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QIO GENERAL MEMORANDUM No. 0205- 03
For Immediate Distribution

TO: Alabama Hospitals

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Utilization/Review/Case Mgt. Staff
Payment Monitoring Program (PEPP/HPMP)
Director of Emergency Department
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FROM: Henry W. Koehler
Chief Executive Officer

DATE: December 16, 2002

SUBJECT: Guidelines for Observation Services

The purpose of this General Memorandum is to provide acute care hospitals with newly established guidelines regarding Observation services. A task force including Alabama Quality Assurance Foundation (AQAF), Cahaba Government Benefits Administrator (Cahaba/GBA), Alabama Hospital Association (ALAHA), Alabama Medicaid Agency, and the Medical Association of the State of Alabama (MASA) met to develop uniform Medicare/Medicaid guidelines regarding Observation services versus Inpatient admissions.

The attached document provides detailed information and clarification regarding the proper use of Observation services for Medicare and Medicaid patients treated in Alabama hospitals. A policy change has been developed, following input from the Centers for Medicare and Medicaid Services (CMS). The change is effective upon receipt of this memo and is as follows:

The attending physician or his/her designee may clarify the original order to admit to inpatient or observation status within the 1st 24 hours, not to exceed 48 hours, from the time of the nurse's inpatient/observation admission note.

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This represents a major change in the policies governing inpatient versus observation status. The attached document gives further clarification and instructions. Guidelines provide procedure and policy issues as well as instructions in billing correctly. Billing issues/instructions are a responsibility of your FI, so any questions regarding billing should be addressed to your FI Provider Representative.

Cahaba/GBA will be issuing an LMRP on Observation early in 2003. However, this policy change is effective immediately. While Medicaid's payment criteria for observation services remains the same (i.e., patient must be admitted through the ED, etc.) they have also endorsed this policy clarification. **Please notify the appropriate personnel in your hospital of this change so that observation stays can be handled and billed appropriately.**

Questions or concerns may be directed to: Joy King, RHIA, CCS, 1-800-760-4550, ext. 3314
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Attachment

cc: AQA Board of Directors; FMQAI; Region VI Project Officer; M. Horsley, ALAHA; Cary Kuhlman, MASA; Frazer Rolen, ALAHA; Lynda Northcutt, Cahaba GBA; Mary Woon, MoO; HCQIP/HPMP Advisory Committee

GUIDELINES FOR OBSERVATION SERVICES

Developed in collaboration with Alabama Hospital Association (AlaHA), Alabama Medicaid Agency, Medical Association for the State of Alabama (MASA) and Cahaba GBA.

Disclaimer: This document applies to claims submitted to Alabama Medicare (Cahaba/GBA). The physician clarification policy change is also endorsed by Alabama Medicaid.

This material was prepared by Alabama Quality Assurance Foundation under a contract with the Centers for Medicare & Medicaid Services. Contents do not necessarily represent the Centers for Medicare & Medicaid Services policy.

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OBSERVATION SERVICES

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OBSERVATION SERVICES

A. Introduction

This document represents a compilation of Medicare regulations that bear on Observation services and brief Inpatient admissions, and summarizes their impact on correct use and billing of Observation. It represents input from an Alabama Quality Assurance Foundation (AQAF)-initiated task force that includes representatives from AQAF, Cahaba/Government Benefits Administrator (Cahaba/GBA), Alabama Hospital Association (AlaHA), Alabama Medicaid Agency, and the Medical Association of the State of Alabama (MASA). It defines the Task Force's interpretation of the regulations and ambiguities that exist.

The correct use of extended outpatient Observation services, and the differentiation of an Inpatient admission from an outpatient Observation, has continued to be a problem for providers nationwide. *Although in many institutions there is no difference between the actual medical services provided in Inpatient and Observation settings, the designation still serves to assign patients to an appropriate category for proper billing & payment.*

The determination of Inpatient or Observation status for any patient is specifically reserved to the admitting physician, although that physician has Medicare guidelines to follow. The decision must be based on the physician's expectation of the care that the patient will require. The general rule is that the physician should order an Inpatient admission for patients who meet acute care screening criteria, i.e. Severity of Illness(SI) and Intensity of Service (IS) criteria, and are expected to need hospital care for 24 hours or longer. Other patients should be treated in the Outpatient setting. Except in the case of the inpatient-only list, physician expectation of a 24-hour stay and associated medical necessity must still be documented.

