US Acute Care Solutions

Documentation Overview

Patients who are placed into the status of "Observation" require specific components of documentation from both a regulatory and coding/billing policies. The time a patient is placed in the status of observation in 2015 is the time the Observation order was written.

The medical record for the Observation patient requires specific pieces which if absent or incorrectly described will impact coding and billing resulting in down-codes and lost revenue. Each of the components and the requirements will be reviewed.

1. Admitting provider - Although the use of the word "admitted" is frowned on by CMS it is the verbiage most hospitals utilize to describe a patient requiring hospitalization. The admitting provider has to write an order to place the patient into observation services. The usual language used is "the patient is being transferred or referred to Observation."

2. Reason for placement of patient in observation status - There are predominantly 2 reasons for placing a patient into observation status:

    a. Requires further evaluation to determine if the patient's initial complaint evolves into a more serious disorder. The classic example is chest pain requiring further evaluation in the use of serial cardiac enzymes, telemetry and provocative testing
    b. Requires ongoing treatment beyond the emergency department stay with the classic example being asthma. The patient requires frequent nebulizer treatments, steroids and ongoing assessment of their respiratory status.

3. HPI - The patient's history of present illness is supposed to describe the patient's condition in more detail. Optimal coding is looking for a minimum of 4 identifiers related to the specific complaint. An example is chest pain with description of: location, quality, acute or gradual onset, exacerbating features, pain scale or associated symptoms to name a few.

4. ROS - Review of systems requires that 10 separate systems be identified. An example is the cardiac system - you cannot use chest pain and palpitations as 2 points for review of systems. Each system gets 1 point.

5. PMH - Documentation of any past medical conditions is required such as HTN, CAD, DM etc.

6. PSH - Documentation of any past surgical conditions is required such as CABG, Appy, etc.

7. FH - This is a definitive requirement meaning if it's missing, the chart is automatically down-coded. The requirement here is that the patient's mother and father need to be identified as "Alive and Well" and if so any medical problems; or if deceased what the cause of death was. You cannot leave this blank or use "none" or "non-contributory". If the patient doesn't know the FH due to being adopted, then this should be noted.

8. SH - This requires the documentation of 3 primary components: tobacco use, alcohol use and drug use.

9. Physical Exam - The physical exam similar to ROS has a specific number of systems that must be documented. Optimal coding dictates that 8 separate systems must be documented.

10. Medical Decision Making - This category has undergone a significant amount of scrutiny based on documentation that needs to define why the patient is in observation status and what is keeping them in that status. This usually is broken into 2 components:
    a. The patient's initial complaint and what is going to be done to further evaluate or treat the patient. An example is the chest pain patient. Chest pain rule out acute coronary syndrome with serial cardiac enzymes, telemetry, EKG and cardiac consult in the morning. This describes what is being done for the patient over the next several hours they are in observation status.
    b. The second piece is plans related to secondary conditions the patient may have and how those conditions will be managed. Example is hypertension - continue current medicines and monitor blood pressure or diabetes - Continue current medicines, diabetic diet and monitor blood glucoses.

11. Signatures and date and times: Each time documentation occurs on the patient in observation services the provider must sign and date and time their order.

12. Frequency of Documentation - When frequency is discussed individuals want to know how often patients in observation status should have documentation instituted. CMS is rather vague on the subject and uses the term "frequent" without any real guidelines. The important point is to document why the patient remains in observation status. What active evaluation components or ongoing treatment components are being continued and how has the patient progressed. The standard is that patients in observation status will be seen 3 times in a 24-hour period. The three times are as follows and satisfy the requirements and fit with the average LOS of 20 hours:
    a. Admitted
    b. Rounded
    c. Discharged

13. Discharge Summary - This is required by CMS and needs to have the following elements in place:
    a. Time patient placed into observation status
    b. Reason patient placed in observation status
    c. Work-up completed
    d. Treatment rendered
    e. Outcome of work-up or treatment – condition of the patient
    f. Outstanding studies – cultures, lab tests, etc.
    g. Follow-up

14. Discharge Order - Every patient in observation status that is discharged must have an order for discharge, which needs to be signed, dated and timed.

