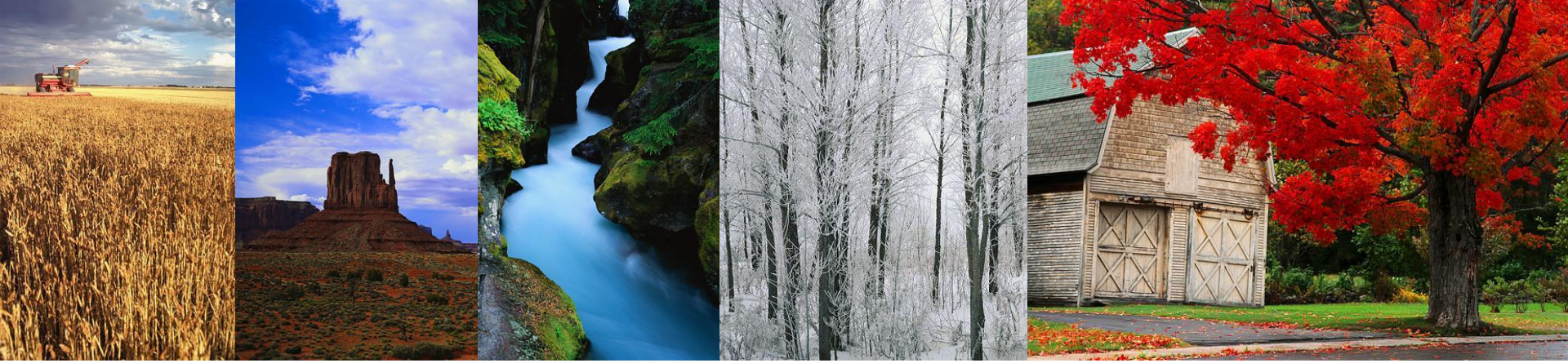

Observation Services

September 7, 2012 (Part 1)

RHPI
RURAL HOSPITAL PERFORMANCE IMPROVEMENT

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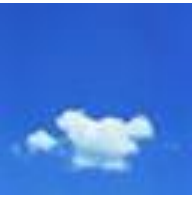
Presentation Sources



This presentation was prepared using CMS (such as Medicare Claims Processing Manual and the Medicare Benefit Policy Manual) for regulations available at the time of this presentation and other resources such as AHA or HCPro. It is not intended to grant rights or impose obligations. It may contain references or links to statutes, regulations, or other policy materials.

The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations.

We encourage participants to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Objectives – Part 1

- **The participant will:**
  - Verbalize at least three reasons why it is important to understand the Observation level of care
  - Explain what RACTrac is and review overview of the survey outcomes
  - Repeat 4 key reasons to use Observation
  - Verbalize when Observation may and may not be used in correlation with surgery
  - Be able to explain what is calculated as start and end time of an Observation stay
  - Verbalize what “Active Monitoring” is and how it impacts Observations hours

Why The Need To Know

Why The Need To Know?

- IP criteria is becoming more difficult to meet but those same patients may meet Observation criteria
- Too many hospitals have chosen to teach "when in doubt, place the patient in Observation" and physicians are leaving them in Observation for 2 and 3 days which may needlessly decrease IP utilization
- Observation does not count for the 3 day IP criteria for SNF and may needlessly prevent Medicare payment for SNF
- Important to assign the "right patient at the right level of care at the right time"
- CMS requires rural hospitals to be in compliance with Observation regulations
- RAC is reviewing rural PPS hospitals and have started auditing CAHs

Why The Need To Know?

- RAC is reviewing medical records and other medical documentation to identify improper payments to providers. Improper payments include:
  - **incorrect payment** amounts;
  - incorrectly coded services (including Medicare Severity diagnosis-related group (MS-DRG) **miscoding**;
  - non-covered services (including services that are **not reasonable and necessary**); and
  - **duplicate services**

- **93%** of the hospitals participating in AHA RACTrac surveys **indicated medical necessity denials were the most costly complex denials**
  - The majority of medical necessity denials reported **(64%) were for 1-day stays** where the care was found to have been provided in the **wrong setting**, not because the care was not medically necessary

- RAC **appeals are costly** (staff time and consultant cost)

RACTrac Findings

Based on RAC (Recovery Audit Contractors) Reviews

See AHA RACTrac Initiative

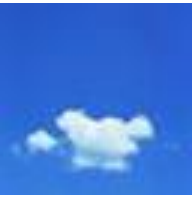
http://www.aha.org/advocacy-issues/rac/ractrac.shtml

See Results of AHA RACTrac Survey, 1st Quarter 2012 – Reported 05/2012

http://www.aha.org/content/12/12Q1ractracresults.pdf

AHA RACTrac

- **AHA created *RACTrac*—*a free, web-based survey—in response to a lack of data*** provided by CMS on the impact of the RAC program on America's hospitals.
  - 2220 hospitals are participating in the surveys
  - 1,854 reporting activity and 366 reporting no activity through March 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals

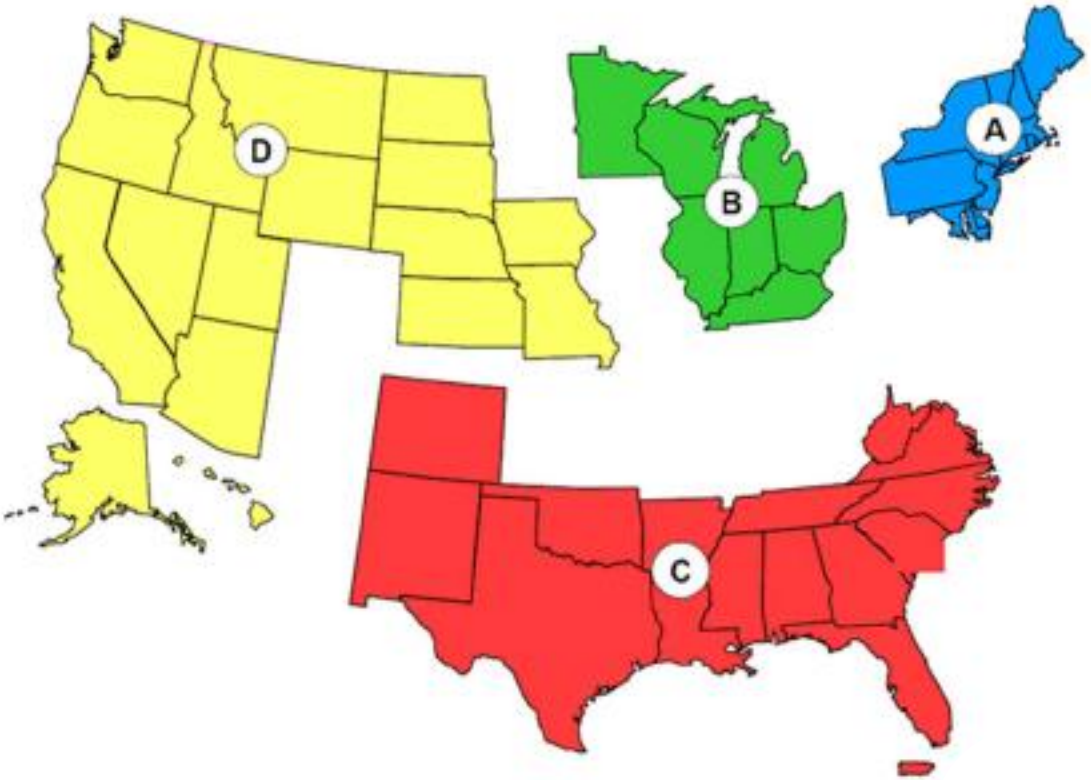


- Hospitals use AHA's online survey application, *RACTrac (accessed at* www.aharactrac.com), to submit their data regarding the impact of the RAC Program

- Survey questions are designed to collect *cumulative RAC experience data,* from the inception of a hospital's RAC activity through the 1st quarter of 2012.