AQAF as the Quality Improvement Organization (QIO) is responsible for reviewing Inpatient admissions on a case-by-case basis to determine if the admission was medically necessary. The QIO is authorized by Medicare law to make these determinations which are binding for purposes of Medicare coverage. (Medicare Intermediary Manual (MIM) 13-3-3101).

The task force has obtained input from the Centers for Medicare & Medicaid Services (CMS) and has determined that **the attending physician or his/her designee may clarify the original order to admit to Inpatient or Observation status within the 1st 24 hours, not to exceed 48 hours, from the time of the nurse's Inpatient/Observation admission note.** This represents the major clarification in the rules governing Inpatient vs. Observation status.

B. Guidelines for Use of Observation Services

Observation services are defined as “the use of a bed and periodic monitoring by a hospital’s nursing or other ancillary staff, which are reasonable and necessary to evaluate an Outpatient’s condition to determine the need for possible Inpatient admission.” [Medicare Intermediary Manual (MIM) 13-3-3112.8A]

Physician Order is Required for Medicare/Medicaid

1. Observation services are payable only when provided under a physician’s order (or under the order of another person who is authorized by state statute and the hospital’s bylaws to admit patients).
2. Orders that are unclear or state simply “Admit” with no clarification of patient status will be considered an order to admit to Inpatient status. The order must be written prior to initiation of the Observation services. An Observation service may be converted or progressed to Inpatient admission if the physician writes an order for Inpatient admission.

NOTE: Some commercial Observation patients automatically convert to an Inpatient at 24 hours without a physician order, while Medicare & Medicaid patients require a physician order to convert from Observation to Inpatient.

3. **The attending physician or his/her designee may clarify the original order to admit to Inpatient or Observation status within the 1st 24 hours, not to exceed 48 hours, from the time of the nurse’s Inpatient/Observation admission note.**
4. If the patient’s Inpatient admission was based on a clerical error (misinterpretation of the physician’s order), a correction can be made to the patient’s status to reflect what the physician ordered (Observation) prior to submitting the claim.

Outpatient Observation services are not to be used as a substitute for medically unnecessary Inpatient admissions. Likewise, Observation services are not to be used as a substitute for a medically necessary Inpatient admission where the patient meets acute care screening criteria (SI/IS). Observation services must be patient-specific and not part of the facilities’ standard operating procedure or protocol for a given diagnosis or service. Observation services, generally, do not exceed 24 hours. Some patients may require a second day of Observation. (Medicare Intermediary Manual Transmittal #1689)

C. Considerations for Use of Observation Services

Observation services can be loosely divided into 4 categories: 1) Observation associated w/ a medical condition, a) without separate payment, b) with separate payment; 2) Observation following Outpatient surgery; 3) Observation associated with Outpatient testing/services; 4) Treatment Room visit.

Observation associated with a Medical Condition

1. When a patient arrives at the facility in an unstable medical condition (generally via the Emergency Dept.), Observation services may be reasonable and necessary to evaluate the medical condition to determine the need for possible admission to the hospital as an Inpatient.
2. An unstable medical condition may be defined as:
 - a. variance from generally accepted normal lab values, and
 - b. clinical signs/symptoms on presentation that are above or below normal range and require further monitoring & evaluation. Changes in the patient's status or condition are anticipated and immediate medical intervention may be required.
 - c. Documentation in the patient's medical record must support medical necessity for the Observation service.
3. Brief observation periods that follow an ED evaluation will not be covered as medically necessary if the service would normally have been provided within the time frames and facilities of an ED visit. For example, the transfer of a patient from the ED to the floor solely to administer an enema would not be considered an appropriate observation stay as that service would normally be included in the ED visit.
4. Brief Observation periods following an office visit or at the direction of an off-site physician may occur, but they would generally involve a simple procedure (such as a breathing treatment or pelvic exam) and would be more appropriately billed as a treatment room visit.
5. Observation services for conditions that do not meet criteria for separate payment are included in the E/M code assigned for the facility, i.e. E/M code for the ED visit. The facility E/M code level should reflect all services performed during the Observation portion of the stay.

