OUTPATIENT OBSERVATION SERVICES FOR MEDICARE PATIENTS
Reporting Guidelines – 2010

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Effective Date: January 01, 2010

Definition of Observation Service:

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they can be discharged from the hospital. Observation services are commonly ordered for patients who present to the Emergency Department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Purpose of Outpatient Observation Service:

The purpose of observation service is :
1. To determine the need for further treatment or
2. for inpatient admission

Thus, a patient may be discharged, or be admitted as an inpatient.

Coverage of Outpatient Observation Services:

1. Observation services are covered only when provided by the order of a physician.
2. Observation services must also be reasonable and necessary to be covered by Medicare.

Services That Are Not Covered as Outpatient Observation:

The following type of services are not covered as outpatient observation services:
1. Postoperative monitoring during a standard recovery period, which should be billed as recovery room services.
2. Routine prep or recovery prior to or following diagnostic testing in a hospital outpatient department, which are included in the payments for those diagnostic services.
3. Observation should not be billed concurrently with therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).

Observation Time:

Start time:
Observation services begins at the clock time documented in the medical record, which match the time that observation care is initiated in accordance with the physician's order for observation services.

End time:
A patient's time in observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

Note: Observation time would **not include** the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home.

Counting Observation Time:

Hospitals should round to the nearest hour.

Example :

Start time: 3:03 p.m. = 3:00
End time: 9:45 p.m. = 10:00

Total observation time = 7 hours

CMS Guidance on Duration of Observation Services

- The decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

  In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

UB Reporting of Observation Hours:

- All of the hours for the entire period of observation must be reported in a single line and the date of service for that line is the date that observation care begins (if a period of observation spans more than 1 calendar day).

Requirements to Received Payment for the Composite APC:

All of the following requirements must be met in order for a hospital to receive an APC payment for the extended assessment and management composite APC:

1. **Observation Time**
   - Observation time must be documented in the medical record.
   - The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.
2. **Additional Hospital Services**
   a) The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
      - *A Type A or B emergency Department visit (CPT codes 99284 or 99285 or HCPCS code G0384); or
      - Clinic visit level (99205 or 99215); or
      - Critical care (99291); or
      - Direct referral for observation care (G0379), must be reported on the same date of service as the date reported for observation services.

   b) No procedure with a "T" status indicator can be reported on the same day or day before observation care is provided.

** A Type A emergency department is defined as an emergency department that is available 24 hours a day, 7 days a week and is either licensed by the State in which it is located under applicable State law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.*

This definition of Type A emergency departments should neither narrow nor broaden the group of emergency departments or facilities that are currently correctly billing CPT emergency department visit E/M codes.

Type A emergency departments should bill CPT emergency department E/M codes, as they have been billing in the past.

A Type B emergency department is defined as an emergency department that meets the definition of a "dedicated emergency department" as defined in 42 CFR 489.24 under the EMTALA regulations. It must meet at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an

urgent basis without requiring a previously scheduled appointment; or
(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Hospitals must bill for visits provided in Type B emergency departments using the G-codes that describe visits provided in Type B emergency departments.

(CMS Claims Processing Manual, Chapter 4, Sect.160)

3. Documentation

a) The patient must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b) The medical record must include documentation that the physician explicitly assessed patient risk to determine that the patient would benefit from observation care.

4. Revenue Code

Hospitals are required to report observation charges under the following revenue codes:

Revenue Code	Subcategory
0760	General Classification Category
0762	Observation Room

5. Bill Type

Only observation services or direct referral for observation services billed on a 13X bill type may be considered for a composite APC payment.

HCPCS CODES FOR REPORTING OBSERVATION SERVICES:

CODE	DESCRIPTION	APC - STATUS INDICATOR	OPPS Payment Status
G0378	Hospital observation service, per hour	N	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
G0379	Direct referral for hospital observation care *(Hospitals should only report code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.)*	Q3	Paid under OPPS: Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service.