Distribution of Hospitals by RAC Region and Hospitals Participating in *RAC*Trac by RAC Region, through 1st Quarter, 2012

	Percent of Hospitals Nationwide	Percent of Participating Hospitals by Region
Region A	15%	16%
Region B	19%	24%
Region C	40%	35%
Region D	26%	25%

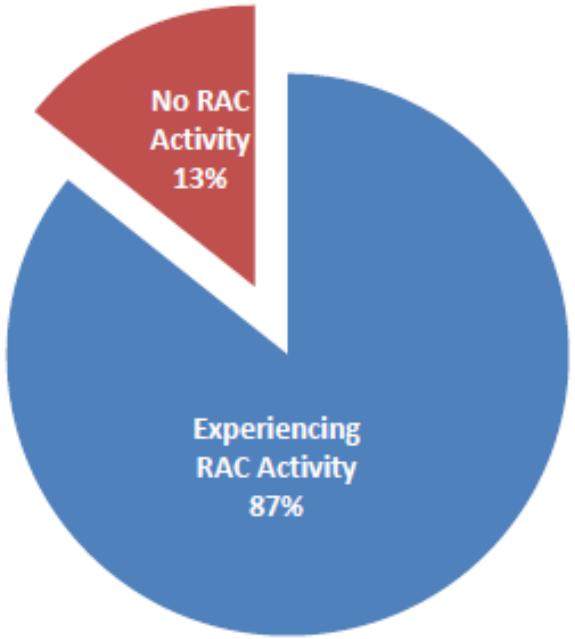


Source: Centers for Medicare and Medicaid Services

AHA RACTrac

More than nine out of ten hospitals participating in RACTrac reported experiencing RAC activity through March of 2012.

Percent of Participating Hospitals Experiencing RAC Activity, 1st Quarter 2012

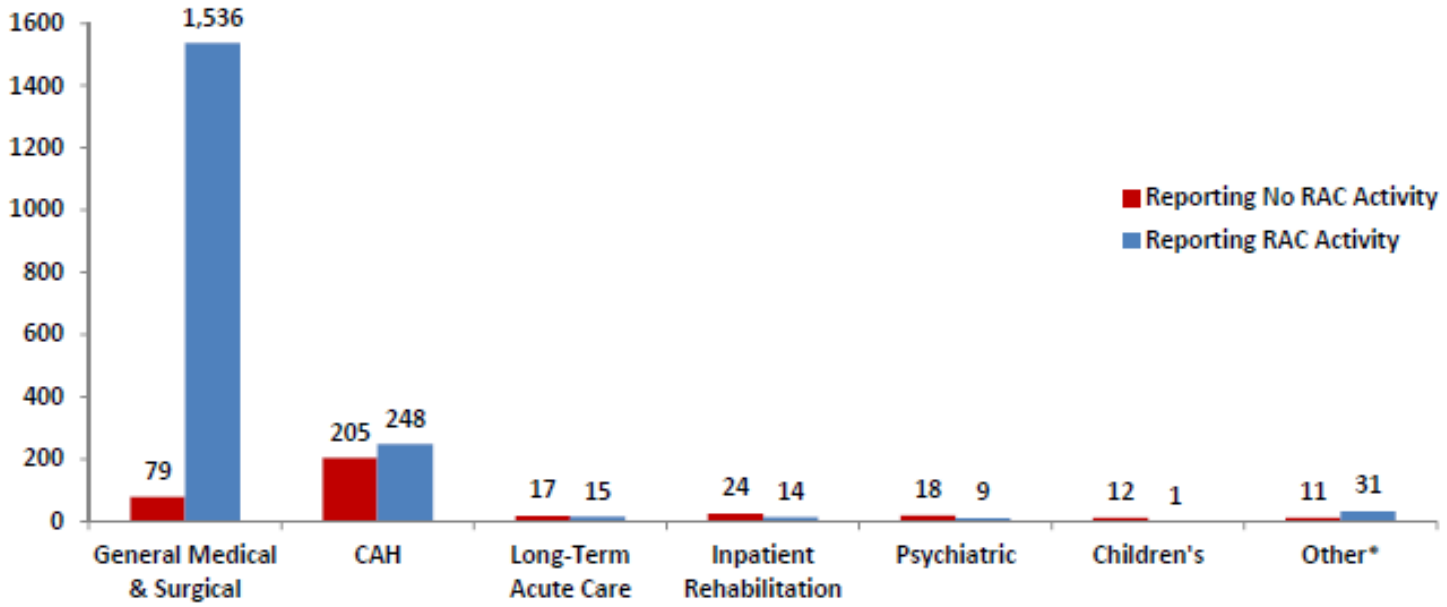


Source: AHA. (May 2012). *RACTrac* Survey
AHA analysis of survey data collected from 2,220 hospitals: 1,854 reporting activity, 366 reporting no activity through March 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

AHA RACTrac

The majority of hospitals reporting RAC activity were general medical and surgical hospitals.

Number of Hospitals Reporting RAC Activity by Hospital Type, through 1st Quarter 2012



**Other includes: Cancer, Chronic Disease, Alcohol and Other Chemical Dep., Heart, Obstetrics & Gynecology, Orthopedic, Other Specialty, and Surgical hospitals.*

Source: AHA. (May 2012). *RACTrac* Survey
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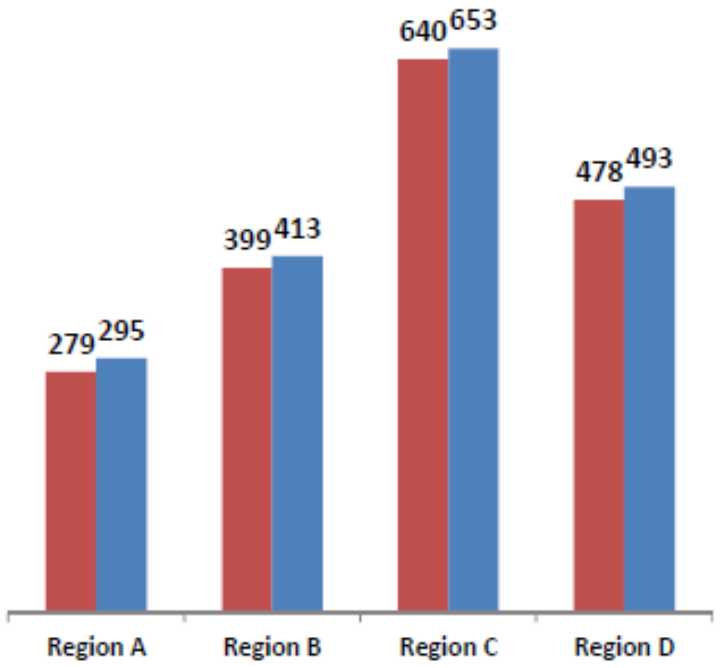
RAC Region C has the highest number of hospitals reporting RAC activity.