a) **No Separate Payment for Observation associated w/ Medical Condition**

Indications for Observation vs. Inpatient Admission

The following conditions lend themselves to use of Observation services because they generally lack medical necessity for Inpatient admission unless specific complications or comorbidity exist. The complications/comorbidities would need to be clearly documented in the medical record. *Note that the following are only guidelines; in any case where an Inpatient admission is reviewed for appropriateness of setting, medical necessity is always evaluated on a case-by-case basis based on the documentation supporting the specific admission.*

1. **Syncope, decreased responsiveness:** The evaluation of both uncomplicated syncope and decreased responsiveness, particularly in the elderly, represents a search for a serious underlying pathology that is generally completed in 24 hours or less. These diagnoses thus constitute

classic examples of extended Observation, and are only medically necessary for an Inpatient admission in the presence of complicating factors that would lead to an expectation of a prolonged stay.

2. **Atrial arrhythmias:** Atrial arrhythmias, including those that necessitate hospitalization for scheduled or unscheduled cardioversion and scheduled pacemaker insertion (for many atrial or ventricular indications), generally require hospitalizations that are 24 hours or less and are thus appropriate for Observation. Comorbidities and complications both may create medical necessity for an Inpatient stay.
3. **Renal Colic:** Based on current standards of care, kidney stones seldom require Inpatient admission. Excessive sedation, protracted vomiting or the need for a more definite procedure (diagnostic or therapeutic) in the morning may require extended Observation. In the absence of infection or complete obstruction, an Inpatient admission based on an expected stay of >24 hours is seldom initially necessary.

b) Separate Payment for Observation associated w/ Medical Condition

Indications for Observation vs. Inpatient Admission

The following conditions lend themselves to use of Observation services because they generally lack medical necessity for Inpatient admission unless specific complications or comorbidity exist. The complications/comorbidities would need to be clearly documented in the medical record. *Note that the following are only guidelines; in any case where an Inpatient admission is reviewed for appropriateness of setting, medical necessity is always evaluated on a case-by-case basis based on the documentation supporting the specific admission.*

1. **Rule/Out Myocardial Infarction:** Use of Observation to rule out MI in the case of a *low-risk* chest pain is a classic example of extended Observation. The initial 18-24 hour period is used to search for pathology that would necessitate an Inpatient stay. An Inpatient stay is not necessary unless significant comorbidity exists (in which case the expectation of a prolonged stay also exists), evidence of significant pathology is uncovered or the patient remains at risk at the end of 24 hours. Note that the use of cardiac monitoring on an otherwise stable patient does not signify ICU level of care, regardless of the physical location of the bed. However, if the patient is actually receiving ICU services (such as cardiac meds or close monitoring due to unstable vital signs), the patient should appropriately be admitted as an Inpatient.
2. **Asthma or COPD:** Patients with asthma and COPD frequently respond to aggressive treatment in the ED or Observation, thereby averting Inpatient hospitalization. An Inpatient admission is not usually medically necessary unless significant comorbidity exists, the attack is unusually severe (e.g. requiring intubation), the patient has a history of requiring a prolonged

Inpatient stay, or the patient failed to respond to aggressive management during extended Observation.

3. **Congestive heart failure:** Patients with mild CHF frequently respond to aggressive diuresis in the ED or Observation, thereby averting Inpatient hospitalization. An Inpatient admission is therefore not usually medically necessary unless significant comorbidity exists, the failure is unusually severe (florid pulmonary edema), the patient has a history of requiring prolonged hospitalization, or the patient failed to respond to aggressive diuresis during extended Observation.

