

MEDICARE PART A BULLETIN

May 16, 1997

Hospital Medicare Bulletin H-79

TO: All Medicare Participating Hospitals

FROM: Andy DePirro, Director Provider Relations

SUBJECT: **OUTPATIENT OBSERVATION SERVICES**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to all appropriate health care facility personnel.

As a direct result of evidence of abuse, the Health Care Financing Administration (HCFA) revised instructions for outpatient observation services, effective for services rendered on and after November 1, 1996. HCFA has placed strict limits on the amount of hours a beneficiary can be placed in outpatient observation. The revised outpatient observation regulations advise that the observation period is to be utilized to monitor the patient's condition and determine whether the patient should be admitted as an inpatient or discharged from outpatient observation and ultimately the hospital.

HCFA's revised instructions, published in Hospital Medicare Bulletin H-69, dated September 30, 1996, indicated that instances should be rare that a patient remains in outpatient observation in excess of 48-hours. Those instructions also said that HCFA was unable to envision any scenario in which a hospital retains a patient in observation status for more than 48-hours without admitting them as an inpatient when appropriate. Therefore, HCFA now limits outpatient observation to a period of 48-hours. All outpatient observation services that exceed 48-hours (where the provider is seeking Medicare reimbursement), must be submitted to the intermediary to request an exception to the 48-hour regulation. All claims that are submitted with more than 48-hours of covered outpatient observation services, will be reviewed for medical necessity.

Providers will be notified via an Additional Development Request (ADR) letter, of the medical documentation needed for the review. The documentation must substantiate the medical necessity for observation services in excess of 48-hours. Also, a letter from the patient's physician should be attached to the medical documentation. This letter should indicate why the patient (after 48-hours of outpatient observation) was not admitted as an inpatient and what condition prevented the patient from being released from outpatient observation.

BILLING OUTPATIENT OBSERVATION SERVICES

Providers should ensure that the following information is reported on claims that contain outpatient observation services:

Revenue code 762 (observation room). DO NOT report outpatient observation services under revenue codes 760, 761, 769, etc.

Units of outpatient observation services are to be reported in increments of time. Therefore, for every

hour spent in outpatient observation providers should report one (1) unit. Minutes are to be rounded up to the nearest hour. Providers should begin counting outpatient observation services from the time that the physician wrote the order for the patient to be placed in outpatient observation.

Providers should always report the total number of hours and charges that were accrued while the patient was in outpatient observation. Providers must ensure that they accurately reflect the actual covered and if applicable non-covered hours/units and associated charges in the appropriate fields on the HCFA-1450 (UB-92) claims form.

NOTE: Providers should not report outpatient observation services in excess of 48-hours, unless they are requesting an exception to the 48-hour regulation. The medical documentation must substantiate the need for outpatient observation services in excess of 48-hours in order for the intermediary to grant the exemption from this regulation.

MEDICAL REVIEW OF OBSERVATION CLAIMS

The following actions may occur during the medical review of outpatient observation claims:

The number of outpatient observation service units will be compared to the itemized breakdown of charges. Incorrect or inappropriate reporting of observation units will result in a return-to-provider (RTP) claim and reason code 56802 will be assigned. (56802 = incorrect/inappropriate units associated with outpatient observation room services were reported on the claim. Please review the medical records and ensure that the appropriate units are reflected in the units field before the claim is resubmitted to Medicare for payment consideration.)

Medical documentation for outpatient observation claims that exceed 48-hours should contain a physician's statement indicating why the patient remained in outpatient observation services in excess of 48-hours. Therefore, it is imperative that the physician provide detailed justification for the decision to continue observation services. If detailed justification is not provided, or if this justification does not clearly indicate medical necessity for observation services in excess of 48-hours, the claim will be denied. (These claims will be either fully or partially denied depending upon the extent of over-utilization that occurred.)

Claims will be denied that exceed 48-hours of observation services where the medical documentation contains an order for the patient to be admitted as an inpatient.

Claims will be denied that exceed 48-hours of observation services where the medical documentation (i.e., physician's order) does not clearly state that the patient should be admitted as an inpatient or for outpatient observation.

Claims that exceed 48-hours of observation but lack medical documentation to justify reimbursement will be denied with or without the physician's exception letter (i.e., patient is awaiting placement in a skilled nursing facility/nursing home, awaiting transportation home, or hospital release papers are awaiting the physician's signature.)

Claims that exceed 48 hours of observation services will be released from medical review if the following has occurred:

- The patient received proper written notice of non-coverage; and

- The units and charges associated with the observation in excess of 48-hours are reported as non-covered.

NOTE: Providers may be asked to submit a Corrective Action Plan (CAP), detailing the corrective steps taken to ensure program compliance with the 48-hour outpatient observation regulation.

Providers may elect to request a reconsideration whenever they are in disagreement with the intermediary's decision to deny outpatient observation services. The reconsideration request must be received within six (6) months from the date of the denial and should contain a physician's response indicating why the patient required outpatient observation services in excess of 48-hours.