Number of Participating Hospitals Reporting RAC Activity by Region, through 1st Quarter 2012



States By RAC Region

Region A: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont

Region B: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin

Region C: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico, and U.S. Virgin Islands

Region D: Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, and Northern Marianas

RAC TRAC

Source: AHA. (May 2012). *RACTrac* Survey
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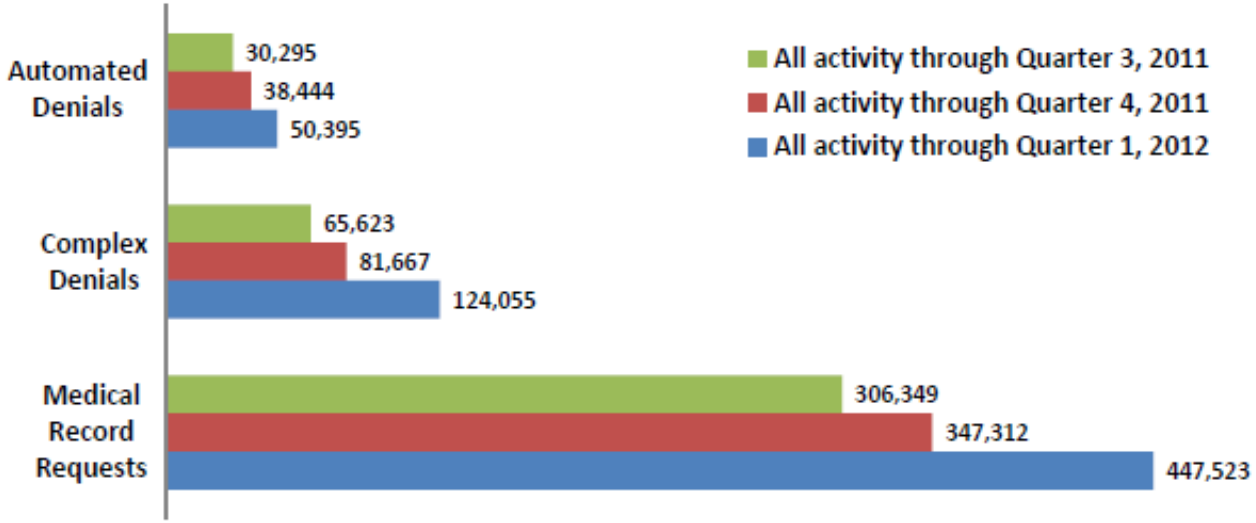
AHA RACTrac

Participants continue to report dramatic increases in RAC denials and medical record requests.

Reported Automated Denials, Complex Denials and Medical Records Requests by Participating Hospitals, through 1st Quarter 2012



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For ***automated reviews,*** *RACs use* computer software to detect improper payments

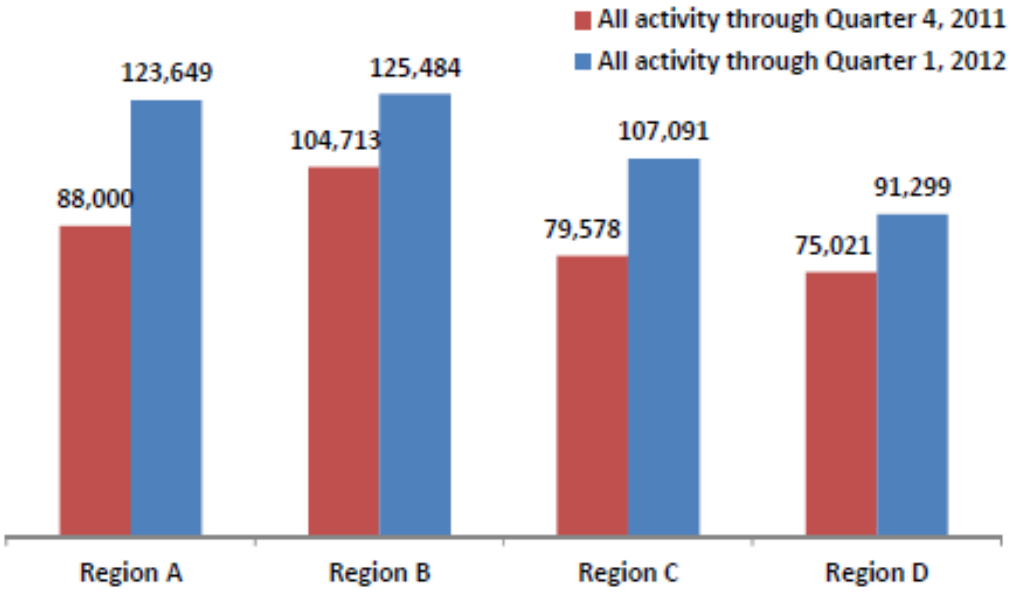
but ***complex medical-record reviews*** are conducted by humans.

AHA RACTrac

For the first time, Region A reported the highest number of record requests. The average number of records requested from a hospital is much higher in Region A than in other regions.

Number of Medical Records Requested from Participating Hospitals With Complex Medical Record RAC Activity, through 1st Quarter 2012

Average Number of Medical Record Requests per Reporting Hospital, through Q1, 2012	
Region A	773
Region B	578
Region C	364
Region D	499



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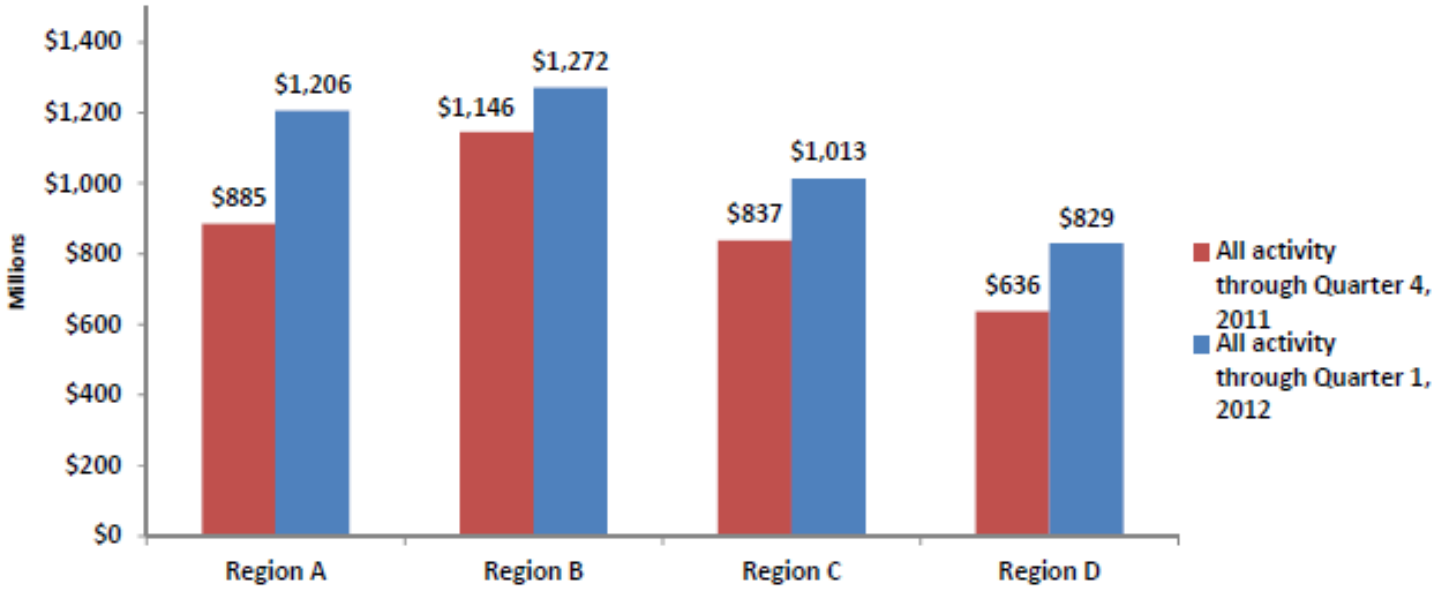
AHA RACTrac

Among participating hospitals, $4.3 billion in Medicare payments were targeted for medical record requests through the 1st quarter of 2012.

Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 1st Quarter 2012, in Millions



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The average value of a medical record requested in a complex review varied slightly across RAC Regions.

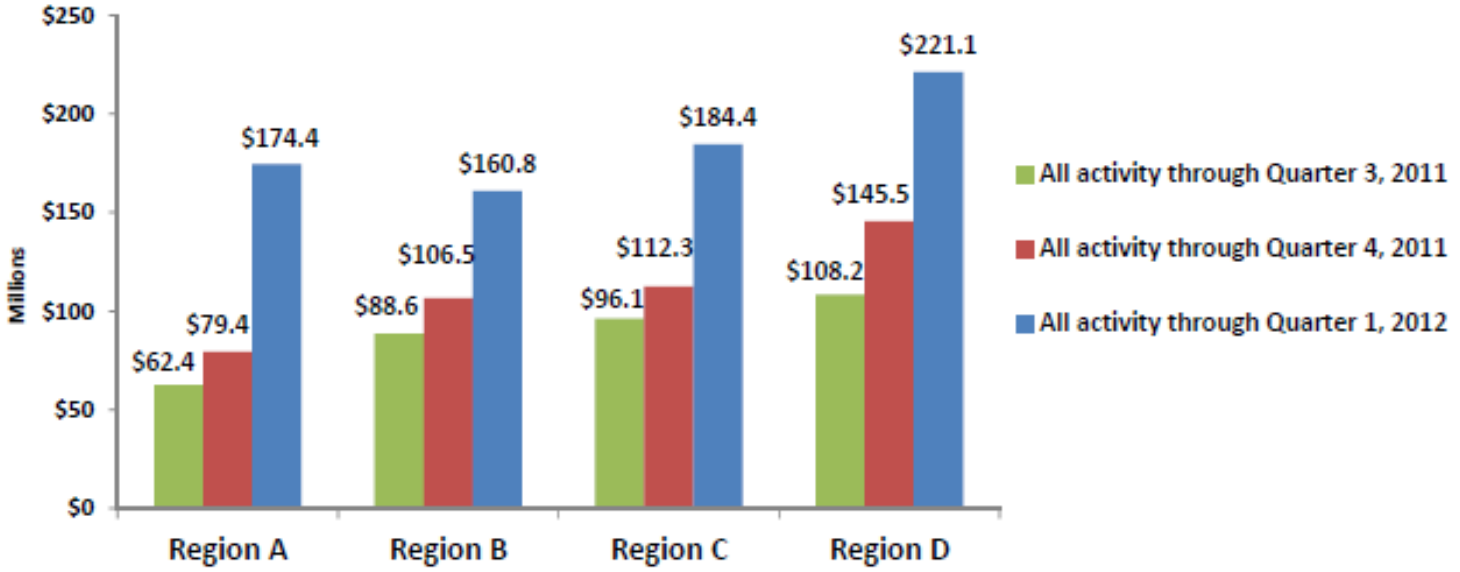
Average Value of a Medical Record Requested in a Complex Review Among Hospitals Reporting RAC Activity, through 1st Quarter 2012

Source: AHA. (May 2012). *RACTrac* Survey
AHA analysis of survey data collected from 2,220 hospitals: 1,854 reporting activity, 366 reporting no activity through March 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

AHA RACTrac

$741 million in denials were reported through the first quarter of 2012, nearly double the amount of denials reported through the last quarter of 2011.

Dollar Value of Automated and Complex Denials by RAC Region for Participating Hospitals, through 1st Quarter 2012, Millions



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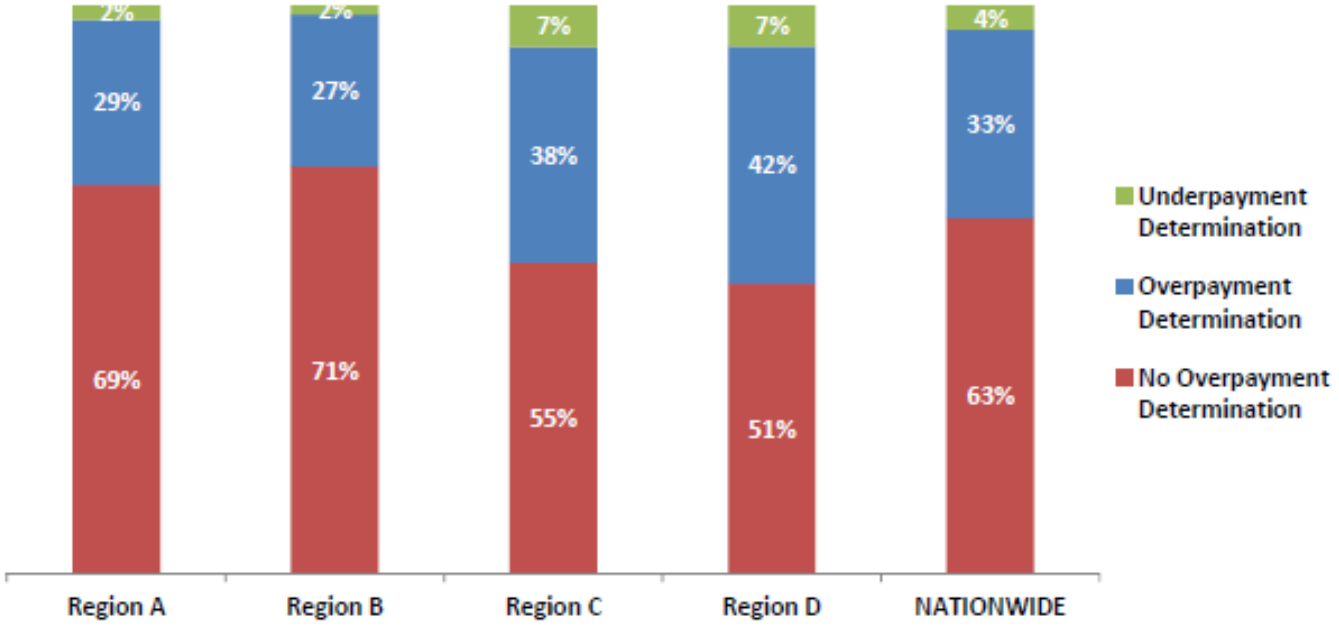
AHA RACTrac

Over two-thirds of medical records reviewed by RACs **did not** contain an improper payment.