Separate payment may be made for Observation services (APC 0339) for 3 medical conditions (Chest Pain, Asthma, and Congestive Heart Failure-CHF) when certain criteria are met: (Refer to Program Memo A-02-026, 3/28/02)

1. There must be a physician order for Observation.
2. Observation begins at the “clock time” that is entered in the Nurse’s Observation admission note.
3. Observation care must be for more than 8 hours and up to 24 hours. All costs beyond 24 hours are packaged into the APC payment for Observation (APC 0339).
4. Observation ends at the “clock time” documented in the physician’s discharge order or at the time the nurse signs off on the physician’s discharge order.
5. The physician must write, time, and sign regular progress notes during the Observation time.
6. The physician documentation must show evidence of risk stratification criteria being used to determine that the patient would benefit from Observation care. This risk stratification can be published criteria or generally-accepted medical standards of care.
7. Mandatory tests are to be performed, as follows:
 - a. For **Chest Pain:** at least 2 sets of cardiac enzymes, either CPK (CPT 82550, 82552, 82553) or Troponin (CPT 84484 or 84512) and 2 sequential EKGs (CPT 93005). **NOTE:** Repeat CPK or Troponin levels will require modifier –91 along with the CPT code. Repeat EKGs will require either modifier –76 or –77 along with the CPT code.
 - b. For **Asthma:** a peak expiratory flow rate (CPT 94010) or pulse oximetry (CPT 94760, 94761, or 94762).
 - c. For **Congestive Heart Failure:** a chest x-ray (CPT 71010, 71020, or 71030) and an EKG (CPT 93005), and pulse oximetry (CPT 94760, 94761, or 94762). **NOTE:** Pulse oximetry codes 94760, 94761, & 94762 are treated as packaged services under OPPS. *Although as packaged codes no separate payment is made for these codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that Observation services for CHF and asthma diagnoses meet the criteria for separate payment.*
8. There must be a diagnosis code from the list of acceptable codes published by CMS to justify medical necessity. (See Attachment 1).

9. HCPCS code G0244 must be used along with the diagnosis code to support medical necessity for these patients, in order to receive the separate APC payment for Observation.
10. In addition to the G0244, there must be an E/M code for the ED, clinic visit, or critical care billed on the day before or the day of admission to Observation (99218 – 99220 or 99234 – 99236, critical care 99291 or 99292). Both the associated E/M code and the Observation code are paid separately if the Observation criteria are met and G0244 and the E/M codes are billed on the same claim.
11. The E/M code must also be billed with the –25 modifier in order for the Observation APC to be paid.

Although the above criteria for separate payment are somewhat restrictive, CMS wants to emphasize that payment is made for all medically necessary Observation services provided in the Outpatient setting. Payment for Observation services not meeting the criteria for separate payment in APC 0339 are included in the payment for the Clinic, ED, or Surgical Procedure visit—the payment is packaged into the APC in which those services were provided. It is therefore important to ensure that the level of E/M code assigned for the facility (especially for ED visits) reflect any time/services involved in assessing the patient for placement into Observation.

Observation following Outpatient Surgery

1. Coverage of Observation services following Outpatient Surgery is allowed only when the patient has an uncommon or unusual reaction to the surgical procedure (e.g., difficulty awakening from anesthesia, drug reaction, intractable vomiting, or other post-surgical complications) which requires monitoring or treatment beyond that customarily provided in the postoperative period. Routine preop and recovery room services are included in the CPT procedure code and should **not** be billed as Observation services. Standing orders following Outpatient Surgery are **not** covered as Observation services.
2. The Observation service begins at the point in time when the reaction occurred (based on MD order and time entered by nurse on Observation admit note) and ends when it is determined whether or not the patient requires Inpatient admission (based on MD order and time on nurse's notes). Medical review decisions will be based on documentation in the medical record.
3. Although CMS does not increase the APC reimbursement for extended Observation after a procedure, it is crucial to note these additional hours on the claim for statistical purposes for future decisions impacting reimbursement.

