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Patient Status Training Toolkit for Utilization Review

Kimberly Anderwood Hoy Baker, JD, CPC
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**Notices for Care Not Covered by Medicare**

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About the Author

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Chapter 1

Medicare Requirements for Observation

Observation Services

Medicare covers observation care as an outpatient service under Part B. The Medicare Benefit Policy Manual defines observation as a “well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

Two key parts of this definition are the assessments and decision. Medicare mentions assessments and reassessments, presumably to emphasize the active period of care leading to the decision to discharge the patient or admit him or her as an inpatient. Once a decision has been made regarding the patient’s disposition, the care no longer meets this definition of observation, which becomes especially important if the decision has been made to discharge the patient to an alternate, lower level of care that is not available. In these cases, the continued care at a lower level, in lieu of discharge, does not meet the definition of observation because the decision to discharge the patient has been made. Notices for these cases will be discussed in a later chapter.
Documentation requirements

Observation services can be ordered by physicians and other providers authorized by state law and hospital bylaws to admit patients or order outpatient tests. Physicians (e.g., emergency department (ED) physicians) who can order outpatient tests may order observation services even though they may not be authorized under hospital bylaws to admit patients for inpatient status. This allows some flexibility for placement of patients in observation. Note that standing orders for observation after surgery are not accepted. Orders for observation must be specific to the patient’s need for continued monitoring in response to clinical factors.

In addition to the order for observation, documentation must reflect that the patient is in the care of a physician. *The Medicare Claims Processing Manual* requires notes at the time of registration and discharge as well as other appropriate progress notes to be “timed, written, and signed by the physician.” The manual’s emphasis on the physician writing the progress notes aligns with the requirement for assessment and reassessment in the definition for observation. Assessing and reassessing a patient in observation ensures the patient is receiving active care and not simply a lower, custodial level of care. (See Case Study 1.1 on the download page for an example—link in table of contents.)

Like other services covered by Medicare, observation must be reasonable and necessary or, in other words, medically necessary. The physician must document that he or she assessed patient risk to determine that the patient would benefit from observation services. Documentation should describe what risks are present that prevent the patient from being safely discharged either home or to a lower level of care and how the patient would benefit from further observation at the hospital. Documentation of this assessment provides the basis of the medical necessity of the observation services. This
is particularly important if the observation services are to later serve as a basis for meeting the 2-midnight benchmark—discussed below—because only medically necessary observation is counted toward meeting the benchmark.

**Noncovered observation**

CMS states in the *Medicare Benefit Policy Manual* that only in rare and exceptional cases will reasonable and necessary outpatient observation services span more than 48 hours. It’s important to note that after 48 hours of medically necessary observation the patient will have reached the second midnight and is eligible for inpatient admission under the 2-midnight benchmark. By 48 hours, the decision to admit the patient should be clear or, if the decision has been made to discharge the patient, then the services no longer meet the definition of observation and should not continue to be billed as observation services.

Notwithstanding the foregoing, a hospital may report more than 48 hours of medically necessary observation in situations when the inpatient admission order was not issued or not signed before the patient’s discharge. In these cases, if the order had been written and signed, the care would qualify under the 2-midnight benchmark as inpatient care, but because there was no valid inpatient order, the hospital will have to bill the care as observation. A Medically Unlikely Edit prevents more than 72 hours of observation from being reported.

Hospitals should not continue to report observation beyond the point when the decision has been made to discharge the patient to home or a lower level of care, with some allowance for discharge instructions. This care does not meet the definition of observation and is not covered. Hospitals should not report observation simply because the patient is occupying a bed at the hospital, although at times internal bed management systems
may not have another category for the patient. If this is the case, the hospital must segregate the covered and noncovered observation care when billing that care to Medicare.

Care provided for the convenience of the patient, family, or physician or while the patient is awaiting a ride home is not considered covered observation and should not be reported as covered to Medicare. Transportation issues are common and, if the patient has no transportation, the hospital may provide care until transportation is available, but this care is not considered covered observation care by Medicare. Physician convenience often involves consultations or outpatient testing where the patient is kept in the hospital until these services can be rendered. If the patient can safely be discharged and receive these services on an outpatient basis, then keeping the patient in observation is not considered covered. (See Case Study 1.2 on the download page for an example.)