Percent of Completed Complex Reviews with and without Overpayment or Underpayment Determinations for Participating Hospitals, by Region, through 1st Quarter 2012



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AHA RACTrac

- 96% of denied $$ were from **complex chart reviews**
- The **% of complex denials** by RAC region for participating hospitals are:
  - Region A = 18%
  - Region B = 22%
  - Region C = 37%
  - Region D = 23%

- **Average $$ value** of an automated denial was $521 and $5,839 average for a complex denial respectively
  - 64% of all reported automated denials are from Region C

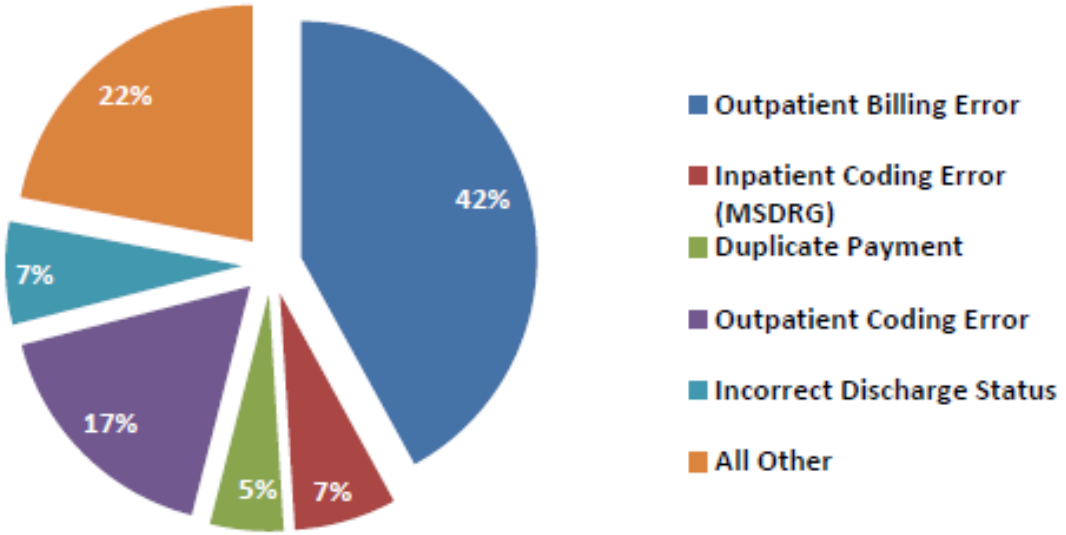
- 78% of the **automated denials are on the OP basis** and 18% on the IP with 8% in other such as physician services and DME

- 97% of the **complex denials** are on the **IP basis**

RACs are issuing automated denials for many different reasons.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 1st Quarter 2012

Survey participants were asked to rank denials by reason, according to dollars impacted.



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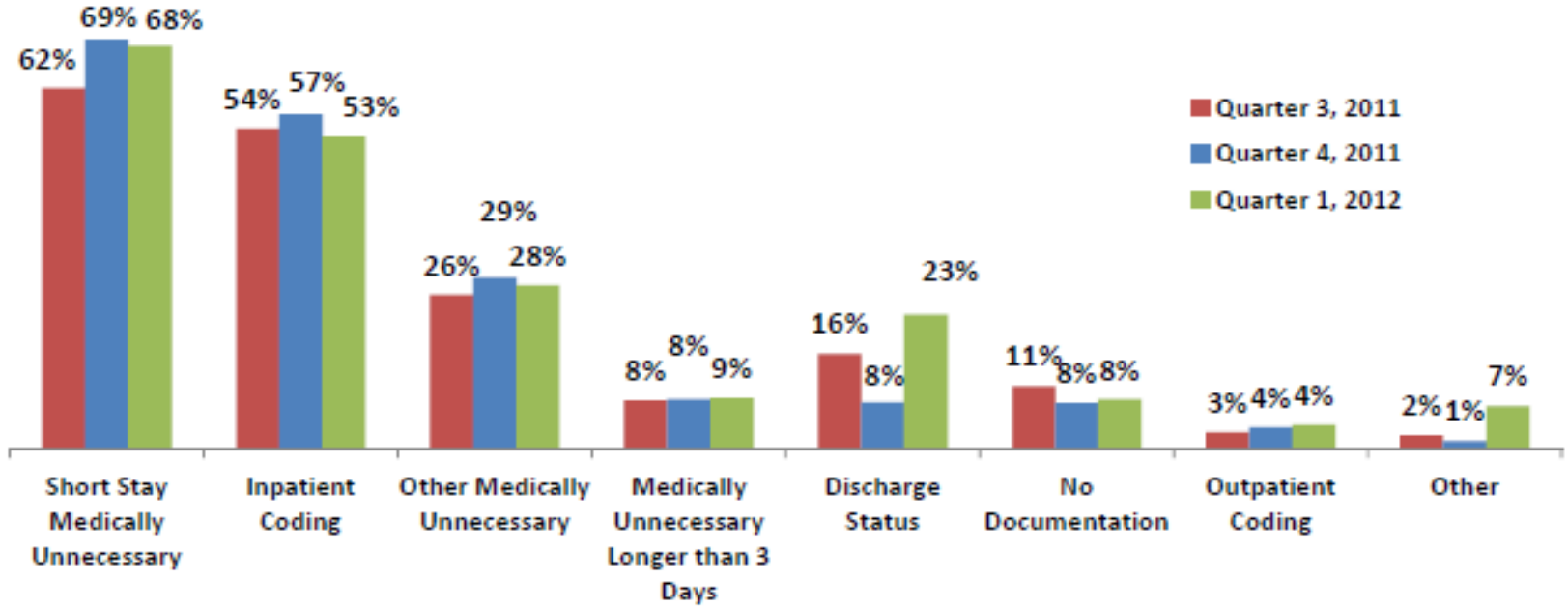
The majority of complex denials are short-stay medical necessity denials.

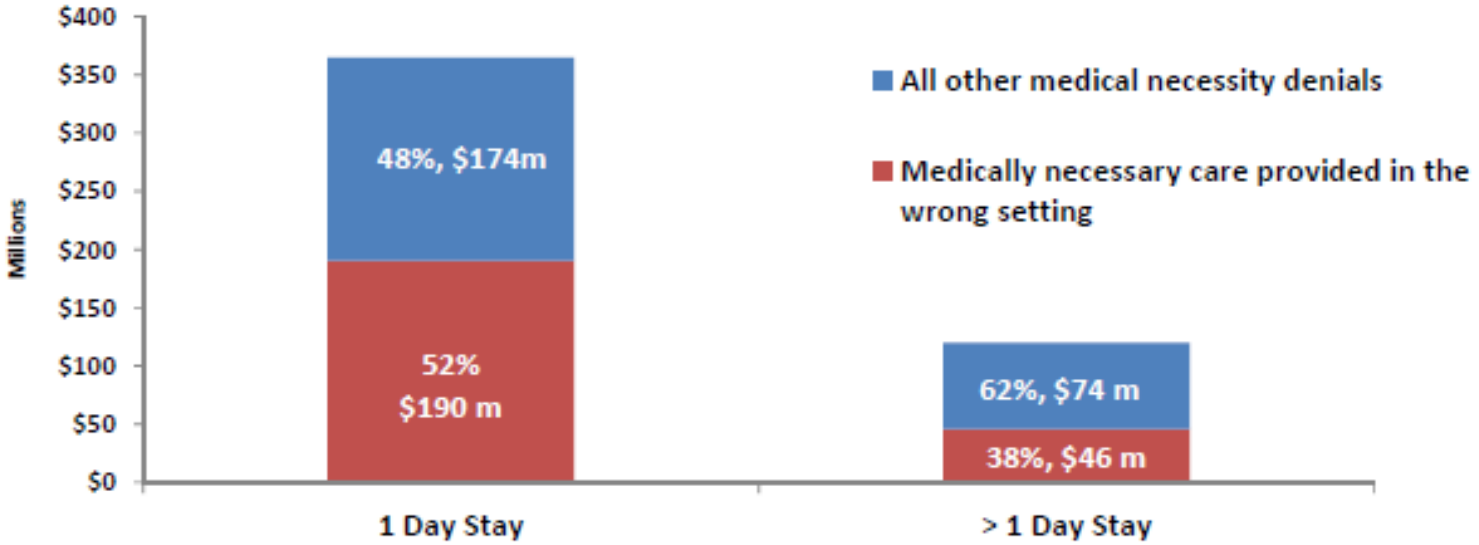
Percent of Participating Medical/Surgical Acute Hospitals with RAC Activity Experiencing Complex Denials by Reason, 3rd and 4th Quarter 2011, 1st Quarter, 2012

Survey participants were asked to select all reasons for denial.