Observation associated with Outpatient Testing/Services

1. For scheduled OP diagnostic tests, the routine prep and immediate recovery period following the test is not considered an Observation service. Reimbursement is included in the CPT code for that service. However, if the patient has a significant adverse reaction as a result of the test that requires further monitoring, further Observation services may be reasonable & necessary.
2. Observation services would begin at the time when the reaction occurred, (based on MD order and time entered by nurse on Observation admit note) and would end when it is determined whether or not the patient required Inpatient admission (based on MD order and time on nurse's notes).
3. Observation status does not apply when the patient is given administration of blood only and receives no other medical treatment. The use of hospital facilities is inherent in administration of the blood and is included in the CPT code. The same would be true for chemotherapy administration.
4. When the patient has been scheduled for an ongoing therapeutic service for a known medical condition, a period of time is often required to evaluate the response to that service. This period of evaluation is a component of the therapeutic service and is not considered an Observation service.
5. In general, only diagnostic services can be performed while the patient is in Observation status. If therapeutic services are ordered and/or expected to be performed, the patient should be evaluated for Inpatient status utilizing the SI/IS criteria.
6. Although CMS does not increase the APC reimbursement for extended Observation after a diagnostic test, it is crucial to note these additional hours on the claim for statistical purposes for future decisions impacting reimbursement.

Indications for Observation vs. Inpatient Admission

The following condition lends itself to use of Observation services because it generally lacks medical necessity for Inpatient admission unless specific complications or comorbidity exist. The complications/comorbidities would need to be clearly documented in the medical record. *Note that the following is only a guideline; in any case where an Inpatient admission is reviewed for appropriateness of setting, medical necessity is always evaluated on a case-by-case basis based on the documentation supporting the specific admission.*

1. **Cardiac Catheterization and Electrophysiologic Mapping:** Based on current standard of care, these procedures are usually performed on an outpatient basis, although they are frequently converted to Inpatient if a therapeutic intervention is ultimately required. In the absence of unusual complications or comorbidity, they represent appropriate Outpatient procedures rather than Observation or Inpatient admission.

Treatment Room Visits

Treatment room services consist of those Outpatient services, furnished on hospital premises, which require use of a bed and periodic monitoring for a relatively brief episode of time in order to carry out certain non-surgical procedures that are not performed in a specialized suite that is otherwise billable. Treatment room services are not synonymous with Observation and are used to reimburse for facility usage associated with minor procedures where those facility services are not otherwise reimbursed or bundled. *Note that the primary difference between Treatment Room and Observation services is that the use of the Treatment Room is an expected part of a minor procedure, and replaces the charge for operating room and recovery room. Conversely, the Observation service is an unexpected service beyond the normal recovery period due to an unresolved question concerning the patient's condition.*

Other Services not billable as Observation services include:

Claims for Observation services will be denied as not reasonable and necessary under §1862 (a)(1)(A) of the Social Security Act. This includes claims for services that are not medically necessary, which duplicate other services, or which are provided in inappropriate settings. The reasons are delineated in 13-3-3112.8.E and include:

1. Services provided for the convenience of the patient, hospital (facility), the health care provider, family member, or physician.
2. Claims that are submitted for Outpatient procedures that are listed on the **Medicare Inpatient Only** list will be denied in their entirety. (65FR 18457, Appendix E). The manual does not allow flexibility in this area. *Note that careful attention must be paid to the admissions practices of those physicians, as the provider is not allowed to retrospectively change an Outpatient Surgery to an Inpatient admission.*
3. Services not medically reasonable or necessary for the diagnosis or treatment of the patient.
4. Services that normally would require an Inpatient stay. The availability of outpatient Observation **does not** mean that procedures such as angioplasty with stent placement may be performed on a patient in Observation status.
5. Services provided when an overnight stay is planned prior to the performance of diagnostic testing or therapeutic services (e.g., planned or anticipated overnight stay following surgery, chemotherapy, or blood transfusions.)

D. Beneficiary Considerations

Hospitals are encouraged to develop policies to inform the beneficiary of their admission status and financial responsibilities therein.

Days in outpatient Observation do not count toward the three-day qualifying stay required for Medicare coverage of a skilled nursing facility admission.

If the hospital intends to place or retain a patient in Observation status for a non-covered service, the beneficiary must be given proper written advance notice of non-coverage under the limitation of liability procedure. (See section 230.6E of Medicare Hospital Manual).

