Observation Services Present Compliance Challenges

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Observation services have been a top fraud and abuse target of the Office of Inspector General (OIG) of the Department of Health and Human Services, primarily due to the complexity of the Medicare billing regulations and the potential for abuse. New regulations regarding reimbursement for these services are complex and confusing, increasing providers' risk of being reimbursed inappropriately (meaning under- and overpaid). This article will explain the new regulations and the importance of ensuring compliance with the reimbursement rules for observation services.

What Are Observation Services?

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

Although the implementation of the Medicare outpatient prospective payment system (PPS) resulted in observation services being less of a Medicare compliance risk because these services were no longer separately reimbursable, recent regulatory changes have resulted in renewed emphasis on the potential compliance risks of observation reimbursement.

Effective with the January 2002 revisions to the outpatient PPS, hospitals can be reimbursed for a subset of observation services. Once again, the regulations regarding reimbursement for these services are complex and confusing, increasing providers' risk of being reimbursed inappropriately.

Observation Services Before PPS

Prior to hospital outpatient PPS implementation, hospitals were separately reimbursed for Medicare observation services on a reasonable cost basis. Outpatient observation services were charged by the number of hours, with the first observation hour beginning when the patient was placed in the observation bed. A maximum of 48 hours of observation was reimbursed. If a patient was retained on observation status for 48 hours without being admitted as an inpatient, further observation services were denied as not reasonable and necessary. Services that were not covered as observation included:

- Services that were 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 were covered under Part A, such as a medically appropriate inpatient admission, or as **part of another Part B service**, such as postoperative monitoring during a standard recovery period that should be billed as recovery room services. Routine preparation services furnished prior to diagnostic testing and recovery following the test were not separately reimbursed. Observation services were not separately reimbursed when the patient was receiving concurrent therapeutic services, such as chemotherapy
- **Standing orders** for observation following outpatient surgery
- Services that were **ordered as inpatient services** by the admitting physician, but billed as outpatient by the billing office
- **Outpatient claims for inpatient care**, such as complex surgery clearly requiring an overnight stay

With the implementation of the outpatient PPS, observation services were no longer separately reimbursable, because payment for observation was included in the APC payment for the procedure or visit with which it was furnished. Hospitals were still required to report observation charges under revenue code 762, Observation Room, to properly capture cost data for future updates to the PPS. The number of hours the patient was in observation was to be reported in the units field.

Changes Effective April 1, 2002

Effective for services furnished on or after April 1, 2002, observation services meeting very specific criteria are separately payable. A separate APC payment is made for observation services for patients having diagnoses of chest pain, asthma, or congestive heart failure, when certain additional criteria are met. All other observation services continue to be packaged.

The March 28, 2002, Centers for Medicare & Medicaid Services (CMS) Program Memorandum A-02-026 described in detail the 2002 outpatient PPS changes, including requirements for payment of observation services. CMS identified the specific ICD-9-CM codes that must be reported to show the patient has one of the qualifying diagnoses for payment under the observation APC. Initially, CMS stated that one of these diagnosis codes must be reported in the principal or secondary diagnosis fields to be recognized, but later changed this requirement to allow reporting of the qualifying diagnosis in the admitting diagnosis field, when appropriate.

The August 7, 2002, Program Memorandum A-02-075 instructed fiscal intermediaries that the admitting diagnosis would be taken into account when determining separate observation payment for services furnished on or after April 1, 2002, when the bill is submitted or resubmitted, or when an adjustment bill is submitted after January 1, 2003. It is important to note that while this change was effective for dates of service on or after April 1, 2002, the admitting diagnosis field would not be recognized for any claims submitted prior to January 1, 2003.

A hospital may bill for a separate APC payment (APC 339) for patients with diagnoses of chest pain, asthma, or congestive heart failure, subject to certain criteria being met. HCPCS code G0244, Observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum eight hours, maximum 48 hours, must be reported for these observation services. An evaluation and management (E/M) code for the emergency room, clinic visit, or critical care is required to be billed on the day before or the day that the patient is admitted to observation. Both the associated E/M code and G0244 are paid separately if the observation criteria are met and the E/M code associated with observation must be billed on the same claim as the observation service. An E/M visit must be billed with modifier -25 if it has the same date of service as code G0244. Observation services are packaged into the E/M visit if all observation criteria are not met.