The majority of short-stay medical necessity denials were because the care was provided in the wrong setting, not because the care was not medically necessary.

Reason for Medical Necessity Denials by Length of Stay Among Hospitals Reporting Medical Necessity Denials, 1st Quarter 2012



Not all RACTrac compatible vendors have made accommodations to allow hospitals to answer this question yet. As a result, the volume of medical necessity denials for inappropriate setting may be under-represented in this chart Furthermore, older RAC claims may not be classified as "inappropriate setting" by the hospital.

- The % of complex denials by $$ amount due to **lack of medical necessity** - % by region is reported as:
  - Region A = 53%
  - Region B = 57%
  - Region C = 75%
  - Region D = 67%

- Percent of Participating Hospitals Reporting the **MS-DRG for Medically Unnecessary** with the Largest Financial Impact

1st Quarter 2012

Medical Necessity Denials

MS-DRG	Description	% of Total Denials
312	SYNCOPE & COLLAPSE	25%
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	24%
313	CHEST PAIN	9%
69	TRANSIENT ISCHEMIA	6%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	3%

- The % of participating hospitals with **denials reversed** during the discussion period nationally is:

  Yes = 30% No = 57% Do Not Know = 10%

- *The **discussion period** is intended to be a tool that hospitals may use to reverse denials and avoid the formal Medicare appeals process. All RACs are required to allow a **discussion period in which a hospital may share additional information and discuss the denial with the RAC.** During the discussion period a hospital may gain more information from the RAC to better understand the cause for the denial and the RAC may receive additional information from the hospital that could potentially result in the RAC reversing its denial*

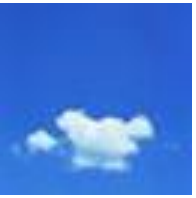
- When **hospitals choose to appeal**, they win 75% of the time! Hospitals reported a total of $51.5 million in overturned denials thus far – 51% of denials overturned was because the care was found to be medically necessary

- **The moral of the story is:**
  1) Timely UR chart review
  2) Physician and staff education
  3) Care manager to develop strong relationship with physicians – requires CEO support
  4) Physician to document medical necessity
  5) Report all denials to pertinent departments
  6) Review charts of all requests for complex medical record review by RAC
  7) Respond to RAC timely
  8) Appeal as appropriate
  9) Offer physician and staff on-going education using info from the RAC review response
  10) Assign key staff to keep tract of what the RAC in your region and others are reviewing

What is Outpatient Observation?

What is Outpatient (OP) Observation?

- Observation care is a well-defined set of specific, clinically appropriate services that include:
  - A **hospital-based** service which represents a category or a patient status
  - **Determined by a physician's order**
  - Observation services = **"Ongoing short-term treatment, assessment, and reassessment"** to decide on inpatient or discharge
  - **Care provided before a decision can be made** regarding whether a patient will require further treatment as an inpatient, or may be safely discharged
  - **Documentation must include progress notes** to give a patient snap shot in time, vital responses to treatment, well being, not so well being…



Outpatient (OP) Observation

- Observation status is commonly assigned to patients who:
  1. Present to the emergency department and who then require a significant period of treatment or monitoring before a clinical decision is made concerning their next placement.
     - **Unsure of the diagnosis**
     - **Unsure of the possible course**
     - **Will the patient remain stable after treatment?**
  2. Or, are **in need of unexpectedly prolonged recovery after outpatient surgery**

- The hospital should ensure that once there is sufficient information to render this clinical decision, **the patient should be expeditiously admitted, appropriately transferred, or discharged.**

- **Physician Evaluation**

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

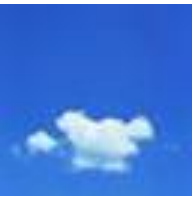
  b) The medical record must include documentation that the **physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.**

- **Medicare Claims Processing Manual, Chapter 4 § 290.5.1.**

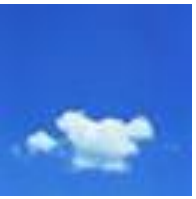
Where can an Observation patient be placed?

- Patient **may be placed** in medical-surgical, ICU/CCU, ED, SDS, or Special Observation Unit – do ensure that they are registered for the correct level of care and bill for the correct level of care regardless of where they are
  - It's **not where but <u>WHY</u>** that counts

- **CMS Survey Procedure**
  - Review the medical records for patients who are in observation status at the time of survey. Verify that the medical record includes an **order to place the patient in Observation status, including the clinical reason for Observation**, such as "Place patient in Observation to rule out possible myocardial infarction (MI)." or "Place patient in ICU Observation or telemetry bed to rule out possible MI

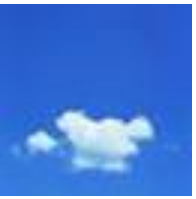


- Medicare - **CAH**
  - Per hour meeting criteria + ancillaries for each patient
  - Billed on the ED UB-04 if preceded by an ED visit
  - Billed and paid separately from IP if patient is admitted
  - At FYE (fiscal year end), for cost reporting purpose, the total hours of Observation meeting criteria are divided by 24 to determine # of days
  - # of days are paid at the same rate as acute per diem



How Are Hospitals Paid For Observation Services?

- Medicare – **PPS**
  - The I/OCE determines whether observation services billed as units of G0378 are separately payable under APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter.
  - Therefore, hospitals should bill HCPCS code G0378 when observation services are ordered and provided to any patient regardless of the patient's condition.
  - The units of service should equal the number of hours the patient receives observation services.



❑ Medicare – **PPS (continued)**

- **2008 Observation Final Rule: (CMS 1392-FC pg 274-280 and 890-910) - CMS Deletes APC 0339 and creates two composite APCs for extended assessment and management, of which** observation care is a component. CMS views this as "TOTALITY" of care provided for an outpatient encounter.

- **Two New APCs: Observation "Extended Assessment and Management" Composite APCs**
  - **APC 8002 Level I**: Extended Assessment and Management Composite APC **(Observation following a direct admission or clinic visit)**
  - **APC 8003 Level II**: Extended Assessment and Management Composite APC **(Observation following an emergency level 4 or 5 visit)**

- Note: Includes both ED Visit and Observation Visit

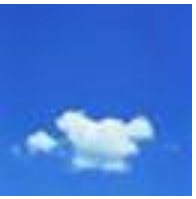
❑ Medicare – **PPS (continued)**

- ***2008 Criteria***

  Composite APC 8002 (Level I Prolonged Assessment and Management Composite) (meeting criteria)

  – Note: The composite APC will apply,

  - **regardless** of the patient's **particular clinical condition,**
  - if the **hours of observation** services (HCPCS code G0378) are **greater than or equal to eight** and **billed on the same date as HCPCS code G0378** and
  - **there is not a "T" status procedure** on the same date or day before the date of HCPCS code G0378.



- **Other payors** – as directed or per contract

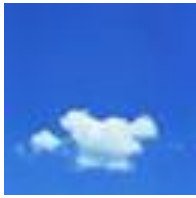
Medicare Observation

- Medicare asks:

  "Could they have been treated as OP vs IP?"

Chest Pain / RO AMI	Lower back pain
Simple pneumonia	Renal colic
Asthma/COPD	UTI
Atrial arrhythmias	Fracture / sprain / strain of arm or leg
CHF	Syncope or decreased responsiveness
Gastroenteritis / Esophagitis	Dialysis

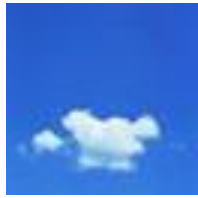
- **The decision to admit a patient as an inpatient** requires complex medical judgment including:
  - Consideration of the patient's medical history
  - Current medical needs
  - The medical predictability of something adverse happening to the patient
  - The availability of diagnostic services/procedures, and
  - When and where the patient presents.



