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Observing the regulatory nuances of observation services

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One of the most common services provided to hospital patients is observation, but there remains significant confusion and ambiguity in the ordering, provision, and billing of observation services. The changing healthcare landscape has also contributed to this, with more Medicare beneficiaries electing to enroll with a Medicare Advantage (MA) plan every year.

What is observation?

Observation is defined by the Centers for Medicare & Medicaid Services (CMS) as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."[1] Yet a search of the Medicare manuals finds no delineation of what services constitute observation.

In simple terms, observation is nursing oversight of a hospitalized outpatient in a hospital bed where there is no other service being provided that also includes such care. For example, when a patient presents to the emergency department (ED) for evaluation, their visit will generate an ED facility fee that covers the costs of nursing, the use of the room, and routine supplies. The patient in the oncology clinic receiving chemotherapy or a blood transfusion will generate a charge for infusion of the medication or blood product. The patient having an outpatient colonoscopy will generate a charge for the colonoscopy, which includes monitoring by a nurse during and after the procedure.

On the other hand, when the ED physician has completed the evaluation of the patient and determined that additional care is indicated and inpatient admission is not indicated, the nursing oversight and room charges necessary during this period can now be accrued if a qualified practitioner orders observation services.

Who can order observation?

This is the first nuance to observation worthy of mention. CMS states that "observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests."

The mention of "admit patients" in this phrase adds unnecessary ambiguity, suggesting that admitting privileges play a role. Observation is a service provided to outpatients, and as such, the only qualification to order observation services is the qualification to order outpatient services at the hospital. If a provider can order a blood test, they can order observation services. With that order, the hospital is then able to compliantly bill for

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the service.

Who can bill for observation?

On the other hand, the professional fee billing for that observation service has several caveats that are not commonly known. There are specific codes established for billing observation services, with Healthcare Common Procedure Coding System (HCPCS) codes for the initial visit, subsequent visits, and discharge from observation care and specific codes for placement for observation services and discharge on the same calendar day. The initial observation visit codes (HCPCS 99218–99220) can only be billed by "the physician who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care."[2] In many hospitals, the ED physician or the covering hospitalist will order observation services to initiate the bed placement, but the care will be provided by another hospitalist or ED physician. In that circumstance, the physician who performs the initial observation service would not be able to use the initial observation visit service codes. It is not specified what codes should be used, but it is presumed the new or established office or other outpatient visit codes (HCPCS 99202–99215) would be used.

In addition, *Medicare Claims Processing Manual* also states that "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." While not specifically stated, this suggests that if the physician orders observation services on one calendar day but then does not evaluate the patient with a face-to-face visit until the next calendar day, as may happen for late-night patients, then the initial observation visit codes cannot be billed.

These nuances in billing are unique to observation services and may be subject to audit, which would require comparing physician professional fee claims to the information available in the hospital medical record and is not a common occurrence. Compliance professionals should consider reviewing their physicians' processes for ordering observation services and choosing the proper observation visit code.

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