Payment for Observation Services;

I. Packaged payment.
Observation services is assigned status indicator N, signifying that its payment is always packaged.

II. Composite payment
In certain cases when observation care is billed in conjunction with Level 5 clinic visit, level 4 or 5 Type A ED visit, level 5 Type B ED visit, critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met.

III. Payment for direct referral for observation services will be made either
1) separately as a low level hospital clinic visit under APC 0604, or
2) packaged into the payment for Composite APC 8002, or
3) packaged into the payment for other separately payable services provided in the same encounter.

Composite APC Payment For Observation Services:

When observation care is billed in conjunction with high level clinic visit, high level Type A or B ED visit, critical care services or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care through one of two composite APCs when certain criteria are met.

Composite APC	Composite APC Title	Criteria for Composite Payment
8002	**Level I Extended Assessment and Management Composite**	1) 8 or more of units of HCPCS code G0378 are billed -- • On the same day as HCPCS code G0379; or • On the same day or the day after CPT codes 99205 or 99215 (level 5 clinic visit); and 2) There is no service with SI = T on the claim the same date of service or 1 day earlier than G0378. Note: *There is no limitation on diagnosis for payment of this composite APC.*
Composite APC	**Composite APC Title**	**Criteria for Composite Payment**
8003	**Level II Extended Assessment and Management**	1) 8 or more units of HCPCS code G0378 are billed – • on the same date of service; or • the date of service after 99284, 99285 (level 4 or 5 Type A ED visit), or G0384 (Level 5 Type B ED visit, or 99291(critical care service), and; 2) There is no service with SI = T on the claim on the same date of service or 1 day earlier than G0378. Note: *There is no limitation on diagnosis for payment of this composite APC.*

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim.

Payment for Direct Referral for Observation Care (G0379):

Hospitals should report G0379 when observation services are the result of direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services.

Payment for G0379 will be made either:

1) Separately as a low level hospital clinic visit under APC 0604
2) Packaged into payment for Composite APC 8002 (level I Extended Assessment and Management Composite)
3) Packaged into the payment for other separately payable services provided in the same encounter.

APC	APC Title	Criteria for Payment
0604	**Level 1 Hospital Clinic Visits**	1) HCPCS code G0378 are billed -- • On the same day as HCPCS code G0379; and 2) There is no service with SI = T or V, or critical care on the same date of service as code G0379. Note: *There is no limitation on diagnosis for payment of this composite APC.*
8002	**Level I Extended Assessment and Management**	1) 8 or more of units of HCPCS code G0378 are billed -- • On the same day as HCPCS code G0379; and

	Composite	2) There is no service with SI = T or V, or Critical Care on the same date of service as code G0379. Note: *There is no limitation on diagnosis for payment of this composite APC.*
If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator **N** and will be packaged into payment for other separately payable services provided in the same encounter.		

References:

Medicare Claims Processing Manual, Chapter 4-Part B Hospital, Rev. 07-30-09
CMS Transmittal 1760, CR 6492
MLN Matters 6751, Jan. 2010
MLN Matters 5946, January 2008
MLN Matters 5438, Jan. 2007
CMS Transmittal No. 1882, CR 6751, December 21, 2009
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CMS Transmittal No. 82, CR 5946, February 8, 2008
CMS Transmittal No. 1445, CR 5946, February 8, 2008
CMS Transmittal 1139, CR 5438
Medicare Benefit Policy Manual, Chapter 6, Section 20.6
Medicare Claims Processing Manual, Chapter 4, Section 10.2.1
Medicare Claims Processing Manual, Chapter 4, Section 240.1
Medicare Claims Processing Manual, Chapter 4, Section 290
OCE Observation Criteria, specifications V9.1
APC 2008, 2009, 2010
NGS, Power Point Presentation-Observation Services 2008
HCPCS Level II 2009, 2010
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