# Billing and Coding Observation Services 2017

This document serves as a brief overview of the practice of billing and coding for medical services.

## Introduction

Patients requiring hospitalization are classified as either inpatient or outpatient – referred to as "level of care." Observation, surgical short stay and infusion patients are considered "outpatients." This determination is based primarily on the degree of the patient's illness and expected duration of time in the hospital. Case managers use tools to assist in determining a patient's level of care – Interqual or Milliman's. CMS has developed time based measures that state-patients who require hospitalization for longer than 2 mid-nights should be placed into inpatient level of care termed the "2-Mid-Night Rule".

In general, an inpatient will typically stay in the hospital for about 4 days where as outpatients (observation, surgical short stay, infusion) will stay less than 24 hours.

These 2 categories are treated very differently from a billing and coding perspective.

Billing and coding is broken into 2 buckets:

1. Professional Fee - billed by a provider (MD, DO, PA, NP) for clinical services provided.
2. Facility Fee - which are billed services provided by the hospital.

CMS (Medicare and Medicaid) reimburses for inpatients utilizing DRG's or diagnostic related groups that bundle clinical services provided by a hospital together under Part A Medicare. CMS pays for outpatient services under Part B.

## Emergency Department CPT Codes

These services are provided by MD's, DO's, PA's or NP's. The clinical service is billed utilizing Emergency Management Codes (E/M codes) developed by the AMA which defines how much a professional is paid for services to a patient. This payment is based on several components and include documentation and time spent managing and evaluating the patient. Private insurers typically pay based on CMS rates (i.e. 150% of CMS) or based on a pre-negotiated rate.

There are 6 primary Emergency Department E/M CPT (current procedural terminology) codes: 99281, 99282, 99283, 99284, 99285 (referred to as level 1 – 5) and a critical care code. This service level is determined predominantly by provider documentation focused around the history and physical exam and medical decision making.

There are certain rules around how many E/M codes can be submitted in a 24-hour period. If the patient is seen by more than 1 provider in the same specialty in a 24-hour period, only *one* E/M code can be billed out unless the additional provider is from a different specialty or housed under a separate tax ID number.

## Observation Status Rules

Observation Services is an outpatient service. Providers participating in observation services are not required to have admitting privileges in the hospital since observation is an outpatient status. Any credentialed provider in the hospital can provide observation services - this includes MD, DO, PA or NP.

There are specific rules when placing a patient into observation status:

- Rule 1: An order to place the patient in observation services is the start time for observation care delivery. This order can be written by ED physicians or the receiving provider.

- Rule 2: Documentation for the patient placed into observation services requires the following
    1. Separate history of present illness
    2. Separate review of systems
    3. Separate physical exam
    4. Separate decision making

  There are other documentation requirements that can be pulled into the medical record for the observation patient if documented in the ED such as past medical history, family history and social history. If not documented in the ED these items must be documented on the Observation history and physical.

- Rule 3: Documentation that identifies the reason the patient is being placed into observation status is required. Examples are "ongoing evaluation of presenting complaint" or "ongoing treatment of the presenting condition which has not improved following treatment in the ED".

Examples:
*"Emergency Department treatment has not successfully improved the patient's condition for discharge and transfer to the observation unit is necessary for ongoing treatment and stabilization requiring reassessment for discharge or hospital admission."*

*"Emergency Department evaluation of the patient's symptoms and complaint have determined need for ongoing evaluation in the observation unit to undergo further reassessment and testing to determine if those symptoms and complaints worsen and require hospital admission or result in determination for safe discharge."*

- Rule 4: Patients placed in observation status must have frequent documentation in the medical record to justify the patient remaining in observation. Interpretation of this is usually a minimum of 3 documentation requirements in a 24-hour observation period.
    1. Initial history and physical exam
    2. Progress note during the patient's stay
    3. Discharge note

    Patients who remain in observation status less than 24 hours may not require all 3 elements and patients remaining longer than 24 hours may require additional documentation.

- Rule 5: Patients discharged from observation status require a discharge note that identifies what was done to evaluate or treat the patient. A final focused physical exam is required. A final diagnosis is required. Appropriate follow-up, medication reconciliation and discharge instructions are all required.

## Professional Fee Observation CPT Codes

When billing for provider services, the PA or NP billings are usually reimbursed at 85% of the Physician billings for Medicare fee for service patients but at 100% for commercial insurers.

