on day of admission
- Close medical monitoring by physician

IP versus Observation Factor examples:

- Major Surgical Wound and/or Trauma Care documented each shift for surgical, gunshot, stab wound, or severe decubitus. (Inpatient)
- Acute exacerbation of COPD with plan for 48 hours of IV steroids. (Inpatient)
- The use of an ICU bed does not, in of itself, does not necessarily support two nights of IP care.
- Chest pain, rule out MI. If and when MI is confirmed, and in house treatment is planned – IP would likely be appropriate. Chest pain patients are frequently discharged within 24 hours. (Observation)

Appropriate admission status

- Patients at times are referred to Observation when, at the time of admission, the condition of the patient and the provider orders indicate an IP admission would have been the appropriate setting, i.e.
  - Acute respiratory failure
  - Acute exacerbation of congestive heart failure
  - Acute pneumonia (with plans for a minimum of two days intravenous antibiotics)
- Then – 48 hours is up and the intensity of services and acuity of the patient's condition is no longer present
  - Individual circumstances vary

Two Midnight Rule

- Expectation patient will stay over two midnights
- Physician is responsible for decision
  - Patient's medical history
  - Current medical needs
  - Types of facilities available
  - Hospital bylaws and admission policies
  - Appropriateness of treatment in each setting

Two Midnight Rule

- Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners.
- Per the Two-Midnight presumption, Medicare contractors will presume hospital stays spanning two or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. If a stay is not reasonably expected to span two or more midnights, Medicare contractors will assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate.

Two Midnight Rule Certification

- Physician certification is required for ALL Medicare inpatient admissions.
- Begins with the order to admit.
- Certification statement may be entered on forms, notes, or records that the physician signs, or on a special separate form.
- Statement must be signed and documented in the medical record prior to hospital discharge.
- Verbiage: (1) the reason for the inpatient treatment or diagnostic study; (2) "special or unusual services" the patient will receive; (3) the estimated time the patient will stay in the hospital; and (4) plans for post-hospital care.

Two Midnight Rule Expectation and Documentation

- Ordering provider must "expect" that the beneficiary will require care that crosses two midnights. If DON'T "expect" two midnights, then service should be outpatient or observation.
- Ordering provider documentation should support the expectation that the beneficiary will require care spanning at least two midnights when the admission order is written.
- The ordering provider should say, "I believe this patient will require a stay crossing two midnights because...."

Observation Documentation

- Provider documentation should provide justification to support the medical necessity of the admission – and should continue throughout the stay
- Observation is an hourly charge
  - Nursing and ancillary documentation must support the reason for continued Observation services
  - CMS is not specific on nursing documentation requirements
  - Free text is a necessity
    - Template documentation is not patient specific

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Two Midnight Rule exceptions

- If the procedure is a CMS-identified, national exception to the Two-Midnight benchmark
  - IP only procedures list
  - Mechanical Ventilation initiated
  - If the admission otherwise qualifies for a case-by-case exception to the Two-Midnight benchmark because the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a Two-Midnight expectation. Medicare contractors will note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the Two-Midnight benchmark.

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Two Midnight Rule exceptions

- Discharge Summary Documentation:
- If patient leaves prior to anticipated 2 midnight stay, must explain that the patient recovered quicker than expected, or document the other reason for shortened admission:
  - Unexpected Recovery
  - Unexpected death
  - Unexpected transfer
  - AMA departure
  - Unexpected hospice

Considerations

- Noridian ACT Questions and Answers - April 21, 2016.

- Q1. If it were approaching the two midnights, would it be appropriate to admit a patient to inpatient for comfort care?

- A1. Each comfort case is unique and it would depend on the condition of the patient, the expectation of a reasonable 2-midnight stay and the documentation must support medical necessity.

Considerations

- **Q1. Clarify if or when the time prior to the inpatient order can be counted towards the 2-Midnight stay? Does the clock begin only once the inpatient order has been written?**
  A1. Time the beneficiary spent receiving outpatient services including services such as observation, treatment in the emergency department and procedures provided in the operating room or other treatment area are considered for purposes of determining whether the 2-midnight benchmark was met; however, the patient will not be considered an inpatient until formally admitted as an inpatient pursuant to the physician order. (Noridian)

Purpose of Observation

- Short-term treatments and assessments to determine whether a beneficiary should be admitted as an inpatient or discharged.
- May use a variety of outpatient services -such as laboratory tests, drugs, minor procedures, and imaging services to make this decision.
- Can occur anywhere in the hospital
  - the emergency department
  - a separate observation unit
  - or an inpatient unit.
  - According to CMS policy, the decision to admit or discharge usually can be made within 24 hours and should rarely take longer than 48 hours.