Certain diagnostic tests must be performed in order to bill for separate payment for observation services for the three designated medical conditions. These tests must be performed within the dates of the E/M visit plus the first 24 hours of observation and billed on the same claim as the observation services to which they are related. For chest pain, at least two sets of cardiac enzymes and two sequential electrocardiograms must be performed. For asthma, a peak expiratory flow rate or pulse oximetry must be performed. For congestive heart failure, a chest x-ray, an electrocardiogram, and pulse oximetry must be performed. Although pulse oximetry is packaged under the outpatient PPS and no separate payment is made for packaged services, hospitals must separately report the HCPCS code and charge for pulse oximetry to establish that observation services for congestive heart failure and asthma meet the criteria for separate observation payment.

Multiple observation periods reported on a claim may be paid separately if the required criteria are met for each observation stay. If there are multiple observation periods for the same diagnosis, each of the required tests must be repeated for each period of observation. If multiple observation stays are for different diagnoses, the re-use of tests performed during the earlier observation stay (on the same day) is permitted.

Services that are separately payable under the outpatient PPS (procedures with status indicators S, X, K, G, V, or H) can be billed with code G0244 and paid separately. Services with status indicator T are not separately payable with G0244, with the exception of infusion therapy (code Q0081).

Changes Effective January 1, 2003

Prior to January 1, 2003, separate payment for observation services for one of the designated medical conditions required that an admission to observation be made by order of a physician in a hospital clinic or in a hospital emergency department. No payment for observation was made if the observation service was the only service reported on the claim (an evaluation and maintenance (E/M) code for emergency room, clinic visit, or critical care had to be reported on the observation claim in order to receive a separate APC payment for observation).

If a patient presented at the hospital for observation services arranged by a physician in the community (direct admit to observation), and the patient was not seen or assessed by a hospital-based physician, the hospital was allowed to bill a low-

level visit code. This visit code could only be assigned once during the period of observation. Payment for these services was packaged into the APC for the visit.

Effective with services furnished on or after January 1, 2003, for direct admissions to observation from a physician's office for a diagnosis of congestive heart failure, asthma, or chest pain, code **G0263, Direct admission of patient with diagnosis of congestive heart failure, chest pain, or asthma for observation services that meet all criteria for G0244, should be reported with code G0244.** No separate payment is made for G0263, as these costs are packaged into the costs associated with APC 339. This code will take the place of a visit or critical care code in meeting the observation criteria for patients directly admitted to observation. When G0263 is reported, the patient's medical record must show that the patient was admitted directly from a physician's office for purposes of evaluating and treating chest pain, asthma, or congestive heart failure.

The requirement that hospitals bill an emergency department visit, clinic visit, or critical care in order to receive separate payment for observation services for patients not admitted directly from a physician's office continues to remain in effect. To receive separate payment under APC 339, hospitals must report an emergency department visit, a clinic visit, critical care, or code G0263, along with code G0244. Modifier -25 must be used with the E/M code (including code G0263) in order to receive payment for G0244. If more than one period of observation is billed on a single claim, each observation period must be paired with a separate E/M visit.

To receive separate reimbursement for G0244, hospitals must bill observation services for a minimum of eight hours up to a maximum of 48 hours. If a period of observation spans more than one calendar day, hospitals should include all the hours for the entire observation period on a single line on the claim and enter as the date of the service for that line the date the patient is admitted to observation. Observation stays of less than eight hours are packaged services and should not be reported with code G0244.

Observation time begins at the clock time appearing on the nurse's observation admission note, which should coincide with the initiation of observation care or with the time of the patient's arrival in the observation unit. Observation time ends at the clock time documented in the physician's discharge orders or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. This time should coincide with the end of the patient's period of monitoring or treatment in observation.

In order to qualify for separately payable observation services, Medicare requires that the medical record document that the patient was under the care of a physician during the period of observation, as indicated by admission, discharge, and other appropriate progress notes that are written, timed, and signed by the physician.

Also effective January 1, 2003, code **G0264, Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma, or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma when the observation stay does not meet all criteria for G0244, has been created.** This code should be reported instead of a low-level clinic visit for direct admissions to observation for conditions other than congestive heart failure, chest pain, or asthma. This code should also be reported for an outpatient directly admitted to observation with a diagnosis of asthma, congestive heart failure, or chest pain that does not qualify for G0244 because the required criteria are not fully met (e.g., the observation stay was less than eight hours, the qualifying diagnostic tests were not performed, etc.).

It provides a way to recognize and pay for the initial nursing assessment and any packaged observation services attributable to patients that are directly admitted to observation, but whose observation services do not meet the criteria necessary to qualify for a separate observation payment. Code G0264 has been assigned for payment under APC 600, Low Level Clinic Visits. Code G0244 should not be reported in conjunction with G0264. Even for observation services that are not separately payable, observation charges must be reported under revenue code 762, Observation Room. The number of hours the patient is in observation status should be entered in the "units" field.

