Briefings on APCs

Overcome billing and coding challenges for comprehensive observation services

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Billing correctly for observation hours is a challenge for many organizations. Getting it right requires knowing how to calculate observation hours for each patient, which is far from straightforward.

According to CMS, observation hours start accruing not when the patient comes into the hospital, but when the physician writes the order for observation. Observation hours end when all medically necessary services related to observation are complete. In some cases, this means that you can still bill for time spent completing the patient's care after the physician writes the discharge order.

For example, a physician comes in to see the patient at 7:30 a.m. and writes the discharge order, which states discharge will occur pending the completion of tasks X, Y, and Z. The nursing staff finishes up those three tasks and the patient is finally ready to leave the hospital at 11 a.m. The hours between 7:30 a.m. and 11 a.m. are potentially billable observation hours because they were used to complete the patient's medical care. Observation hours therefore end not with the discharge order, but with the completion of medical services.

In addition, because observation services are considered a temporary period to aid in decision-making, CMS states in the Medicare Benefit Policy Manual that only in rare and exceptional cases should observation services last more than 48 hours.

If a case reaches the 48-hour mark and the physician still hasn't made a decision to discharge or admit the patient for inpatient care due to instability or risk of an adverse event if discharged, nor has any documentation made a compelling case for the need to continue observation, the services no longer meet the definition of observation care and the hospital should not bill for future hours. Hospitals should also not report observation hours after the physician has decided to send the patient home or to a lower level of care if the patient is receiving no active treatment and is just in a holding pattern until he or she moves to the next level of care or goes home.

Coding for comprehensive observation services

The 2016 OPPS final rule implemented changes for coding and billing for observation services. Among the changes made by CMS was the creation of a new comprehensive APC (C-APC) for comprehensive observation services.

Specifically, hospitals will now bill all qualifying extended assessment and management encounters, including observation services, through the newly created comprehensive observation services C-APC code 8011. A new status indicator, J2, was also created to specify that more than one service was provided.

CMS now requires hospitals to bundle services provided and previously billed separately-services such as level 3 ED visits, IV infusions, echocardiograms, speech therapy, and similar services. CMS pays a flat rate for the comprehensive observation services, which includes the bundled services.

Hospital staff should bill all hours of observation for a single encounter on one line under revenue code 0762. If the hospital provided observation care to a patient over multiple days, the date of service should be the date that observation care began. Although one rate is now paid for comprehensive observation services, HCPCS code G0378 is still used to bill observation services by the hour. When using this code, the organization should round to the nearest hour. For example, eight hours and 20 minutes in observation would round to eight hours, whereas nine hours and 40 minutes would round to 10 hours. If the hospital provided observation care to a patient over multiple days, the date of service should be the date that observation care began.

The second HCPCS level II code for observation is G0379. This code is used for a direct admission or referral for observation care from a physician in the community. Note that this code is not used if an ER physician or a physician from a provider-based department or clinic makes the referral. This code previously allowed hospitals to bill for costs associated with the visit, including registration and collecting clinical information about the patient, but costs are now bundled with the payment for the comprehensive observation services.

Claims that meet the following criteria will be paid under C-APC code 8011:

- Claims that do not contain a procedure with HCPCS code with status indicator T (indicates a surgical procedure)
- Must show eight or more hours of service under HCPCS code G0378
- No other services on the claim must have a status indicator of J1

Services must be provided the day of or one day prior to the date of service for the following visit codes:

- All ED visit levels, CPT codes 99281-99285 or HCPCS codes G0381-G0384 and critical care services CPT code 99291
- HCPCS code G0463 (hospital outpatient clinic visit)
- Same date of service for HCPCS code G0379 (referred by physician outside of hospital)

Hospitals can no longer bill separately for observation if these services are required after an outpatient surgical procedure. If a patient meets criteria for observation monitoring after the standard surgical recovery period, the hospital can place him or her in outpatient observation, but the cost for the observation care will be bundled into the payment for the surgical procedure.

