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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

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.

How long can observation last?

Observation services begin as soon as the order is placed. At that point in time, whether the patient is in the ED or on a medical unit, the nursing oversight is based on that observation order, and the nurse would contact that physician if there is a change in the patient's condition. Because observation services are billed per hour, it would not be appropriate to wait until the patient arrives on the observation unit or other location to begin counting hours.

The ending of observation is less clear. CMS tells providers that "in the majority of cases, 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." It adds that "in only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours." While 48 hours is a convenient number, the reality of the two-midnight rule is that the decision on the proper admission status is determined by the time of the start of symptom-related care in the ED, and "the decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in medically necessary hospitalizations should not pass a second midnight prior to the admission order being written."[3] In other words, even if the patient began their symptom-related care at 12:01 am, it would be nearly impossible to receive 48 hours of observation before the second midnight arrives since that patient would first have to undergo an ED assessment period of several hours.

The effect of delays in care on observation billing

On the other hand, delays in care that may take the time spent receiving observation services past 48 hours do

occur, but those delays should not compliantly be billed as clinically appropriate observation services. For example, the patient with chest pain who starts observation services on Saturday morning and requires a stress test that cannot be done until Monday morning because the hospital elects not to offer that service on Sundays will pass two midnights, and likely 48 hours, but part of that time was due to the unavailability of stress tests on Sundays. Those delay hours should not be billed as medically necessary observation services but rather be "carved out" from the necessary hours and billed separately as observation room services with revenue code 0762 but without HCPCS code G0378.

Delays also can occur at the end of a visit, as with the patient who received observation services for a syncopal episode with stability to discharge determined by the physician and a discharge order written at noon but whose transportation home did not arrive until 5 pm. While the patient usually remains in the hospital, under the watchful eyes of the nurse, this is being provided as a convenience to the patient and is not compliantly billable as observation services. In fact, in 2015, the U.S. Department of Health & Human Services' Office of Inspector General (OIG) noted in its audit of Northwestern Hospital, "the Hospital incorrectly billed Medicare for observation hours resulting in incorrect outlier payments. Specifically, the Hospital included observation time for services that were part of another Part B service including postoperative monitoring or standard recovery care (10 errors), for time the patients remained in the hospital after treatment was finished (3 errors)."[4]

While is it unusual for an outpatient stay that included observation services to reach outlier payment status, especially since the institution of the comprehensive ambulatory payment classification (C-APC 8011) for observation in 2016,[5] there is always an effect on cost reporting for all claimed charges. If those claimed charges are not medically necessary but rather represent patient or provider convenience, that could be considered an improper claim. It is common for patients to spend time in the hospital awaiting arrival of their ride home, and it is unclear whether CMS expects hospitals to routinely account for these hours and carve them out of their billed observation hours. While it seems two or three units of HCPCS G0378 would be inconsequential, without direct guidance, it is difficult to provide clear recommendations.

In the past, some providers have billed such unnecessary hours on a separate line from the necessary observation hours and used a modifier to indicate they were not medically necessary, and whether the patient was to be charged or the costs to be absorbed by the hospital, but as of late 2021, the Medicare Claims Processing System will no longer allow more than one line of observation hours to be billed with HCPCS G0378.[6] CMS also specifies that the single line must have the date of the start of observation services. This change is in keeping with the definition of observation services, which notes they are "clinically appropriate services."[7] In other words, if the patient is receiving the same services being provided to a patient receiving observation services but that are not clinically appropriate, then, by definition, they are not receiving observation services.

The compliant way to bill for non-necessary services

The easy solution here would be to stop billing such hours completely, but a basic tenet of hospital billing is to ensure all services provided are included on the claim to ensure proper accounting of costs. In addition, in order to be able to shift the cost to the patient or to account for the care as uncompensated care, it must be coded and included on the claim.

The circumstances in each case will determine the appropriate action. In the case of the patient spending a few hours awaiting a ride, or of a hospital delay in providing a service in the midst of a necessary observation stay, it would be appropriate to carve out those hours and bill them with the revenue code for observation room but without a HCPCS code. This will indicate the facility incurred the expense but does not expect reimbursement.

But in order to shift the cost to the patient, a HCPCS code is required. In response to personal communication,

CMS has indicated that for outpatients who are receiving "observation-like" care, the hospital should bill such services with HCPCS A9270 and revenue code 0760 on an hourly basis. This HCPCS code represents a noncovered service, and a chargemaster entry will need to be established and a rate set in a manner similar to how recovery room charges are billed. CMS also instructs that as a statutorily excluded service, an advance beneficiary notice of noncoverage (ABN) is not required but is "strongly encourage[d]."[8] If an ABN is provided, modifier -GY would be added to the claim line. It should also be noted that since the patient was determined to no longer require hospital care, the interval for nursing evaluations can be limited to those required by hospital policy. Likewise, daily physician visits are unlikely to be medically necessary but may be required depending on provisions of the medical staff bylaws. This imposes another compliance issue that each facility must address based on their bylaws and definition of medical necessity.

Does 23-hour observation exist?

It is not uncommon today for insurance companies to preauthorize outpatient surgery as "23-hour observation." This terminology dates back to the time when the 24-hour mark was used as a cutoff for the differentiation of an inpatient from an outpatient. But the use of observation here is flawed. What the insurers are relaying is that they expect the surgery to be performed and billed as outpatient, and this payment includes any costs incurred caring for the patient during their overnight routine recovery period. As the OIG noted in its audit of Northwestern Memorial Hospital, billing such hours as observation hours would constitute an improper claim, especially if billed on a Medicare claim with a resultant outlier payment.[9]

For outpatient surgery, the surgery payment includes all hours of routine recovery. One will often hear reference to the standard recovery period as four to six hours, but that is not correct. In a manual, CMS notes, "Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services."[10] The time range (i.e., four to six hours) is simply the example it provides. For some procedures, the recovery period could be much shorter, as would happen with an excision of a skin lesion. For others, such as a joint replacement, the routine recovery period could last until the next day, conceivably even more than 36 hours.