E. Submitting a Claim for an Inappropriate Inpatient Admission

If an inpatient admission is determined to be unnecessary prior to submitting the UB-92 claim form, the provider must submit a claim for the inpatient admission indicating the provider is liable for the inpatient admission (Bill Type 111). Providers would report occurrence span code 77 (provider liability period) in Form locator 36, which indicates the dates of service are the provider's responsibility. The FI will change the occurrence span code to 79 (provider liability—no utilization). This prevents the provider from collecting Part A (but not Part B) deductible or co-insurance from the beneficiary.

If a claim for the inpatient admission has already been submitted to the intermediary, and then the admission is found to be unnecessary, the provider must submit a corrected UB-92 to Part A, filed as an adjustment to the original claim (Bill Type 117). The corrected UB-92 indicates the provider is liable for the cost of the admission (occurrence span code 77), which the FI will change to occurrence span code 79. Please refer to the UB-92 Manual for details on filing these claims, which is available by contacting AlaHA.

The provider may be able to submit a claim for reimbursement under Part B for certain services provided to the patient, when the admission is found to be unnecessary. The Medicare Intermediary Manual, section 3110, addresses payment that can be made to the provider when the services cannot be billed under Part A. The services that could be billed under Part B include: diagnostic tests, surgical dressings and splints, prosthetic devices, physical and speech therapy, ambulance services, as well as outpatient services that preceded an admission that was found to be unnecessary.

A claim form must be submitted to the FI for any inpatient admission, even if deemed unnecessary by the provider. This assists the FI and CMS in maintaining utilization records and determining remaining eligibility of beneficiaries.

F. CASE SCENARIOS: (Several of the following scenarios are referenced in the Medicare Hospital Manual, Section 230.6.E.

Example 1: A patient comes to the ED complaining of difficulty breathing. The patient is seen by the physician on duty, who orders lab tests, including a blood gas analysis, and an injection to help the patient breathe more easily. The physician then has the patient placed in an outpatient observation unit to determine whether this intervention produces normal breathing. Six hours later, the patient is again seen by the physician, who determines from the patient's

chart and personal observation that the patient's vital signs are normal and the patient has resumed normal breathing. The patient is released. Under these circumstances, the outpatient observation services **are appropriate** and would be included in the APC reimbursement for the ED visit (facility E/M level assigned).

Example 2: A patient comes to the outpatient department to undergo a scheduled surgical procedure. After surgery, the patient experiences difficulty awakening from anesthesia and elevated blood pressure while in the recovery room. These conditions persist through the usual recovery period, and the patient is seen by a physician, who has the patient placed in Observation. The physician leaves orders for the nursing staff to monitor the patient's condition and note any continued abnormalities that might indicate a drug reaction or other post-surgical complications. After a few hours in observation, the patient is no longer lethargic, has a normal blood pressure and shows no other signs of post-surgical complications. The physician, after being advised of this, orders the patient released from the hospital. Observation time begins at the clock time on the nurse's observation admission note. The hospital should note the *appropriate modifier* on the claim to denote the additional units of observation. Under these circumstances, coverage of observation services cannot be covered, since they are covered as part of the APC for the surgical procedure. Although these additional hours will not increase the APC reimbursement for the surgical procedure, it is crucial to note this information on the claim for statistical purposes for future decisions impacting reimbursement for Observation services.

Example 3: A patient comes to the ED in the evening with complaints of sudden severe flank pain which radiates to the inner thigh, nausea & vomiting, urinary frequency and urgency. The exam reveals soreness over the kidney area, spasm of the abdominal muscles and microscopic hematuria. Additionally, an x-ray reveals the presence of a ureteral stone. The patient is admitted to the hospital as an inpatient at 11:00 p.m. The patient is treated with IV fluids, IM morphine, and an anti-spasmodic every four hours. Further diagnostic studies are scheduled for the following morning. During the night, the patient passes a stone through the urethra without complications. The patient is then comfortable without nausea or urinary complications. Therefore, the patient is discharged at 9:00 a.m. and scheduled for follow-up in the physician's office. Although the patient was able to be discharged in less than 24 hours, the admission was appropriate because it was reasonable to expect at the time of admission that the presenting problem would require more than 24 hours to resolve.