- **In order to admit a patient to IP with any of these diagnoses, the physician must document:**
  - Assessment of risk
  - Failed OP
  - Chronic conditions activated
  - Comorbidities
  - Social conditions or disability worsening ***BUT*** need to be able to document the above first – it is not a reason for admission, it is simply a potential documented support to the above for IP care vs OP
  - What "in their judgment" warrants an IP stay

Medicare IP Admit vs OP Observation

- **Medicare monitors other diagnosis** – for example:
  - Abdominal pain
  - RO CVA/TIA
  - Dehydration
  - Hypertension
  - Headache
  - Closed head injury
  - Diabetes
  - Circulatory disorders except AMI
  - Pacemakers
  - Cardiac defibrillator implant
  - Percutaneous cardiovascular procedure

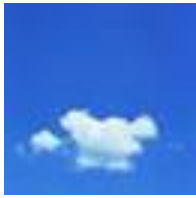


- **Medical necessity documentation** is what can make the difference

- **R/O are automatically denied**

Medicare IP Admit vs OP Observation

- **A physician must evaluate:**
  - The patient's condition
  - The risk if discharged
  - The treatment needs



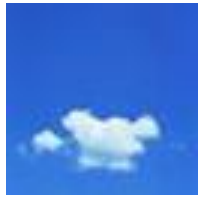
- Admission to IP vs Observation with a **1-day stay** raises a red flag
  - May be appropriate but if reviewed, it better have good documentation as to why IP vs Observation
  - Some other payors automatically changes 1-day stays to the Observation level

Case Management/UR, regardless of the hospital size as well as a 24 hr backup process is a must regardless of the hospital size.

Medicare IP Admit vs OP Observation

- "The physician should **use a 24-hour period as a benchmark**, i.e., he or she should order admission (IP) for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis."

- "However, the **decision to admit a patient is a complex medical judgment** which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and outpatients, the hospital's bylaws and admissions policies, and the relative appropriateness of treatment in each setting."



Appropriate OP Observation Placement

- Per Medicare, **examples include**:
  - Patients, with a **fixed diagnosis**, who are **likely to respond quickly** to therapeutic interventions.
  - Patients with **rule-out or symptomatic** admissions who are receiving diagnostic testing and possible therapeutic interventions to determine the medical condition and need for an inpatient hospitalization such as:

Abdominal pain	Asthma	Atrial fib	Cardiac arrhythmia
Chest pain	CHF	COPD with increased dyspnea	Dehydration
Gastroenteritis	Lithium imbalance	Palpitations	Unstable angina
Observation to determine whether labor exists	Possible overdose	Nausea and vomiting	Possible infectious process

Factors to be Considered

- **Severity of the S&S**
  - Exhibited by the patient on presentation to the hospital
- **Medical predictability**
  - Of the clinical course and potential adverse complications
- **Services required**
  - Will OP be sufficient?
- **Existence of comorbid conditions**
  - That are likely to negatively impact the clinical courses

Consider Observation when

- Diagnosis, treatment, stabilization and discharge can be expected within 24 hours
- Symptoms unresponsive to at least 4 hours of ED treatment (but no need to wait the 4 hrs when you know they meet criteria for Observation)
- Psychiatric crisis intervention / stabilization with observation every 15 minutes
- Refer to InterQual/McKesson or Milliman for more specifics (2012 version)

Appropriate Observation Cases

1. Unconfirmed acute diagnosis that will require more intensive service if it is confirmed or, stated otherwise, **symptoms suggesting a diagnosis that must be ruled out** (e.g., chest pain, abdominal pain, TIA)
2. Conditions **requiring further monitoring** and evaluation to determine the appropriate diagnosis and the need for admission
3. Diagnosed cases **likely to respond to limited treatment**
4. Brief stays **following a planned OP surgery/procedure due to complications**, that require additional monitoring and evaluation beyond what is expected in the normal course of recovery for the procedure that was performed

Appropriate Observation Post Surgery/Procedures

1. Abnormal postoperative bleeding
2. Poor pain management
3. Intractable vomiting
4. Exceptionally long delay from anesthesia recovery

Recovery Room nurse notes must support the patient's post-operative medical needs

Post-Op Observation

Claims processing manual refers to:

- A post routine recovery period and gives an example of recovery as 4 to 6 hours.
- A patient cannot be placed in Observation "to remain under nursing care for a period of time to make sure the patient may be discharged safely" — that is recovery.
- Observation is not for those patients whose surgeon anticipates a medically monitored overnight stay for the patient
- In the case where the surgeon had ordered an overnight stay and the patient shows atypical S & S, the patient may then be placed in Observation if the physician documents a medical problem and issues new orders to support the present situation

Appropriate Observation Cases

- The physician must only place in OP Observation status *after* taking the patient's history into consideration.
- The physician will order tests and treatment concomitant to the diagnosis, document the expectation that the patient will respond quickly to care and place in the appropriate area of care.

Example

A patient is treated in the emergency department for difficulty breathing. The physician orders a peak expiratory flow rate and an inhalation treatment to help the patient breath more easily. The physician has the patient placed in an Observation status to determine whether this intervention produces normal breathing.

Seven hours later (8 hrs to be billable for PPS hospitals), the patient's vital signs are normal and the patient has resumed normal breathing. The patient is released.

What Observation Is Not!

NOT OP Observation services when

- Services are not reasonable or necessary for the diagnosis or treatment of the patient.
- In lieu of IP if they meet criteria for such
- Services are provided for the convenience of the patient, the patient's family, or a physician, (e.g., following an uncomplicated treatment or a procedure, physician busy when patient is physically ready for discharge, patient awaiting placement in a long term care facility).
- Social factors such as transportation issues, inability to provide for activities of daily living, patient convenience or homeless conditions.
- Standing orders for Observation following outpatient surgery.
- Services that are covered under Part A, such as a medically appropriate IP admission

contd.

NOT OP Observation services when

- Services that are part of another Part B service, such as postoperative monitoring during a standard recovery period of a same day procedure/surgery, (e.g., 4-6 hours), which should be billed as recovery room services
  - Example: A cataract surgery or bunionectomy is clearly an outpatient surgical procedure. A total hip replacement, a CABG, an M.I. status post full arrest are clearly inpatient admissions.
- Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services. (such as elderly patient in early the day of a scope for an enema)

contd.

NOT OP Observation services when

- Providing a medical work-up for patients who do not require skilled support or observation services.
  - E.g., diabetic teaching for a patient not requiring skilled services
- Outpatients who require only OP blood administration, OP allergy injections, chemotherapy, IPPB, IM/IV medications or hemodialysis.
- Outpatient diagnostic services including cardiac catheterization, electrocardiogram, glaucoma tests, myelogram, bone scan, X-rays, IVP, cystoscopy, endoscopy, aortogram, ultrasound, CAT scan, nuclear medicine scan, and physical therapy evaluation.
- Services billed as OP observation services without clear documentation (i.e., by written order) of the attending physician's plan to place the patient to an Observation bed.

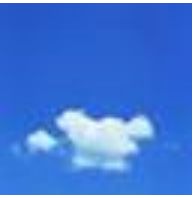
Observation Entry Point & Order

Observation Entry Points

- **Admission from ED**
  - The ED physician determines whether the patient is clinically unstable to go home and calls the PCP or the house physician covering for patients needing more than an ED visit. If the PCP or covering physician agrees, he/she then orders an IP admission OR orders the patient to be placed in Observation.

