Observation Services

Overview of
Requirements

US Acute Care Solutions

Evaluation & Management Services

Appropriately documented observation can be billed;2016 RVUs associated with observation E/Ms include:

E&M	RVU
• Admission & Discharge	
99234	3.77
99235	4.76
99236	6.13
• Initial Observation Care (Admit)	
99218	2.81
99219	3.82
99220	5.22
• Subsequent Observation Care	
99224	1.12
99225	2.05
99226	2.96
• Discharge	
99217	2.05

Key Points

All of the following key elements must be present in the documentation:

- HPI - History of present illness
- PFSH - Past family social history
- ROS - Review of systems
- PE – Physical exam
- MDM - Medical decision making

Observation: Same Day Admit and Discharge

- Designates observation care provided to patients that are admitted and discharged from "observation status" on the same date of service
- Code set 99234-99236

Observation -Admit and Discharge Same Date 3 of 3 key components must meet or exceed Documentation Requirements			
Level	History	Exam	MDM
99234 Detailed Or Comprehensive	Chief Complaint HPI 4 or more Elements ROS 2-9 Systems PFSH 1 of 3 Areas	5-7 Body Area or Organ Systems	Straightforward or Low Complexity
99235 Comprehensive	Chief Complaint HPI 4 or more Elements ROS 10+ Elements PFSH 3 of 3 Areas	8 Or more Organ Systems Only	Moderate Complexity
99236 Comprehensive	Chief Complaint HPI 4 or more Elements ROS 10+ Elements PFSH 3 of 3 Areas	8 Or more Organ Systems Only	High Complexity
**For Patients admitted to observation and discharged on a different date, see codes 99218-99220 and 99217			

Initial Observation Care

- Initiation of observation status, supervision of the care plan for observation, and performance of periodic assessments.
- Code set 99218-99220
- Ref: CPT Manual 2013, pg. 14

Discharge from Observation

- Designates observation discharge services. Patient is discharged from "observation status" on date other than initial date of observation.
- Includes final exam of the patient, discussion of hospital stay, instructions for continuing care, and preparation of discharge records. Ref: CPT Manual 2012, pg. 13
- Code 99217

Observation –Initial and Discharge on Different Dates 3 of 3 key components must meet or exceed Documentation Requirements				
Level	History	Exam	MDM	Typical Time
99218 Detailed Or Comprehensive	Chief Complaint HPI 4 or more Elements ROS 2-9 Systems PFSH 1 of 3 Areas	5-7 Body Area or Organ Systems	Straightforward or Low Complexity	30 minutes at bedside and on patient's hospital floor or unit
99219 Comprehensive	Chief Complaint HPI 4 or more Elements ROS 10+ Elements PFSH 3 of 3 Areas	8 Or more Organ Systems Only	Moderate Complexity	50 minutes at bedside and on patient's hospital floor or unit
99220 Comprehensive	Chief Complaint HPI 4 or more Elements ROS 10+ Elements PFSH 3 of 3 Areas	8 Or more Organ Systems Only	High Complexity	70 minutes at bedside and on patient's hospital floor or unit
Discharge from Observation 99217	Includes final examination of the patient, discussion of hospital stay and instructions for continuing care.			

Subsequent Care

- There are some circumstances when a patient receives observation services for more than 2 calendar dates.
- Includes all care rendered by treating physician on days other than initial or discharge date.
- Code set 99224-99226

Subsequent Care

Two of the three key components must meet or exceed documentation requirements.

- This does not mean that a key component can be omitted only that it does not have meet documentation requirements.
- For example, 99226 requires 4 HPI elements; however, if the PE and MDM are complete the HPI would be acceptable with only 2 elements.

Observation-Subsequent Care 2 of 3 key components must meet or exceed Documentation Requirements				
Level	History	Exam	MDM	Typical Time
99224 Problem Focused	Chief Complaint HPI 1 – 3 Elements Problem Focused Interval History	1 Body Area or Organ System	Straightforward or Low Complexity	15 minutes at the bedside and on the patient's hospital floor or unit
99225 Expanded Problem Focused	Chief Complaint HPI 1 – 3 Elements Expanded problem focused Interval History	2 – 4 Body Areas or Organ Systems	Moderate Complexity	25 minutes at the bedside and on the patient's hospital floor or unit
99226 Detailed	Chief Complaint HPI 4 or more Elements Detailed Interval History	5 – 7 Body Areas or Organ Systems	High Complexity	35 minutes at the bedside and on the patient's hospital floor or unit
**Definition: codes are used to report observation care services on other than initial or discharge date.				

Observation Record Includes

- Provider's Documentation
  - Must satisfy E/M documentation guidelines for observation care *and* meet the documentation requirements for history, examination, medical decision making. Reference: CMS Manual System Transmittal 2282
- Nurses Notes, if applicable
- Medical Necessity Justification

Physician Services

- Admit to Observation
- Conduct a history
- Perform physical exam
- Order and review diagnostic data
- Apply any MDM made in Observation
- Disposition and Diagnosis

Documentation Includes

- Date and Timed order for "Observation to Rule Out Need to Admit"
- Reason for Observation
- Orders for Vitals Checks, Sats and Hourly Assessment of Pain (if applicable)
- Time Observation Discontinued
- Documented Diagnosis for *each and every* day
    - Reference CMS 1995 Documentation Guidelines

Observation Record & Orders

- CMS guideline clarifies that the OBS provider must write the order for OBS: Chapter 12 (Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11) 30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services)
  - Who May Bill Observation Care Codes
    - Payment for an initial observation care code is for all the care rendered by the *ordering* physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.
- For a physician to bill observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Time/Date Counts

- Dated time in and time out of observation status must be documented.

Examples of Observation

This is not an all-inclusive list.

- Chest Pain
- Head Injury
- Difficulty breathing
- Flank Pain
- Dehydration, Vomiting/Diarrhea, IV fluids
- Pregnant with vomiting
- Asthma
- Abdominal pain
- Renal calculi
- Syncope
- Allergic reaction
- Alcohol intoxication
- Drug ingestion/overdose

Medical Necessity

- Lack of diagnostic certainty, where a more precise diagnosis could decide admit/discharge.
- Therapeutic intensity, where extensive therapy has a reasonable possibility of abating the patient's presenting condition, and thereby prevent admission. (Ref: ACEP Observation-Physician Coding 2012 FAQ #3)
- Observation that does not meet the medical necessity rule could be denied for payment.

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