Example 4: A patient is scheduled to have an uncomplicated cataract extraction as an outpatient. The patient expresses a preference for spending the night following the procedure at the hospital despite the fact that the procedure does not require an overnight stay. The hospital may register and treat the patient on an outpatient basis and permit the patient to remain at the hospital overnight. *The overnight stay cannot be reimbursed in addition to the APC for the*

procedure because it is not medically necessary. When this is the case, the patient must be notified in advance that the overnight stay is not medically necessary and that he or she can be charged for the additional services. If unforeseen complications necessitate an inpatient admission, the patient is admitted and a Part A claim is submitted.

Example 5: A patient with precordial discomfort is felt to be at low to moderate risk for MI and is kept in the ICU of a small facility for telemetry and serial enzymes. *This is appropriately performed as an observation because the first 12 to 24 hours will determine the need for an inpatient stay.* The use of the ICU solely as a telemetry room does not require ICU level of services; however, if the patient is unstable (actually receiving an ICU level of care), an inpatient admission would be more appropriate regardless of the anticipated length of stay, as Medicare generally presumes that ICU services are only consistent with inpatient care.

Example 6: A patient has a routine catheterization performed in the cardiovascular suite. The cardiologist uses the word “admit” in his initial orders (as he usually does) but also exclusively uses short stay forms and never moves the patient out of cardiovascular recovery, which always closes at 8 p.m. *Since use of the word “admit” creates confusion, the preponderance of evidence (physician behavior, usual physician practice, standard of care and facility procedures) indicates an intention and delivery of an outpatient procedure.* It would be appropriate to contact the physician in order to clarify the orders and make changes necessary to reflect the appropriate setting for the procedure before submitting the claim.

Example 7: An elderly patient arrives for a scheduled hernia operation after preoperative testing the day before. When the surgeon sees the patient in preop, he notes the presence of an upper respiratory infection and cancels the surgery. *The cancellation of the surgery during the admission assessment aborts the admission process.* All services, including the preoperative testing, may be billed as outpatient since the admission was effectively canceled before completion.

Example 8: A patient presents to the ER in the middle of the night with symptoms indicative of COPD exacerbation. The ER physician decides to admit the patient. The following morning, the attending physician examines the patient and determines that he wants the patient in Observation, rather than inpatient status. He may write a new order to place the patient in Observation status. The time of Observation would begin at the clock time of the nurse’s inpatient admission note.

OBSERVATION RESOURCES

Web Sites:

Centers for Medicare & Medicaid—cms.hhs.gov/manuals
Manuals (Hospital, FI, QIO, Carrier, etc.)

Alabama Quality Assurance Foundation (AQAF)—www.aqaf.com
General Memorandums

Alabama Hospital Association (ALAHA)—www.alaha.org

Alabama Medicaid—www.medicaid.state.al.us

Cahaba/GBA—www.almedicare.com

Medical Association of the State of Alabama (MASA)—www.masalink.org

Federal Register—<http://frwebgate.access.gpo.gov>

HCPRO—www.hcpro.com
e-mail newsletters on APCs, Compliance

ATTACHMENT 1

Medical Necessity for Separate Observation Payment

The correct use of an ICD-9-CM diagnosis code as listed below does not guarantee coverage of an Observation service. The service must be reasonable and necessary in the specific case and must meet the criteria specified for APC 0339.

Effective April 1, 2002, reimbursement for Observation services using APC 0339 requires that one of the following ICD-9-CM codes be present on the UB-92 as a diagnosis.

NOTE: The admitting diagnosis field has not previously been considered when determining that one of the codes is present on the UB-92. Per PM A-02-075, the admitting diagnosis field (form locator 76) will be taken into account when determining separate Observation payment for services furnished on or after 4/1/02, when the bill is submitted or *re-submitted*, or when an adjustment bill is submitted after 1/1/03. This change is retroactive back to 4/1/02.