The services that providers bill for fall under 4 separate categories:

1. **Same Day Admission and Discharge:** These codes are tiered into 3 levels of acuity based on the amount of time the provider spends and the complexity of the patient. Same Day Admit and Discharge codes require documentation of all 3 key components (history, exam and MDM) to be met or exceeded. CMS designates the midnight as the identifier of a change in day status. For a patient to meet this designation the patient must be admitted after midnight and be discharged prior to the next midnight.

   There is a time-based rule using this code for Medicare patients. Patients who are placed in observation services for less than 8 hours and did not cross midnight cannot have this code utilized. These patients are coded with an **Initial Day Code** only. This 8-hour rule does not apply to non-Medicare patients.

| Code | History | Physical Exam | MDM |
|---|---|---|---|
| 99234 | Detailed or Comprehensive | Detailed or Comprehensive | Straight Forward or Low Complexity |
| 99235 | Comprehensive | Comprehensive | Moderate Complexity |
| 99236 | Comprehensive | Comprehensive | High Complexity |

2. **Initial Day Admission:** These codes are utilized for the patient who is admitted past midnight and then remains in observation status past the next midnight. Initial Observation Care codes require documentation of all 3 key components (history, exam and MDM) to be met or exceeded. Length of time is not relevant so the patient placed in observation status at 11pm would be billed using this code as a day one code. A different series of codes would be utilized on the patient after midnight. This code is also utilized on patients placed in observation and discharged in less than 8 hours and the stay did not cross midnight for CMS patients.

| Code | History | Physical Exam | MDM |
|---|---|---|---|
| 99218 | Detailed or Comprehensive | Detailed or Comprehensive | Straight Forward or Low Complexity |
| 99219 | Comprehensive | Comprehensive | Moderate Complexity |
| 99220 | Comprehensive | Comprehensive | High Complexity |

3. **Subsequent Day Codes**: These codes are utilized for the patient who is in day 2 of their observation stay but not being discharged. This happens when patients are placed into observation status late in the day. An example would be an asthma patient placed in observation at 10pm at night and billed the initial day code and then cross midnight. The next day the patient has not improved enough for discharge and crosses a second midnight resulting in this code being utilized. Subsequent Observation Care codes require documentation of at least 2 of 3 key components (history, exam and MDM) to be met or exceeded.

| Code | History | Physical Exam | MDM |
|---|---|---|---|
| 99224 | Problem Focused Interval History | Problem Focused | Straight Forward or Low Complexity - 15 minutes |
| 99225 | Expanded Problem Focused Interval History | Expanded Problem Focused | Moderate Complexity - 25 minutes |
| 99226 | Detailed Interval History | Detailed | High Complexity - 35 minutes |

4. **Discharge Day Code**: The code can only be used on the day of discharge. No other codes are to be used when this code is used for the discharge day. This code is not used for same day admission and discharge status or on patients who were in observation services for less than 8 hours and didn't cross midnight. The discharge code is 99217.

5. **Ancillary Coding:** Providers in observation services can also bill for additional activity if properly documented with additional CPT codes that provide additional professional fee reimbursement. The following are examples though not all inclusive:
    a. Procedures - I & D abscess, lumbar punctures, placement of NG tubes.
    b. Documentation of smoking cessation counseling - either 3-10 minutes or >10 mins.
    c. Reading of EKG's - This requires certain components be documented on the medical record and include - rate, rhythm, axis, intervals and ST changes.

## Professional Fee Coding Constraints

Observation services can be conducted in any location of the hospital including the ED. The ability to code professional fee services are dependent on the provider type providing observation services. There are basically two primary scenarios when it comes to billing for observation professional fee's.

### Scenario One

ED managed observation patients

In this scenario, the patient is managed by the ED provider. This could be in the same ED bed the patient started out in or in a defined area within the ED. The primary point is that clinical service is being provided by an ED provider that also is working in the ED. When this occurs, there are constraints on billing professional fee services. If the patient was placed into observation status before midnight, then only one E/M professional fee can be billed. Either the ED E/M fee for the care given or the Observation E/M fee for the care given. The decision may be based on the anticipated reimbursement for the care delivery in which the provider bills the higher reimbursed E/M code.