Decision Factors

- Severity of patient's signs and symptoms
- Medical predictability of something adverse happening to the patient
- Need for diagnostic studies to aid in decision to admit

Denial Reasons

- Physician documentation does not support medical necessity of admission (or illegible)
- Physicians unaware of admission/observation criteria
- Physician habitually orders - "Admit" -defaults to inpatient
- Truly unnecessary admissions
  - "Social" and convenience
  - Inappropriate site of care

Let's start at the beginning

- Order to refer to Observation
  - States "observation"
  - Dated
  - Timed
  - Signed
- CMS Q&A –
  - Q. *If the physician's order was not clear as to inpatient admission vs observation status, what kind of claim should the hospital submit after discharge?*
  - A. *The hospital cannot bill outpatient observation without a clear order. If the order is not clear, the hospital must bill the stay as an inpatient admission.*

Counting Observation Hours

- CMS FAQ:
- **When do observation hours begin and end?**
  - Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order.
  - Observation time ends either when the patient is discharged from the hospital or is admitted as an inpatient. The time when a patient is "discharged" from observation status is the clock time when all clinical or medical interventions have been completed, including any necessary follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient. However, observation care does not include time spent by the patient in the hospital subsequent to the conclusion of therapeutic, clinical or medical interventions, such as time spent waiting for transportation to go home.

Counting Observation Hours

- Carving out hours
  - Services that require active monitoring -i.e.
    - Outpatient surgery
    - Transfusion
    - Chemotherapy
    - Titrated IV medications
  - Time patient is not being actively observed –i.e.
    - At therapy session
    - Radiology, CT, MRI without close nursing Observation

Counting Observation Hours

- Are all infusion time periods required to be carved out?
- CMS Medicare Claims Processing Manual Chapter 4
  - 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.

Counting Observation Hours

- 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.

Carving out infusions

CMS FAQ: 9974
The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services. Whether active monitoring is 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.

Carving out infusions

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.

FYI – this FAQ has been archived

In most cases, hydration would probably not meet the definition of a drug that requires active monitoring, and therefore would not be carved out of the observation.

48 hours is up – Now what?

- Does the patient require IP admission <u>at this time</u>?
  - Review the orders
  - Review the plan of care
    - Oral meds and routine vitals does not support IP admission
- Is a discharge plan in place?
  - The patient is frequently discharged the following day
- Billing non-covered Observation over 48 hours is an option
  - At times a better option than an unnecessary IP stay denial

What should not be Observation?

- CMS FAQ:
- Patient has outpatient surgery at 3:00 pm and needs to stay overnight. Is this same day surgery or observation?

- **If the patient stays overnight for routine postoperative care, this is outpatient same day surgery. Billing observation hours for routine postoperative monitoring during a standard recovery period is not allowed, even if the patient stays overnight. However, if the patient is experiencing an unusual postoperative complication and requires more than routine postoperative recovery and monitoring, observation status should be used.**

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What should not be Observation?

- Social admissions
  - Family requests
    - No one to care for the patient
    - Need for 3 day SNF qualifying stay
    - "Can't take it anymore"
  - Safety alone is not a qualifier
    - Other care setting could address the needs
    - Provider documentation is the key
      - Orders – assessments, medication review, mental status exams, PT/OT evaluations
      - Noted changes in mental status, gait, stability, not taking medications, etc.
  - Patient request
    - Shows up at the door with their suitcase

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Retrospective orders

- Change in IP status to Observation status only:
  - While the patient is still a patient
  - Condition Code 44 process is followed
    - Requires involvement of the Utilization Review Committee
- The status of the patient cannot otherwise be changed retrospectively, i.e.
  - Provider cannot write an order on the second day "make IP (or Observation) from admission"
  - Provider cannot write a late entry order during the admission to change level of care
  - Provider cannot write a late entry order following discharge to change level of care

PPS versus CAH Observation

- Clinical criteria is the same
  - Short term assessment
  - Assessment and monitoring to determine need for inpatient admission
- Billing is different for Observation to IP
  - PPS – all Observation services are reported on the IP claim
  - CAH – an OP claim and an IP claim are reported

Billing for Observation

- G0378 (RC 762) – (hospital observation per hour)
  - One line item with admission date as date of service when stay spans more than one date
  - Units – chargeable hours of Observation
  - 8 hours minimum
  - Additional code must be on the same claim
    - ED E/M code; or
    - Clinic Visit (hospital based) E/M code; or
    - Critical care E/M code; or
    - Direct referral for Observation – G0379

Billing for Observation

- PPS – Comprehensive APC 8011
  - Not reimbursed when a surgical procedure is on the same claim; or
  - Less than 8 hours of Observation reported
  - See Chapter 4, Medicare Claims Manual for rules

MOON notice

- *On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) Public Law 114-42. The NOTICE Act requires hospitals and CAHs to provide written and oral explanation of such written notification to individuals who receive observation services as outpatients for more than 24 hours.*
  - *effective October 1, 2016.*
  - https://www.cms.gov/Medicare/Medicare-General-Information/BNI/

MOON notice

- *The MOON must be delivered to beneficiaries in Original Medicare and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:*
  - *Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).*
  - *Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON.*
  - *Beneficiaries for whom Medicare is either the primary or secondary payer.*

Questions?

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