Also effective January 1, 2003, code **G0258, Intravenous infusion(s) during separately payable observation stay, per observation stay (must be reported with G0244), has been deleted.** Hospitals should report infusion therapy provided during a separately payable observation stay with code Q0081, Infusion therapy other than chemotherapy. As with G0258, code Q0081 may be reported for infusions started in the emergency department, clinic, or observation area, as long as the infusion continues during the observation stay.

Applicable general Medicare observation criteria, such as non-coverage of observation services when the services are ordered as inpatient services but billed as outpatient, remain in effect.

Centers for Medicare & Medicaid Services (CMS) Program Memorandum A-02-129, dated January 3, 2003, describes in detail the 2003 outpatient PPS changes, including requirements for payment of observation services.

OIG Audits and Observation Services

Recent audit reports from the OIG regarding observation services have focused on service dates prior to PPS implementation. In 2002, the OIG issued several audit reports regarding observation services. These audits all identified a significant percentage of the reviewed observation claims that should not have been reimbursed by Medicare because they did not meet Medicare criteria. The unallowable observation services generally did not meet Medicare requirements because a physician's order for observation was not documented in the medical record or the record contained a standing order for observation.

Observation services are only reimbursable by Medicare when they are provided by the order of a physician or another individual authorized to admit patients to the hospital or order outpatient tests. Standing orders for observation services following outpatient surgery are unallowable. Standing orders prior to surgery are also unallowable because these observation services are typically for the convenience of the patient, the patient's family, or the physician, rather than medically necessary.

In some cases, medical record documentation indicated that there were no complications following the outpatient procedure, and there was no documentation to support the medical necessity of the postoperative observation services. Medicare criteria stipulate that services that are not reasonable or necessary, such as observation following an uncomplicated treatment or procedure, are not allowable for Medicare reimbursement.

A significant number of the unallowable claims identified in the OIG audits had an inappropriate number of observation hours billed. In some cases, the observation time billed by the hospital began at the time the patient arrived at the hospital for a scheduled procedure, included the time the patient was in the procedure room and in a recovery unit, and ended when the patient was discharged.

Time spent prior to a scheduled procedure is not allowable, as observation and time spent in surgery and recovery cannot be simultaneously billed as observation. In other cases, the OIG was unable to determine the appropriate number of hours the patient was in observation, as many hospitals were not tracking the number of observation hours or were incorrectly recording several hours of observation during a single day as one unit/day of observation.

Some of the unallowable observation services identified in the OIG audits were due to lack of consistency between the physician's orders and the claim. The medical records contained the physician's orders for an inpatient admission, but the services were billed as observation.

The hospitals cited in the OIG audit reports for having submitted claims for unallowable observation services cited several factors that contributed to the inappropriate observation claims. These factors include lack of additional training of physicians and staff regarding the terminology to be used when ordering observation services; problems encountered in tracking patient admission types following the implementation of new electronic medical record systems; and problems determining transferred patients' admission status.

Hospitals targeted in the OIG audits developed action plans to address the problems with inappropriate claims for observation services. These action plans included education of physicians and other staff regarding Medicare observation criteria and ongoing review of observation charges to ensure compliance.

The Importance of Monitoring

Although the OIG audits of observation services involved claims for services provided prior to implementation of the outpatient PPS, the recent changes regarding reimbursement for observations services signify a revitalization of compliance risks for these services. The OIG specifically noted in its audit reports that unallowable observation services might recur under this new policy. Therefore, it is likely that observation services will continue to receive close government scrutiny.

It is critical that hospitals closely monitor their claims for observation services to ensure compliance with the regulatory requirements and reimbursement policies that were in effect at the time the observation services were furnished (not the time the claim was submitted). Education of the medical staff and registration personnel is also important, as shown by the results of the OIG audits, in order to ensure proper documentation of the physician's order for type of admission status and appropriate patient registration that is consistent with the attending physician's orders.

Given the complexity of the various requirements for reimbursement of Medicare observation services and the myriad changes in these requirements over the last few years, ensuring compliance with the reimbursement rules for observation services is no small feat. These compliance challenges are compounded by the fact that many commercial insurance companies have observation policies that differ from Medicare policies.

References

OIG audit reports can be accessed at http://oig.hhs.gov/reports.html.

The Final Rule for Calendar Year 2003 Hospital Outpatient PPS Revisions is available at www.access.gpo.gov/su_docs/fedreg/a021101c.html.

The Final Rule for Calendar Year 2002 Hospital Outpatient PPS Revisions can be accessed at www.access.gpo.gov/su_docs/fedreg/a011130c.html.

CMS Program Memoranda can be accessed at www.cms.hhs.gov/manuals/.

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