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LEVEL OF CARE: INPATIENT VERSUS OBSERVATION SERVICES

Presented by:
Palmetto GBA
Provider Outreach and Education





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Objectives

- To increase knowledge and understanding of observation coverage and billing regulations
- To apply given information in a way to positively affect provider billing practices



Table of Content

- Overview
- Inpatient
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Level of Care

- Facility-defined levels of care
 - Inpatient
 - Outpatient
- Medicare does not recognize
 - Extended outpatient
 - 24-hour hold
 - Inpatient observation

Status Decision



- Inpatient hospital admission no longer considered a default decision in all circumstances associated with hospital care
- Recent trend — patients evaluated on hospital outpatient basis through the use of observation services during the process of establishing need for longer period of inpatient care

Length of Stay (LOS) Determines Status



- Care in which expected LOS is less than 24 hours should rarely be rendered in inpatient status unless associated with specific inpatient-only procedures
 - Stays with expected LOS greater than 48 hours should rarely be designated as outpatient unless medical necessity issues exist
 - Stays with expected LOS between 24 and 48 hours should be closely examined by physician



Medical Necessity

- Coverage defined by Title XVIII of the Social Security Act, Section 1862 (a)(1)(A)
- Allows coverage and payment only for services considered medically reasonable and necessary for
 - Diagnosis or treatment of illness or injury; or
 - To improve functioning of a malformed body member



Medical Necessity

- For a service to be considered medically necessary it must be:
 - Appropriate in duration and frequency
 - Suitable for the patient's medical needs
 - Provided in accordance with accepted standards of medical practices
 - Neither experimental or investigational
 - Performed by qualified personnel in appropriate settings



Medical Necessity

- Use medical necessity tools:
 - NCDs
 - LCDs
 - IOMs
 - Screening tools (InterQual, Milliman)
 - Best practices
 - Practice standards



Medical Necessity

- Requires care coordination
 - Physician involvement
 - Utilization review
 - Clinicians
 - Financial/billing/coding
- Even with all the coordination and input of case management, utilization review and quality controls;
 - Medicare views the physician order as binding
 - Physician involvement at all levels is a must



Medical Necessity

- Basis of Medicare coverage is based on medical necessity
- Providers provide evidence of medical necessity through **documentation**



Documentation Requirement

Physicians' orders

- Orders play a necessary **role** in determining medical necessity for payment considerations
- Patient care directives don't constitute coverage or payment directives

Order does not mean coverage requirements met!

- An order is necessary for payment but payment is not based on the order alone

Observation Clinical Documentation



- Physician's documentation must include:
 - A written order for observation services
 - Physician admitting orders, subsequent orders and progress notes must reflect medical necessity of need for observation services
 - Medical record must reflect fulfillment of physician's orders
 - Medical record should reflect changes in clinical status and reasons for admission or discharge



eServices

- eServices is the preferred method of submission for ADR documentation
- Requested documentation can be submitted electronically through eServices
 - Process is secure, time efficient and cost effective!

- **eServices User Guide**

<https://www.palmettogba.com/eServicesUserGuide>



esMD

- Providers can submit requested ADR documentation electronically through esMD
 - Process is secure, time efficient and cost effective!
- Palmetto GBA article:
- Submit Medical Record Documentation via esMD - <https://tinyurl.com/y9r2gmz3>



Status Decisions

- CMS allow for a 48-hour period to assess presenting signs and symptoms as they progress toward improvement, stabilization or decline
- Treating physician initially establishes need for hospital services and subsequently decides on outpatient versus inpatient status



Status Decisions

- Decision based on a determination of:
 - Diagnosis and appropriate therapy
 - Expectation of anticipated timeframes for safe/successful treatment
- Strength of physician's documentation in describing rationale and clinical consideration is essential in support of decision for either status



INPATIENT

Inpatient — Medicare Benefit Policy Manual

CMS IOM 100-02, Chapter 1, Section 10

“An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. 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.”