It is only after the routine recovery period ends that observation services should be ordered on an outpatient surgery patient. This can occur in two situations. The patient may finish the planned recovery period and still require additional care, as with a patient with persistent pain or nausea, or the planned recovery may end prematurely, as with a patient who is in routine recovery and becomes hypotensive and tachycardic, with the physician ordering additional labs, imaging, and monitoring. In both circumstances, the order for observation services should be accompanied by documentation to support the need for the additional care.

It is also important to remember the provision of the two-midnight rule for a Medicare patient having outpatient surgery that specifies that if that patient requires continued medically necessary hospital care that will pass a second midnight, they should be admitted as inpatient and not continue as outpatient.[11] Unfortunately for other insurers, this provision is rarely followed. The plan should be notified if the patient requires unexpected ongoing hospital care to determine if their insurance will authorize inpatient admission.

Commercial and Medicare Advantage use of observation

While the rules for Medicare fee-for-service and surgery on the use of observation are clear, there is significant ambiguity and confusion about observation for other payers for medical patients. Such payers will use commercial criteria sets to determine the correct admission status, regardless of length of stay; will develop internal guidelines on the use of observation, such as a list of diagnoses that always warrant observation; or will

set time-based criteria, such as noting that observation is appropriate for the first 48 or 72 hours of any medical admission unless the patient is admitted to the intensive care unit and meets criteria for such placement.

While payer's use of their own proprietary way of determining proper use of observation is confusing and frustrating, it is not illegal. In most circumstances, the outpatient receiving observation services and the inpatient are receiving the same care by the same providers, so the admission status of the patient is simply a contractual payment issue. Likewise for MA, CMS says, "MA plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services…MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail."[12]

Theoretically, that means MA plans can create their own criteria on the use of observation services. But many have argued to CMS that by developing their own criteria, MA plans are depriving Medicare beneficiaries of rights available to those enrolled in traditional Medicare plans, notably the ability to appeal their discharge. Despite this argument, CMS continues to allow MA plans to disregard the two-midnight rule and allow observation services to be provided for days on end.

Billing observation after an inpatient denial

A common scenario faced by compliance is the question of the inpatient admission that is denied by a commercial or MA payer with instructions that the hospital may bill the stay as observation. With Medicare, a denied inpatient admission can be billed to part B with payment for allowed services, but without an order for observation services, there will be no payment for nursing and room and board. On the other hand, other payers are free to give providers permission to add observation service hours to a claim in order to provide that payment. This is strictly a billing issue and is compliant as a contractual matter between two parties. The claim should include the number of units corresponding to the length of time that the patient was an inpatient with the appropriate carve-outs applied. An order from a provider should not be obtained since retroactive orders are not permitted and the patient never received observation services. Rather, this is strictly following the instructions of the payer, so a provider can get paid for all the care that was provided.

As healthcare reform continues, and the move from volume to value proceeds, perhaps the time will come when billing for hospital service will not be so complex. But until that time, compliantly using observation services remains the requirement.

Takeaways

- Observation services allow payment for nursing and room and board provided to outpatients.
- Professional fee billing for observation has limitations not seen with other professional service billing.
- Observation is limited to 48 hours unless there are delays in care for Medicare. Other payers set their own rules.
- Time spent by patients due to delays in care or convenience are not covered observation services and must be billed differently.
- The use of observation with surgery is infrequent and can never be scheduled.

1 Centers for Medicare & Medicaid Services, "Chapter 6 - Hospital Services Covered Under Part B," § 20.6, *Medicare Benefit Policy Manual*, Pub. 100-02, revised December 31, 2020, https://www.cms.gov/Regulations-and-

Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.
2 Centers for Medicare & Medicaid Services, "Chapter 12 - Physicians/Nonphysician Practitioners," § 30.6.8, *Medicare Claims Processing Manual*, Pub. 100-04, revised March 4, 2022, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.
3 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. 50,496, 50,946 (August 19, 2013) .
4 Brian P. Ritchie, *Medicare Compliance Review of Northwestern Memorial Hospital for 2011 and 2012*, A-05-13-00051, Office of Inspector General, U.S. Department of Health & Human Services, March 2015, https://oig.hhs.gov/oas/reports/region5/51300051.pdf.
5 Ronald Hirsch, "Observation payment creates payment loopholes," *Compliance Today*, 73–75, December 2016, https://assets.hcca-info.org/Portals/0/PDFs/Resources/Compliance_Today/1216/ct-2016-12-Hirsch.pdf.
6 "Incorrect Billing for Part A Outpatient Observation Services," Production Alerts, National Government Services, September 15, 2021, https://www.ngsmedicare.com/web/ngs/production-alert-details?alertid=3357955.
7 Centers for Medicare & Medicaid Services, "Chapter 6."
8 Centers for Medicare & Medicaid Services, "Chapter 30 - Financial Liability Protections," § 50.2.1., *Medicare Claims Processing Manual*, Pub. 100-04, revised January 21, 2022, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c30.pdf.
9 Brian P. Ritchie, *Medicare Compliance Review of Northwestern Memorial Hospital.*
10 Centers for Medicare & Medicaid Services, "Billing and Coding: Acute Care: Inpatient, Observation and Treatment Room Services," revised January 1, 2022, https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52985.
11 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. 50,946 .
12 Centers for Medicare & Medicaid Services, "Chapter 4 - Benefits and Beneficiary Protections," § 10.2, *Medicare Managed Care Manual*, Pub. 100-16, revised April 22, 2016, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.