I. Chest Pain

- 411.0 Postmyocardial infarction syndrome
- 411.1 Intermediate coronary syndrome
- 411.81 Coronary occlusion w/o myocardial infarction
- 411.89 Other acute ischemic heart disease
- 413.0 Angina decubitus
- 413.1 Prinzmetal angina
- 413.9 Other and unspecified angina pectoris
- 786.05 Shortness of breath
- 786.50 Chest pain, unspecified
- 786.51 Precordial pain
- 786.52 Painful respiration
- 786.59 Other chest pain

II. Asthma

- 493.01 Extrinsic asthma w/ status asthmaticus
- 493.02 Extrinsic asthma w/ acute exacerbation
- 493.11 Intrinsic asthma w/ status asthmaticus
- 493.12 Intrinsic asthma w/ acute exacerbation
- 493.21 Chronic obstructive asthma w/ status asthmaticus
- 493.22 Chronic obstructive asthma w/ acute exacerbation
- 493.91 Asthma, unspecified w/ status asthmaticus
- 493.92 Asthma, unspecified w/ acute exacerbation

III. Congestive Heart Failure

- 391.8 Other acute rheumatic heart disease

- 398.91 Rheumatic heart failure (congestive)
- 402.01 Malignant hypertensive heart disease w/ congestive heart failure
- 402.11 Benign hypertensive heart disease w/ congestive heart failure
- 402.91 Unspecified hypertensive heart disease w/ congestive heart failure
- 404.01 Malignant hypertensive heart & renal disease w/ congestive heart failure
- 404.03 Malignant hypertensive heart & renal disease w/ congestive heart failure and renal failure
- 404.11 Benign hypertensive heart & renal disease w/ congestive heart failure
- 404.13 Benign hypertensive heart & renal disease w/ congestive heart & renal failure
- 404.91 Unspecified hypertensive heart & renal disease w/ congestive heart failure
- 404.92 Unspecified hypertensive heart & renal disease w/ congestive heart & renal failure
- 428.0 Congestive heart failure
- 428.1 Left heart failure
- 428.9 Heart failure, unspecified

New Codes Effective 10/1/2002

- 428.20 Unspecified systolic heart failure
- 428.21 Acute systolic heart failure
- 428.22 Chronic systolic heart failure
- 428.23 Acute on chronic systolic heart failure
- 428.30 Unspecified diastolic heart failure
- 428.31 Acute diastolic heart failure
- 428.32 Chronic diastolic heart failure
- 428.33 Acute on chronic diastolic heart failure
- 428.40 Unspecified combined systolic & diastolic heart failure
- 428.41 Acute combined systolic & diastolic heart failure
- 428.42 Chronic combined systolic & diastolic heart failure
- 428.43 Acute on chronic combined systolic & diastolic heart failure

ATTACHMENT 2

G Codes to go in effect 1/1/03 (See PM A-02-129, dated 1/3/03)

G0263: Initial nursing assessment of patient admitted directly from MD's office to Observation w/ chest pain, CHF, or asthma (meets all criteria for G0244)

1. G0263 would be billed with G0244. G0263 would have a status indicator of "N" to show that charges submitted would be packaged into APC 0339.
2. Billing G0263 would require that the medical record show the patient was admitted directly from the MD's office to Observation for evaluation of chest pain, asthma, or CHF. It would be billed under revenue code 762.

G0264: Initial nursing assessment of patient admitted directly from MD's office to Observation with a diagnosis other than chest pain, asthma, or CHF (does not meet all criteria for G0244)

1. G0264 would be paid under APC 600. This G code would replace billing the low-level E/M code presently required.
2. No separate payment would be made for services billed with G0264. Hospitals would be required to use revenue code 762 alone or revenue code 762 with one of the codes for packaged Observation services (99218 – 99220, 99234 – 99236).
3. G0264 would establish a separate code into which costs for these patients could be packaged and recognized.

The billing data for G0263 and G0264 would be used to review provisions for payment of Observation services in future updates of OPSS.

Billing for Infusion Services in Observation: Bill Code G0244 + Q0081 to bill for infusion services performed during a separately payable Observation Stay (meets requirements for G0244). (See PM for further details).