Inpatient

- Admission purpose
 - For beneficiary to receive inpatient services
 - As defined by 42 CFR 409.10
- Admission decision is made by the physician responsible for patient's care at the hospital



Inpatient

- Must have order for admission
 - **Admit** with no other clarifier means inpatient
- Must be for purpose of receiving covered inpatient services
 - Inpatient services are those that cannot safely or effectively be rendered at a lesser LOC without jeopardizing health or safety of patient



Determining Factors

- Factors to be considered when making decision to admit include
 - Severity of signs and symptoms exhibited by patient
 - Medical predictability of adverse event happening to patient
 - Need for diagnostic studies that appropriately are outpatient services
 - Availability of diagnostic procedures at the time when and at the location where the patient presents

CMS IOM 100-02, Medicare Benefit Policy Manual, Chapter 1,
Section 10 — Covered Inpatient Hospital Services Covered
Under Part A



CONDITION CODE 44

Policy and Billing



Condition Code 44

- Where hospital or Utilization Review (UR) determines admission doesn't meet inpatient criteria
 - Hospital may change status from inpatient to outpatient
- All conditions **MUST** be met:
 - Change in status made prior to patient discharge/release
 - Inpatient claim was not submitted
 - Practitioner and UR concur
 - Concurrence is documented in medical record



Condition Code 44

- When hospital has determined criteria was met to submit an outpatient claim
 - Entire episode of care billed as outpatient
- Services reported on 13X or 85X TOB
 - Status changed from inpatient to outpatient — report condition code 44
 - Condition code 44 does not affect amount of outpatient payment that would otherwise be made



Conditions Not Met

If conditions for use of condition code 44 are not met, providers submit:

- 110 TOB for non-covered inpatient stay
- 12X TOB for covered inpatient ancillary services

CMS IOM 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 10, and 100-04, Medicare Claims Processing Manual, Chapter 4, Sections 240 and 240.1



Reminder!

Please note that the Part A/B Rebilling process does NOT apply to those inpatient admissions where condition code 44 criteria has been met!



OUTPATIENT

Outpatient : Medicare Benefit Policy Manual



CMS IOM 100-02, Chapter 6, Section 20.2

“A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital or CAH.”



Outpatient Status

- Patient is an outpatient:
 - Not admitted as an inpatient
 - Registered
 - Receives hospital services
- Observation is an outpatient status
 - Clearly defined set of services
 - Direction for billing
 - Allows physician decision making



Outpatient Observation

- A patient in observation may receive other ancillary services to determine if he/she should be admitted or discharged
- These rendered services should be submitted on claim along with the observation room



OBSERVATION ROOM SERVICES



Definition

- Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short term treatment, assessment and reassessment
 - While a decision is made regarding whether patient will require further treatment as a hospital inpatient or able to be discharged from hospital



Definition

- Observation services are commonly ordered for patients who present to the emergency department, then require a significant period of treatment or monitoring in order to make a decision concerning admission or discharge



Definition

CMS IOM 100-04, Medicare Claims Processing Manual, Chapter 4, Section 290.1

“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.”



Key Concepts

- Outpatient services = ordered by physician for treatment, monitoring, and physician decision-making period
- CMS IOM 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 20.6

“When a physician orders that a patient receive observation care, patient’s status is that of an outpatient. Purpose of observation is to determine need for further treatment or for inpatient admission.”



Orders

- **Inpatient admission** = order for admit to inpatient
- **Observation** = order to place in observation
- Medicare does not view observation as a status; it is an outpatient service
 - However, since the possibility for an APC payment for observation time exists, there must be a doctor's order for observation to begin calculation of time



Reporting Observation Hours

- Observation time begins at clock time documented in patient's medical record
 - Coincides with the time that observation care is initiated according to doctor's orders
- **Example:** Mr. Smith began observation at 1 p.m. and discharged to home at 9 p.m.
 - Units on claim will be 8