Example: A patient arrives and is seen in the ED for chest pain. The ED provider sees a patient at 7am in the morning and decides to place the patient into observation status and do serial troponins. The patient remains in the ED for 8 hours getting monitored and then after the patient rules out the decision is made to discharge the patient home with appropriate follow up. Assuming all appropriate documentation is completed for either a Level 5 ED E/M code or a same day admit discharge Observation Code Level 3 E/M the ED provider can only bill one of the E/M codes since they are billing in the same specialty and the patient was placed into the observation unit before midnight and discharged before midnight and had an 8 hour plus stay. If the provider bills a level 5 ED E/M code, the average Medicare reimbursement would be $177. If they bill the observation Level 3 E/M it would be $230. The provider is eligible and may opt to bill the observation professional fee if all documentation requirements are met.

If, however the patient was seen in the ED and placed into observation services AFTER midnight, stayed more than 8 hours and was ruled out for an MI and discharged with appropriate follow-up then both the ED professional fee and the same day Observation Admit Discharge code can be billed. Documentation for such a patient must be separate and distinct as described earlier.

The primary constraint here to bill additionally for observation services is midnight. Patients placed into observation before midnight can only have one E/M code billed - ED or Observation. Patients placed after midnight can have ED and Observation codes billed if appropriate documentation has been completed.

## Scenario Two

Observation patients are managed by a different specialty than Emergency Medicine or the Observation Unit is a closed area separately staffed with a unique tax-ID number different from the ED.

In this scenario, the patient is placed into Observation Status and managed by a different provider than an ED provider. Patients are routinely transferred out of the Emergency Department to a different geographic area of the hospital and managed by a different group of providers. The providers may be in a different specialty such as Internal Medicine or Family Practice and provide care wherever the observation patient is placed or the providers could be working in a special area that services only Observation patients. This could be an area managed by APP's (NP's or PA's) practicing under a separate tax ID number and billing for observation services. For Medicare Fee for Service patients the APP would bill under their NPI number with a separate tax ID and be paid 85% of the physician reimbursement for Medicare fee for service patients. For other insurance types the APP is reimbursed the same as the physician fee.

With this scenario, the Observation codes are billed separate and distinct from the ED E/M codes regardless of when the patient is placed into Observation Status. Documentation requirements must all be met by the Observation Provider.

**MEDICARE FEE: SCHEDULE 2017**

| | | |
|---|---|---|
| *Same Day Admit & Discharge* | | |
| Level 1 | 99234 | $135.30 |
| Level 2 | 99235 | $171.55 |
| Level 3 | 99236 | $221.07 |
| *Initial Day* | | |
| Level 1 | 99218 | $101.21 |
| Level 2 | 99219 | $137.81 |
| Level 3 | 99220 | $188.42 |
| *Subsequent Day* | | |
| Level 1 | 99224 | $40.55 |
| Level 2 | 99225 | $73.93 |
| Level 3 | 99226 | $106.59 |
| *Discharge Day* | | |
| | 99217 | $73.93 |

## Facility Fee Services

Hospitals bill for services independent of the physician billing. The Observation coding for Hospitals is extremely complex. There are significant rules around code types to be utilized for observation services and this document is not all inclusive. It must be remembered that observation services are an outpatient status and therefore is coded and reimbursed much differently than an inpatient.

### APC: Ambulatory Payment Classifications

This is a method of paying hospitals for outpatient services and was created by CMS in 1997 when the OPPS (outpatient prospective payment) system was established. These payments are made only to hospitals by the government. Each APC is composed of services which are similar in clinical intensity, resource utilization and cost. This is a fixed payment by the government to the hospital for a particular APC. APC payments apply to Outpatient Surgery, Outpatient Clinics, Emergency Department Services and Observation Services. APCs also apply to outpatient testing like radiology and nuclear imaging and certain therapies (drugs, IV infusions and blood products). These APCs are linked to various codes described below including HCPCS codes and each has a status indicator associated with them (J1, J2 etc.)

This payment methodology is not utilized by commercial payers. Commercial payers reimburse based on contract agreements formed with the hospital based on a percent of overall charges.

## Outpatient Coding

There are 3 primary codes that are utilized by coders for outpatient patient types:

1. **ICD codes:** International Classification of Diseases-ICD-10. These are diagnostic codes that create a uniform vocabulary for describing the causes of injury, illness or death. This code was established by the "World Health Organization" in the 1940's. The number following the code is the version number. We are currently in version 10.