Documentation Requirements

1. There must be an order to "admit to observation", "admit to observation unit" "place patient in observation status" or "Patient to Observation" on the chart. This order establishes the start time for observation services. Alternatively, the provider can document the date/time of the observation start time. Alternatively:
    a. If the patient is admitted into inpatient status, providers must manually dictate the Observation start time in their last progress note.
    b. For patients discharged from Observation but not admitted, the initial Observation time automatically is placed in the discharge note by the EMR system.
    c. The HPI time should not be used for the Observation start time as it is not unusual for that time to be 30 – 60 minutes post decision to go to Observation, shortening Observation LOS which in some cases could reduce the Observation LOS to < the requisite 8 hours.

2. If the Observation patient is subsequently admitted, please document clearly that the patient will be admitted for inpatient treatment. "Transfer to Dr. X's service" is not acceptable; charts with this statement regarding disposition have been returned for refined disposition explanation. Progress notes should support the need for inpatient care.

3. The end time for Observation services should be documented clearly; it is suggested that the provider say as much directly in the EMR.
    a. If you wish to use the discharge note date/time as the end time for Observation status that can be done. The coders can be asked to look in the discharge note or for the time stamp of the d/c note, but looking in two places is maximum.

4. Observation discharge: per CMS, coding of the discharge from observation status "…is to be utilized by the provider to report all services provided to a patient on discharge (Observation course).
    a. IDEALLY the discharge summary should include:
        i. A final exam of the patient (focused for the system(s) being observed)
        ii. Date and time of the placement into and discharge from Observation
        iii. Discharge diagnosis (admission or discharge from Observation)
        iv. Discharge medications
        v. Disposition/Follow up (admission or discharge from Observation)

CHARTS WILL BE RETURNED FOR THE COMPLETION OF DOCUMENTATION IF THERE IS NOT AN OBSERVATION START TIME, OBSERVATION STOP TIME, A FOCUSED PHYSICIAL EXAM AT DISCHARGE, or an UNCLEAR DISPOSITION FROM OB on the record.
This is not the complete list, but represents the most common reasons for sending the chart back to the provider for completion.

Statements Used for Observation Placement

1. "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."

2. "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."

Transfer of Observation to Inpatient Status

When a patient is being converted from observation status to inpatient status, a number of elements need to be identified on the medical record. These elements include:

1. Documentation of the reason the patient's status has changed. An example is the chest pain patient who develops elevated cardiac enzymes and rules in for a myocardial infarction and is now admitted as an inpatient to the hospital.
2. Documentation of the accepting physician who will now care for the patient in inpatient status.
3. An admitting order to place the patient into inpatient status.

Coding and Billing for Observation Services

Observation services utilize E/M (Emergency Management) codes to bill for professional fee services by providers. These are a group of outpatient codes utilized by the Emergency Department Providers and Practitioners Offices. As a provider you do not have to have admitting privileges at the hospital to manage a patient in observation status since the patient is in an outpatient classification. Providers can be Physicians, Nurse Practitioners or Physician Assistants. When billing for provider services, the PA or NP billings are usually reimbursed at 85% of the Physician billings. The services that providers bill for fall under 4 separate headings. The following are the categories and billing codes:

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. CMS designates the stroke of midnight as the identifier of a change in day status. For a patient to meet this designation the patient must be admitted after 12:00 midnight and be discharged prior to the next midnight.

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. **First Day Admission:** These codes are utilized for the patient who is admitted past midnight and then remains in observation status past the next midnight. 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. These are the following Frist Day Admission codes.

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 out codes as day one. The next day the patient has not improved enough for discharge and crosses a second midnight resulting in this code being utilized.

Code	History	Physical Exam	MDM
99224	Detailed or Comprehensive	Detailed or Comprehensive	Straight Forward or Low Complexity-15 minutes
99225	Comprehensive	Comprehensive	Moderate Complexity-25 minutes
99226	Comprehensive	Comprehensive	High Complexity-35 minutes

4. **Discharge Day Code**: The code can only be used itself on the day of discharge. No other codes are to be utilized when this code is used for the discharge day. This code is not used for same day admission and discharge status. The discharge code is 99217.

5. **Ancillary Coding:** Providers in observation services can also bill for additional activity if properly documented. 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.