Observation Hours

- General standing orders for observation services following surgery is not recognized
 - Do not report as observation services that are part of another service such as postoperative monitoring during standard recovery period (4-6 hours)
- Patients undergoing diagnostic testing
 - Routine preparation furnished prior to testing and recovery afterwards
 - Included in payment for diagnostic tests



Observation Hours

- Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is part of procedure (e.g., colonoscopy, chemotherapy)
- *Example:* May record for each period of observation beginning and end time
 - During procedure, add length of time for observation periods together to reach total number of units
 - May also deduct average length of time of procedure from total time that patient receives observation

Observation End Time



- Ends when all medically necessary services related to observation are completed
 - May include medically necessary services after discharge order, but before patient is discharged
 - Observation time does not include time spent after treatment is finished and patient is waiting for transportation
- If observation spans more than one day
 - All hours must be included on one line
 - Line item date of service is date observation began



OBSERVATION SERVICES

Billing Requirements



General Billing Requirements

- Hospital observation services, per hour = HCPCS G0378
 - Status indicator N, signifying payment is always packaged
 - In most situations observation is supportive and ancillary to other services provided



Packaging

- Packaged services are items/services that are considered an integral part of another service
- No separate payment is made for packaged service
 - Cost of item/service is included in APC payment

Requirements to Receive APC 8011

- No limitation on diagnosis for payment of APC 8011;
 - Comprehensive 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
 - I/OCE evaluates every claim received to determine if payment through a comprehensive APC is appropriate



Observation Time

- Time must be documented in medical record
 - Begins at the clock time documented in patient's medical record, which coincides with the time observation services are initiated in accordance with physician's order
 - 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 inpatient
 - **Units reported with G0378 must equal or exceed 8 hours**



Additional Hospital Services

- Claim must include one of these services in addition to the reported observation services
 - Type A or B ED visit (99281 - 99285 or G0380 - G0384); or
 - Clinic visit (G0463); or critical care (CPT 99291); or
 - Direct referral for observation G0379 (APC 5013) must be on same DOS as the date of observation services
- No procedure with a T or J1 status indicator can be reported on claim



Direct Referral

- Direct referral for observation is reported using HCPCS code G0379
 - 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



Direct Referral

- Payment for direct referral for observation care will be made either
 - Separately as a hospital visit under APC 5013 (Level 3 Examinations & Related Services) or
 - Packaged into payment for comprehensive APC 8011 (Comprehensive Observation Services) or
 - Packaged into the payment for other separately payable services provided in the same encounter



Criteria for payment of G0379

- G0379 under either APC 5013 or 8011 include:
 - Both HCPCS codes G0378 (Hospital observation services, per hr.) and G0379 (Direct referral for hospital observation care) are reported with the same DOS
 - No service with a status indicator of T or V or Critical Care (APC 5041) is provided on the same day of service as HCPCS code G0379



Additional Hospital Services

- Claim for observation must include one of following services:
 - Type A or B ED visit – 99284, 99285 or G0384
 - Clinic visit – 99205 or 99215
 - Critical care – 99291
 - Direct referral for observation care reported with G0379 must be reported on same date of service as observation



Physician Evaluation

- Patient must be in care of physician during period of observation
- Physician assessed patient risk to determine that patient would benefit from observation



Non-Repetitive Services

- Non-repetitive services on same date of service as direct referral for observation care or observation services must be reported on the same claim
 - Because OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care are reported on same claim



Beneficiary Notification

- Hospitals must **not** bill the patient for reasonable and necessary observation services when the OPPS packages payment
- Hospitals should not confuse “packaged” payment with non-coverage/nonpayment



Beneficiary Notification

- If service meets definition of observation services or would be otherwise covered; then provider must decide whether items/services are medically reasonable and necessary
 - If not; issue an Advanced Beneficiary Notice (ABN)
 - Refer to CMS IOM 100-4, Chapter 30 - Financial Liability Protections at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf>



Beneficiary Notification

- If ABN is not issued, provider may be held liable for cost of item/service
 - Unless provider is able to demonstrate that they did not know and could not have reasonably been expected to know that Medicare would not pay for the item/service

THANK YOU!



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