   ICD-10 codes are used to represent a doctor's diagnosis and the patient's condition. In the billing process these codes are used to determine medical necessity.

2. **CPT codes:** Current Procedure Terminology - these codes are used to document most medical procedures performed in a physician's office. This code set is published and maintained by the American Medical Association (AMA). CPT codes are 5 digit numeric codes that are divided into 3 categories and an additional set of modifiers.
   a. CPT Category I: This is the most common category and divided into 6 ranges which correspond to 6 major medical fields:
      i. Evaluation and Management E/M: 99201-99499
      ii. Anesthesia-00100-01999; 99100-99140
      iii. Surgery 10021-69990
      iv. Radiology 70010-79999
      v. Pathology and Laboratory 80047-89398
      vi. Medicine 90281-99199; 99500-99607
   b. CPT Category II: Corresponds to performance measurement and in some cases laboratory or radiology test results. These are 5 digit alphanumeric codes are typically added to the end of a Category CPT I code with a hyphen. These category II codes are optional and may not be used in place of category I. They are predominately used to provide more accurate information specifically related to the performance of health professionals and health facilities.
   c. CPT Category III: These codes correspond to emerging medical technology. These are never used in observation.
   d. CPT modifiers: CPT codes have addendums that increase the specificity and accuracy of the code. These are 2 digit numeric (example-50-bilateral procedure modifier) or alphanumeric codes (example-P1-a normal healthy patient) that are added to the end of CPT I codes.

3. **HCPCS codes:** Health Care Common Procedure Coding System - these are a set of codes based on CPT codes developed by CMS and maintained by the AMA. These codes primarily correspond to the services, procedure and equipment not covered by CPT codes. Like durable medical equipment, prosthetics, ambulance rides and certain drugs and medications. These are the official codes for outpatient medical care, chemotherapy drugs and Medicaid and Medicare among other services. These codes are divided into 2 types:

a. HCPCS I: These codes are identical to CPT codes and used in the same way. They are designated HCPCS codes when billing Medicare or Medicaid but for the most part it's a technicality and not a different code.
b. HCPCS II: These are designed to represent non-physician services such as ambulance rides, wheelchairs, walkers and other durable medical equipment. These codes are used to identify the products and pieces used for a CPT coded procedure. Like CPT, these codes are 5 characters long but are alphanumeric. These codes are listed by 16 alphabetic groupings. Only the "G group" (temporary procedures and professional services) applies to Observation services.
c. HCPCS modifiers: Allow for greater accuracy and can be extremely important in the reimbursement process. These modifiers provide additional information about a procedure or services without redefining the service provided. An example is LC-left circumflex artery or TA: left foot, great toe.

## Hospital Charges

Every patient entering the hospital for whatever reason will have a set of charges which will accumulate during their stay to determine what their bill will look like. These billed charges are linked to the hospitals charge-master. This master list defines the charge of everything from a Tylenol tablet to a set of crutches. The only real rule that hospitals must follow is that these charges for services or equipment must be itemized and that all patients be charged the same regardless of insurance or lack thereof. There is no consistency between hospitals related to how much they decide to charge for an item. Beyond specific charges like drugs or labs there are miscellaneous charges that might cover linens or hourly charges that are instituted for patients placed in observation services for example.

This list of itemized charges or billed charges is subject to adjustment by both the government (CMS), based on coding allowances or by commercial insurances in the form of contractual adjustments. For an observation patient, for example, the following billed charges may be itemized:

Example: simple chest pain patient

1. Triage charge
2. EKG charge
3. IV placement charge
4. Aspirin charge
5. Oxygen charge
6. Telemetry charge
7. Individual lab charges
8. Hourly charge for observation minus carve-out if patient is off the observation unit
9. CXR charge
10. Room charge
11. Linen charge
12. Meal charge

On average the Observation patient billed charges amount to over $10,000.

## Observation Coding and the Government

To dig into this deeper requires an understanding of how an observation chart is then coded for the facility. Medicare and Medicaid are different in the facility fee world because they have set rates on how much they will pay for a service which is directly linked to the APCs discussed earlier. Commercial payers have contractual adjustments to billed charges which may be simply a percentage of charges but is usually more than what the government pays for the same service.

APCs and their coding result in a prospective payment based on a relative weight assigned to the description of the service.