**Billing for observation**

Hospitals should bill covered hours of observation with HCPCS code G0378. Hospitals should not use this code to report noncovered hours of observation, even if the charges for the noncovered observation are reported in the noncovered column. Medicare is unable to determine the covered and noncovered hours from the reported charges. The processing system will treat all reported units of service as covered, which could cause potential compliance issues due to the methodology Medicare uses to reimburse observation. (See Case Study 1.3 on the download page for an example.)

Report all hours of observation from a single encounter on a single line. The line item date of service is the date the observation services began, regardless of whether some of the services spanned the midnight hour and were provided on subsequent dates of service.
Use an additional HCPCS code, G0379, to report the direct placement of the patient in observation from a location outside the hospital. Do not use this code if the order for observation was initiated in the hospital or a provider-based department. Hospitals commonly use this code for referrals from a private physician’s office or freestanding physician’s office owned by the hospital as well as for transfers from an ambulatory surgery center. (See Case Study 1.4 on the download page for an example.)

Bill observation services with G0378 and G0379, and report them with revenue code 0762 (Observation Hours). If the hospital performs ancillary services while the patient is in observation status, report these services using appropriate revenue codes and HCPCS codes as applicable.

**Counting hours of observation**

The unit of service for G0378 is hours, rounded to the nearest hour. Observation time begins when observation care is initiated in accordance with the physician’s order, as documented in the medical record. Observation time ends when the patient is 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.

Covered observation may end prior to physical discharge when all medically necessary services related to observation have been completed. Reported observation time would not include the time the patient remains in the observation area after treatment is finished for reasons such as waiting for transportation home or waiting for available placement in an alternate facility. After covered observation is completed, other covered services may still be reported separately using applicable HCPCS codes, including visit codes. (See Case Study 1.5 on the download page for an example.)
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Non-reportable observation

Medicare considers some observation services to be bundled to other services described by HCPCS codes. Like any other bundled service, observation should not be reported if it is considered bundled to (or part of) another service. Common situations where observation is bundled to other services include the following:

- Observation provided concurrently with diagnostic or therapeutic services for which active monitoring is already part of the service
- Routine preparation for and recovery from diagnostic tests
- Postoperative monitoring during a standard recovery period (e.g., 4–6 hours)

Subtract time spent providing these services from the overall time in observation to prevent reporting observation during times when it is bundled to other services on the claim. When determining the amount of time to subtract from the overall observation time, the provider may choose to document the beginning and end times for services with active monitoring or subtract an average length of time for the service with active monitoring. (See Case Study 1.6 on the download page for an example.)

Supplement: Payment for Observation Services

Covered observation services can be paid in three ways:

1. They are packaged into the C-APC for observation services (8011)
2. They are packaged into a visit APC for direct referral for observation
3. They are packaged to the other services on the claim
The C-APC for observation services makes a single payment for encounters that include a clinic or critical care visit along with observation if no surgical service is provided. The following are the criteria for payment of the C-APC for observation:

- One of the following assessment visits billed on the same day or the day before observation care:
  - A clinic visit billed with G0463
  - A Type A ED visit billed with 99281–99285
  - A Type B ED visit billed with G0380–G0384
  - A critical care visit billed with 99291
  - Direct referral for observation billed with G0379

- At least eight hours of covered observation care billed with G0378

- No status indicator “T” service (surgical procedure requiring anesthesia, including local anesthesia) reported on the day of or the day before the observation care

The C-APC for observation pays for all services provided in the encounter and billed on the same claim with the visit and observation services, including diagnostic testing and drug administration services that would normally be paid separately.

If payment for the C-APC for observation cannot be made because too few hours of observation were reported, then payment for the encounter with observation may be made under APC 5013 (Level 3 Examinations and Related Services). This payment is made if:

- Direct referral for observation is reported with G0379 on the same date of service as G0378

- No service with status indicator “T” or “V” is provided on the same date of service as the direct referral
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The APC for Level 3 Examination and Related Service only makes payment for the referral assessment (G0379) and observation (G0378). Diagnostic testing and drug administration that would normally be paid separately continues to be paid separately in addition to the Level 3 Examination and Related Services APC.

Covered observation services that do not qualify for payment as part of the C-APC for Observation or Level 3 Examination and Related Services are packaged to other separately payable services the patient received. This may include an observation stay that would otherwise qualify for separate payment but is packaged because it is billed with a “T” procedure (a surgical service) or an observation stay of less than eight hours. (See Case Study 1.3 on the download page for an example.)
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