OUTPATIENT OBSERVATION SERVICES POST ASC SURGERY

Patients undergoing ambulatory surgical center (ASC) procedures should not be routinely admitted postoperatively to an outpatient observation bed. The intent of ASC surgery is that the patient arrives, has surgery, and is discharged the same day. Only ASC patients that experience postoperative complications should be considered for admission into outpatient observation services. A physician may feel that outpatient observation is medically necessary post-surgery when an ASC patient experiences the following:

- The inability to urinate (requiring catheterization);
- The inability to keep solids or liquids down (requiring continued intravenous feeding);
- The inability to control pain (requiring intermuscular or intravenous medications);
- The inability to move the lower extremities and safely ambulate after spinal anesthesia (requiring continued bed rest and sensation assessment);
- Unexpected surgical bleeding (requiring frequent dressing checks, dressing changes, and/or dressing reinforcements); or
- Unstable vital signs (requiring continued monitoring and perhaps drug intervention).

Although this list is not all inclusive, and unforeseen complications do occur post-surgery, it is expected that these instances be rare. Observation would be appropriate when the recovery period exceeds normal expectations for the type of surgery/procedure performed (i.e., generally 4 to 6 hours), or when the patient's condition requires observation. In other words, an ASC claim would rarely be associated with a medically necessary admission into observation services unless the patient had a complication post-ASC-surgery.

HCFA QUESTIONS AND ANSWERS REGARDING OUTPATIENT OBSERVATION

HCFA has received several inquiries concerning the revised policy on observation services that was effective November 1, 1996. The following is a list of questions and answers that was recently published by HCFA. This information is included in this bulletin publication to help answer some of the questions providers have regarding outpatient observation services. Providers may reference Hospital Medicare Bulletin H-69, published September 30, 1996, for additional information regarding Outpatient Observation Services.

QUESTION 1:

A person was admitted as a hospital outpatient for a surgical procedure on November 1, 1996.

The surgical procedure is on the list of covered ambulatory surgical center (ASC) procedures. The patient became unstable and was admitted to observation on the same day as the surgery. The patient remained in observation until November 4, 1996. In the past, the first day of observation services was billed on the ASC claim, while the remaining days of observation were billed separately. However, this requires two separate bills, and splits the observation hours. Under the new regulations, how should this be billed?

ANSWER 1:

The hospital should continue to separate these charges and submit two separate claims, the fiscal intermediary (FI) would pull the two claims together to adjudicate them appropriately. Current instructions found in Section 440 C. 2. of the Hospital Manual require both treatment room and observation revenue center codes to be folded into the ASC blend on the day of surgery. This will be corrected in an upcoming manual change, so that the treatment room charges will continue to be folded in, but observation charges will not. The ASC Pricer will also be adjusted to reflect this change. Please note that the intent is to limit the services subject to the ASC blend to the same list of services that are encompassed in the ASC group rate. Thus, observation services should be paid outside the blend (when warranted) but treatment room services should be paid within the blend.

QUESTION 2:

A patient receives chemotherapy from a hospital outpatient department and while receiving the chemotherapy, they stay in the hospital for four or five days. We understand that the hospital cannot bill the chemotherapy as an observation service. However, can the hospital bill for the chemotherapy as an outpatient service when the patient spends four or five nights in a treatment room while receiving the chemotherapy? If the hospital can bill this chemotherapy as an outpatient service, what is the proper revenue code?

ANSWER 2:

Outpatient services are ambulatory services, with the patient expected to go home on the day services are rendered. Intravenous chemotherapy protocols vary in length from infusions lasting half an hour to those lasting twenty-four hours a day for five days. Some protocols vary depending on the patient's condition, with healthy patients able to tolerate a drug's being infused in three hours, while a cardiac patient might require the same drug to be given over twenty-four hours. Hospitals should admit patients requiring infusions lasting overnight or longer; the inpatient DRG 410 is intended for this situation. Charges for outpatient chemotherapy should be reported in revenue centers 331 (Chemotherapy - injection), 332 (Chemotherapy - oral), or 335 (Chemotherapy - IV). It is not appropriate to report treatment room charges in order to augment reimbursement. If a pattern of billing treatment room with chemotherapy is detected, HCFA will require edits be installed to limit treatment room charges.

QUESTION 3:

Is there a limit to the number of hours that can be billed for a treatment room?

ANSWER 3:

Currently there is no limit. Logically, treatment room charges represent lesser procedures, such as sigmoidoscopy, that do not require the resources of a surgical suite. Thus, charges should normally be limited to no more than two hours, and usually less. If hospitals have an endoscopy suite, it is expected that colonoscopies and other scope procedures reflect that revenue code, rather than an operating room code. Treatment room charges are a substitute for those room charges, and not an additional line item. If it appears that a pattern of abuse is developing, HCFA will require edits be installed to monitor these services.

QUESTION 4:

If a patient is admitted as an inpatient after being in observation for more than 48-hours, is a separate physician's order required for the inpatient admission or is the patient automatically considered admitted?

ANSWER 4:

A specific order is required. It could be a verbal or telephone order, later countersigned. The concept of a "deemed" or automatic admission was once considered, but not implemented.