Although hospitals are not paid separately for ancillary services under C-APC code 8011, all ancillary services received are reported on the claim under their corresponding HCPCS codes. Use the revenue codes corresponding with their related cost center, such as the following:

- Laboratory, 30X and 31X
- Radiology, 32X, 35X, and 61X
- Covered drugs, 25X and 636
- Noncovered self-administered drugs, 637

Under Medicare OPPS policies, outpatient therapeutic services in hospitals and critical access hospitals must meet the following requirements:

- Provided in a hospital or a provider-based department
- Ordered by a physician or nonphysician provider
- Integral although incidental to the services that the facility is providing
- Provided under the appropriate level of supervision

Grasping the complexity of carve-outs

Sometimes, observation billing requires organizations to also have a grasp of what not to bill or, more specifically, how to carve out nonreportable services. This might include time the patient spent in imaging for a CT with contrast when he or she was monitored by other clinical staff. The same would be true for any other service that includes active clinical monitoring, such as chemotherapy or a blood transfusion.

If your organization isn't clear whether a service falls into this category, ask your Medicare administrator what type of services it considers to be monitored and should thus be subtracted from observation time.

CMS includes the following two options for calculating these carve-outs for observation time:

- Document the beginning and end of monitored procedures and subtract that time from observation using either a manual or automated process.
- Subtract the average length of time for a given procedure. This will require the facility to create a policy or procedure to ensure that all calculations include a consistent methodology. For example, the organization might establish a guideline that a transfusion of one unit of blood takes three hours.

Whatever process your organization uses, it's likely that it will be a costly investment because these carve-outs require staff members to look at medical records to calculate this time, adding to the cost of care. With a bundled payment for comprehensive observation services, it may be most cost-effective to adopt a policy of automated calculation of carve-out time for monitored services.

Ensuring proper patient status

In addition to ensuring that these requirements are met, it's also important to ensure that patient status was determined accurately. Sometimes, patient status is not correct, and the problem needs to be addressed using condition codes 44 or W2.

If a patient is insured by Medicare, the hospital will need to file a change of status using condition code 44 if the patient has not yet been discharged from the hospital. However, if the patient's status was found to be inaccurate after he or she was discharged, the hospital can use condition code W2 to change the patient's status.

Condition code 44 is most often used when the utilization review (UR) committee determines that a patient wasn't assigned to the correct status or no longer meets inpatient status criteria. To use the code, the following must be true:

- The physician has already written an inpatient order
- The patient has not yet been discharged
- The claim has not been submitted

The UR committee notifies the hospital, the patient, and the attending physician in writing of its decision that the admission does not meet inpatient criteria no later than two days after the determination. Documentation should indicate the reason for the determination, as this information will assist coders. The patient may be placed in outpatient observation with the agreement of the attending physician or with the concurrence of at least two physician members of the UR committee. Physician concurrence of patient status must be documented in the chart along with who was involved with the change in status, why the change was made, and what care was provided to the patient.

The order for outpatient observation cannot be backdated, but the entire episode of care will be billed as an outpatient episode using bill type 13X or 85X, reporting condition code 44 on the UB form in one of the Form Locators 24-30, or electronically in Loop 2300, HI segment, with qualifier BG on the outpatient claim (CMS, Medicare Claims Processing Manual, Section 50.3, Chapter 1, 2015). The hours the patient spent in an inpatient bed prior to the order change to observation can be submitted on the outpatient claim using revenue code 0762.

If not all of the criteria are met to initiate condition code 44, the hospital uses bill type 12X for covered "Part B only" services provided to the patient, such as diagnostic lab tests, radiology services, surgical dressings, and some other services listed in the Medicare Benefit Policy Manual.

If the UR committee determines after the patient has already been discharged from the hospital that the patient's stay as an inpatient was not medically necessary, it's important to self-deny the claim and resubmit it for payment under Part B Medicare. If the claim is not self-denied, it is likely that a Medicare Administrative Contractor (MAC) will deny the hospital's inpatient claim under Medicare Part A as not medically necessary. In this instance, if the hospital agrees and does not plan to appeal the decision of the MAC, it can resubmit the claim for payment of any eligible services under Medicare Part B. This can be done using condition code W2, which may also be referred to as Part A to B rebilling.

Part A to B rebilling must be submitted using a 12X or 13X type of bill within one calendar year of the "through" date of the original Part A medical services. The form must include condition code W2 along with the treatment authorization code A/B rebilling (see MLN Matters MM8445).

The rules regarding observation billing can be complicated, so it's important to audit and monitor billing regularly to ensure compliance.

Editor's note

Blondo is the manager of case management at Washington Adventist Hospital in Takoma Park, Maryland. This article is an excerpt from HCPro's Observation Services Training Handbook. For more information, see www.hcmarketplace.com.

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