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Observation Is Attracting Audit Attention; Hours Are a Risk, And Watch Out for the MOON

By Nina Youngstrom

At least two Medicare administrative contractors (MACs) have set their sights on observation services, and there may be more to come. WPS is auditing observation stays that are longer than 48 hours in a Targeted Probe and Educate review, but even without drawn-out stays, observation billing can go awry because it's based partly on reporting the hours correctly, which isn't always a straightforward proposition. Meanwhile, National Government Services (NGS) said late last month it will deny claims when there are errors on the Medicare Outpatient Observation Notice (MOON). That was a shocker because compliance with the MOON—which informs patients they are outpatients receiving observation services and not inpatients—is a condition of participation, not a condition of payment, experts say.

“There are patients in observation who need to be there and there are patients in observation who don't need to be there, and we want to separate the necessary hours from the unnecessary hours,” said Ronald Hirsch, M.D., vice president of R1 RCM, at a Feb. 6 webinar sponsored by RACmonitor.com. The National Correct Coding Initiative has an edit that kicks in at 72 hours, although Medicare limits coverage of observation services to 48 hours by way of the two-midnight rule, he noted.

Observation hours are billed to Medicare with G0378. When patients receive observation for eight or more hours and have had an associated visit in the emergency room or hospital-owned clinic, or a critical care or community care physician visit, hospitals are paid a comprehensive APC (C-APC 8011). It bundles all the services provided during observation, including room and board, nursing services, labs and imaging. However, when patients are directly transferred to hospitals for observation from another hospital, urgent care center or other site, hospitals can't bill Medicare for C-APC 8011 because they didn't provide the associated visit, Hirsch said. With direct observation referrals, hospitals report the hours with G0379, and they're paid a la carte for the services.

Do the Math for Observation Compliance

Because observation payment depends on the clock, hospitals must keep track of observation hours. CMS says observation starts when the physician writes the order. “Medicare also tells us you can't count hours for observation from the start of care to discharge without looking at what went on during the stay. You have to carve out diagnostic or therapeutic procedures when there is active monitoring” (e.g., colonoscopies). Hospitals can record the start and stop times for diagnostic services and treatments or use average times and subtract them from total observation hours, Hirsch said. CMS doesn't define “active monitoring,” but as long as you have a list of procedures that require active monitoring and a policy, “you have a defensible position.” He recommends looking at Tenet Healthcare Corp.'s patient-status policy.^[1]

There's a limit to how long patients should receive observation services. “Observation should never pass 48 hours, because if you do, you should be admitted” under the two-midnight rule, Hirsch said. Suppose a patient is placed in observation at 7 p.m. for chest pain, and after labs and a stress test are normal, the physician writes the discharge order at 3 p.m. Because the patient's spouse doesn't pick her up until 9 a.m. the next morning, the

necessary observation stay is 20 hours. In billing the hours, the hospital would subtract three hours for the stress test and bill 18 hours “courtesy time” on a separate line for the time the patient spent waiting for her ride, Hirsch said.

Unnecessary Hours Are Billed With GZ Modifier

Sometimes the amount of time the patient spends in the hospital waiting for a ride is negligible and won’t move the needle, but “patients who stay an extra night because they have no ride home or stay an extra couple nights because the hospital doesn’t offer a stress test on the weekends is more significant,” he said. “That’s what WPS is getting at in its reviews.”

Whether patients stay in observation eight, 15 or 20 hours, for example, the C-APC 8011 payment is the same. “You won’t get additional money on your claim, but it’s reported as a cost,” Hirsch said, which is why hospitals should be precise after the eight-hour threshold. With the chest-pain patient, the hospital would bill 17 units of G0378 and 18 units of G0378 with the GZ modifier, which tells Medicare you’re writing off those charges.

Maybe the chest-pain patient who is cleared for discharge refuses to leave the hospital. At 3 p.m., the patient is presented with an advance beneficiary notice (ABN), and she mulls over whether to continue the hospital stay until finally going home at 5 pm. The hospital would bill 17 units of G0378 (for the medically necessary care), two units with the GZ modifier (for the time she spent thinking things over) and 16 units with the GA modifier, which signals the patient signed an ABN, allowing the provider to bill the patient for the services that Medicare considers medically unnecessary, Hirsch said.

How are observation hours counted in the context of condition code 44 to reclassify inpatients as outpatients when it’s apparent the admission isn’t medically necessary in terms of patient status? That can get complicated, but Hirsch said hospitals must distinguish inpatient from observation hours. For example, a patient with nausea and vomiting is placed in observation at 5 p.m. Sunday after presenting to the emergency room. On Monday morning at 7 a.m., the attending physician admits the patient as inpatient, but at 3 p.m. she’s ready for discharge. Because the physician recognizes the admission was a mistake, the hospital activates condition code 44 and changes it back to observation at 4 pm. The patient is discharged at 7 p.m. after tolerating dinner. The hospital would submit a claim with condition code 44, including 14 units of G0378 for the initial hours in observation dated on the day observation began; eight units of uncoded observation services, indicating only revenue code 9762 without a corresponding HCPCS code; and an additional three units of G0378 on a separate line with the date the second observation order was written.

Will MOON Errors Cause Denials?

Patients are kept in the loop with a bird’s-eye view of inpatient vs. observation charges because hospitals are required to give patients the MOON, using CMS’s form without deviation. But there have been MOON errors, according to a Jan. 30 NGS webinar. Common errors include not delivering the form on time; not stating a “clinical, patient-specific reason for why they are not an inpatient”; and reformatting the MOON.

During the webinar, an NGS representative said the MAC will deny observation payment for MOON errors, according to attorney Larry Vernaglia, with Foley & Lardner in Boston. He doesn’t think NGS is “on solid legal ground” to do that. “They have the best of intentions, but I think the MAC is dead wrong,” Vernaglia said. “We have brought it to CMS’s attention.”

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1 Tenet Healthcare Corp., “Clinical Determination of Appropriate Patient Status,” *Regulatory Compliance Policy*, May 12, 2016, <http://bit.ly/2Spv8ua>.

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