QUESTION 5:

An average patient (one without special needs) does not properly perform the preparation for an outpatient diagnostic test at home. Therefore, the hospital has to perform this function prior to the test. The hospital uses a treatment /observation room to prepare the patient for the diagnostic test. Can the hospital receive reimbursement for the use of the room in addition to being reimbursed for the test itself? Is the test preparation considered part of the test and not eligible for separate reimbursement? Also, can observation be billed for the monitoring of the patient due to an adverse reaction to the test?

ANSWER 5:

Routine test preparation is not separately reimbursable, whether performed by the patient or by the facility. Test preparation itself does not qualify for observation, and observation should not be billed concurrently with the test. Observation should only be billed if the patient meets the conditions for observation. If the patient experiences problems during or following the test, and a physician orders the patient observed until the problems are resolved, or the need for admission becomes apparent, the hospital may bill for observation. If the FI sees a pattern of observation and/or treatment room charges in association with diagnostic tests, they will suspect inappropriate use and investigate.

QUESTION 6:

If an outpatient diagnostic test has to be performed in a treatment room because it cannot be performed in the hospital's lab, can the hospital charge a facility fee for the use of the treatment

room?

ANSWER 6:

It is not clear what sort of diagnostic test this question involves. Generally, it would not be appropriate to bill treatment room charges concurrently with a diagnostic test.

QUESTION 7:

If a patient is in observation for a day or two and is then admitted as an inpatient, are the observation services bundled into the DRG payment like other preadmission services?

ANSWER 7:

Yes.

QUESTION 8:

Since observation services are to be billed in units of one hour, should charges for observation be expressed as an hourly charge? A hospital has a flat \$300 charge for the first three (3) hours of observation. If the patient needs additional observation, the hospital charges another flat \$300 charge for the next three (3) hours (hours 4 through 6). If the patient requires a total of four (4) hours of observation, the hospital wants to charge \$600 for the four (4) hours (\$300 each for two three-hour increments) or should they have an hourly rate of \$100 per hour of observation?

ANSWER 8:

Flat rate billing is not an acceptable methodology in any case. The hospital should bill hourly charges (i.e., 4 hours of observation x \$100 hourly rate = \$400).

QUESTION 9:

If an observation bed is not available at the time the order for observation is written, does observation begin when the order is written or when the patient is actually placed in the observation bed? Similarly, does an observation period end when the physician signs the discharge order or when the patient actually leaves the observation bed?

ANSWER 9:

The period of observation begins when the physician orders it (and when the monitoring of the patient actually begins) whether the patient is in an "observation" bed or not. The point of observation is for the hospital staff and physician to observe the patient, rather than simply for the patient to occupy a bed. If the patient is admitted as an inpatient, observation charges should not continue even if an inpatient bed is not immediately available. Observation ends when the physician so orders, in writing or verbally. If the patient is discharged to his or her home, but the family cannot immediately pick him up, observation is no longer warranted.

QUESTION 10:

Hospitals reimbursed via the prospective payment system (PPS) are required to roll in (or bundle), diagnostic and therapeutic services rendered during the 3 days/72-hours preceding an inpatient stay. Current observation instructions state that after 48-hours of observation, a patient is either discharged, admitted as an inpatient, or an exception is requested. If a hospital keeps a patient for 3days/72-hours (and does not request an exception) and then admits to inpatient, how should this be billed?

ANSWER 10:

If the hospital does not wish to request an exception, then they should bill the 48-hours of observation services as covered and 24-hours as noncovered, showing the charges accordingly. This would eliminate the requirement for medical review of the claim, because the hospital is not requesting an exception for the additional 24-hours of observation.

QUESTION 11:

Can a hospital submit a bill for observation services that exceeds 48-hours?

ANSWER 11:

Yes. A hospital may bill for more than 48-hours if they wish to request an exception. The presence of more than 48-hours reported in the units field would prompt medical review. If a hospital keeps a patient more than 48-hours and understands that the services are not covered, they may show those hours as noncovered.

QUESTION 12:

If an outpatient observation stay is denied because the patient met criteria for inpatient care, can the facility then submit a bill as inpatient?

ANSWER 12:

As a general rule, a patient's status cannot change after discharge. However, upon review of the medical documentation, it may be found that the patient actually was admitted as ordered to an inpatient bed, and it was a decision by the billing office to submit an outpatient claim. In these cases, it is appropriate to require an inpatient claim, and to refer the provider to the FI's Program Integrity/Fraud and Abuse Unit.

QUESTION 13:

If recovery from an outpatient surgical procedure exceeds the normal four (4) to six (6) hour recovery period, can the amount of recovery in excess of the four (4) to six (6) hours be billed as observation?

ANSWER 13:

Observation services can be billed for a recovery period that exceeds six (6) hours. However, observation services should not automatically be billed because a recovery period exceeds six (6) hours. Four (4) to six (6) hours is used as a guideline for a normal recovery period. Observation would be appropriate when the recovery period exceeds normal expectations for the type of surgery and when the patient's condition requires observation. If the requirements for observation services are not met, no additional payment can be made. The necessity for observation services should be determined on a case by case basis.

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.