Example:

| HCPCS Code | Service | Status indicator | APC | Relative weight | Payment rate |
|---|---|---|---|---|---|
| 99281 | ED visit-level-1 | J2 | 5021 | 0.8044 | $59.30 |
| 99285 | ED visit level-5 | J2 | 5025 | 6.5926 | $486.04 |
| G0378 | Observation | J2 | 8011 (C-APC) | 29.4849 | $2,174.14 |
| 93005 | EKG | Q1 | 5733 | 0.7587 | $55.94 |
| 71020 | CXR | Q3 | 5521 | 0.8247 | $60.80 |
| 96374 | IV push med | S | 5693 | 1.2533 | $92.40 |
| 12031 | Lac repair 2.5cm | T | 5052 | 3.0594 | $225.55 |

There are literally 100's of APC's that are identified for services provided. In the above examples, there is one APC identified for Observation Services which is C-APC 8011. This is referred to as a Composite APC because it resulted in certain services being bundled or included in the governments payment for that service.

There are 2 types of Observation HCPCS codes that can be utilized:

- Type 1: G0379 - Direct Referral to observation is modified by Status Indicator J2 for a single code payment of $480.69

- Type 2: G0378 - C-APC 8011 composite payment of $2,174.14.

## C-APC Bundle

There are 4 rules that apply to the C-APC 8011:

- Rule 1: The claim must contain a minimum of 8 or more units of service (hours) described by HCPCS code G0378. This 8 hours cannot include carve out time that must be extracted when a patient is transferred out of the observation unit for testing in another area of the hospital.

- Rule 2: Patients who have a status indicator T procedure (surgical procedure, EGD, colonoscopy, etc.) either the day before or the day of the patient being in observation services will be ineligible for C-APC 8011.

- Rule 3: A HCPCS type A - ED visit (99282-99285; 99291) or G0384 type B ED visit code or G0463 clinic code is required to be billed on the day before or day of the patient being placed in observation status.

- Rule 4: The patient must be under the care of a physician or non-physician during the observation care and have an order for observation, admission notes, progress notes, discharge notes.

### Understanding the bundled payment

The term bundle denotes that all services provided are now paid for with a single payment. Several services under this new C-APC are lumped under the single payment.

These bundled services include

1. ED visit
2. Most lab tests
3. Most medications
4. Therapeutic injections and infusions will not be paid separately when billed on a claim subject to payment through a composite rate or a claim containing a J2 service. i.e. Observation
5. Stress testing
6. Monitoring
7. Room charges/meals/linens and supplies

Items which can be billed and paid for separately include:

1. EKG
2. Certain radiology studies
3. Certain screening procedures - diabetic teaching
4. Physical therapy
5. Certain vaccines

# Payment to the Hospital for Observation

## Government

As dictated above-payment for observation services is a prospective payment by CMS (APC payment) which has a significant number of bundled components. This payment methodology is to institute risk sharing between the hospital and government. It also is an attempt to transition several procedures into the outpatient arena. When it is noted that if you have a T-status indicator such as an EGD or colonoscopy, the hospital will only get paid for the procedure. The same with outpatient surgical procedures like laparoscopic cholecystectomy. This payment methodology also has a significant impact on hospitals with long observation length of stays since the C-APC is only covering about 24 hours of hospital care.

## Commercial

The commercial insurance companies currently pay a contracted rate with the hospitals for observation services. It is likely that insurers will institute similar bundled payments in the future.

## The Patient

There are co-pay responsibilities for patients being placed into observation services. If the patient is insured by CMS, this is usually 20% of what the government has agreed to pay the hospital. The average co-pay for an inpatient stay by a Medicare beneficiary is about $1,216 for an average DRG.

Beneficiaries may be charged for self-administered drugs taken during their outpatient stays because Medicare Part B generally does not cover them with an average charge amount being about $207.

For example: For a chest pain patient in 2014 the average Medicare beneficiary placed in inpatient status would pay approximately $981in co-pay versus placement in outpatient status with a co-pay of $344.

With the implementation of the new C-APC the Medicare Beneficiary will like have a consistently lower co-pay for services since many of the services provided are now bundled in the overall hospital reimbursement.

Commercial insurance plans have marked variability in what deductible the patient is responsible for when placed into observation services. This can be highly variable depending on the patient's level of deductible.