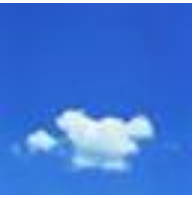
- Admission from a **post OP surgery or procedure**
  - **This must not be, in any way, anticipated**

- **Direct from a physician's office**
  - A physician sees a patient in his/her office and orders the patient to go directly to the hospital to an Observation status for diagnostic tests and medical monitoring.



Ordering Observation (Overview)

- Determine and document medical necessity
- Requires a physician order for the Observation status of care
- Every order must have a documented reason for such – ie – 1 Liter Normal Saline (NS) bolus for dehydration
- Provide Observation in a licensed hospital area
- Physician must monitor, assess and document periodically in the medical record
- Know the difference between routine Observation and post OR/procedure
- Track hours and report all appropriate hours regardless of the LOS and regardless of the reason for the stay
- Document ALL charges regardless of whether they are separately payable or not
- Calculate Observation hours appropriately based on documentation – see upcoming sections

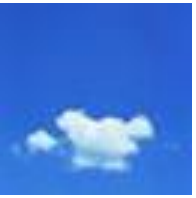


Observation Order

- All verbal orders must be authenticated based upon federal and state law. If there is no state law that designates a specific time frame for the authenticated of verbal orders, such must be authenticated within 48 hours by a practitioner responsible for the care of the patient

- IOM Pub. 100-04 states that the term ***"admit"*** refers to the decision to provide inpatient care.

- Recommend pre-typed orders:
  - ✓ Admit to IP
  - ✓ Place in Observation
  - ✓ Bed for OP monitoring (not Observation)



- "Standing Orders" for Observation is not acceptable

Observation Order

- Sample **Admission Orders:**
  - Admit to inpatient
  - Admit to Dr. _____ care
  - Set of orders labeled "Admission Orders"

- Sample **Observation Order**
  - Place patient in Observation
  - Refer to Observation services

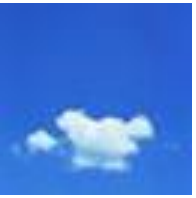
- Orders must be **dated and timed** prior to the start of the Observation time – cannot be retroactive for any reason

- "We are going to reiterate that backdating or retroactively editing admission orders to add missing data or alter confusing orders is never permissible under Medicare"
  - Dan Schroeder – from an Open Door Forum

- In PPS hospitals – ED, Observation and IP end up on the same account # - CAHs have different account #s

Observation Order

- **Recommend *not* using "admit to"** – has been confusing for some and care was billed as an acute admission vs OP observation
  - Errors in billing Part A for IP vs Part B for OP Observation
  - Must use **revenue code 0762 for OP Observation regardless of the place**
- Recommend using **"place patient in Observation services"**
- Recommend stating the **place for Observation**, e.g., medical floor, ICU, ED, Observation unit
- **Registration clerks are not to proceed** with admission process if the level of care the physician is placing the patient in is not clear.



Observation Start & End Time

Medicare Claims Processing Manual – Chapter 4, Section 290.2

290.2.2 - Reporting Hours of Observation
(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)
Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour.

For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

Observation **End Time**

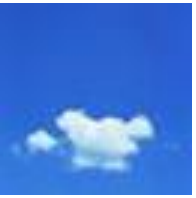
Medicare Claims Processing Manual – Chapter 4, Section 290.2

A beneficiary's time receiving 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.

- **Observation may end before discharge when:**
  - The need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately such as the case where the patient much have surgery
    - In this case, the patient would be discharged from Observation and registered for Same Day Surgery
  - Reported 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**.

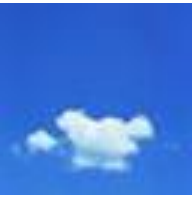
Observation **Maximum Time**

- With Medicare, Observation is **usually 24-hour period or less** and in only rare and exceptional cases do reasonable and necessary outpatient Observation services span more than 48 hours and potentially up to 72 hrs – highly discouraged
- **Physician's assessment** of the patient's need for continued observation ideally is throughout but **at the very least at 24 hours** to determine the need for continued stay, admission to IP or discharge
- **Midnights spent in observation cannot be applied to the 3-day qualifying stay for an admission to a skilled bed**



Sample Chart Review

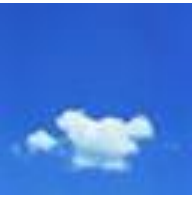
- Billing for observation is dependent first upon the presence of a provider documenting medical necessity and ordering observation services, then
- On documentation that services took place, then
- On when the ordered services were completed



Sample Chart Review

- Examples of services provided that may be billable or not:

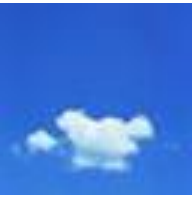
- Provider orders NS for Hydration, slow drip, 600ml over 3 hours
  - Nurse documents start time only
  - Bill NS J7040 as a supply. Bill nothing for hydration because we can only document that the service was ordered not performed



Sample Chart Review

- Example 2:

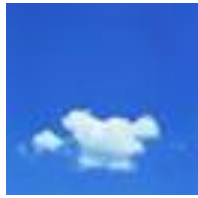
- Provider Documentation with time stamp 12:40 discharges patient
  - Nurse documents discharge orders reviewed with patient at 3:00pm and patient discharged. No nurse notes between 12:40 and 3:00pm, and no indication in either note patient was having additional testing or treatment.
  - End Observation time at 12:40 and bill accordingly. There are no notes to support that observation care and outpatient services were not completed by 12:40



Active Monitoring During an Observation Stay

Active Monitoring

- **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.

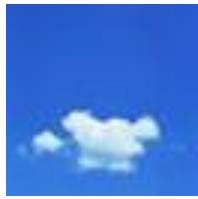


- Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

- Facility should have an observation **policy that defines services requiring active monitoring**, e.g.,
  - Procedures requiring any sedation such as a scope
  - Chemotherapy or complex infusion therapies
  - Some hospitals define requiring active monitoring with services such as ECG, RT treatment, MRI/CT Scan, push drugs…. (see later slide for time calculation)
  - Many hospitals only count more time consuming test where they are with a hospital employee - such as MRI, CT, Treadmill, physical therapy but not RT and push drugs
    - Note: could add "unless in the cases where an RN has to be present during MRI/CT Scan due to acuity" – but then again, should that patient be an IP if so unstable?
  - Some only consider the 1st one or two hours of blood transfusion as "active monitoring"
    - **NOTE:** An OP transfusion does not meet criteria for Observation but a patient in Observation may receive a blood transfusion

Active monitoring

- CMS does not define active monitoring, so **facilities must establish their own guidelines** based on their scope of practice.
- Agree to what your hospital will consider "active monitoring" and **add to the Observation P&P**
- Once a facility determines which services provide active monitoring, they should **train the teams** involved in reporting accurate start and stop times, and make a determination as to who completes the final encounter form to include Observation hours.

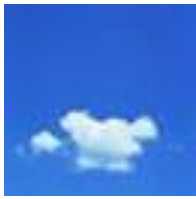


Calculating Active Monitoring Time

- CMS states that observation hours should not be reported while services requiring active monitoring are being performed.

- **Provider-friendly change to tracking observation hours**

- In the July OPPS update, CMS made a manual change to the section on counting observation hours that was very provider-friendly. CMS amended Medicare *Claims Processing Manual*, Chapter 4 290.2.2 "Reporting Hours of Observation," to allow providers to use average times when determining the amount of time to subtract from observation time for other procedures



Next Step

Next Step

- Review and discuss material from today with key staff at your hospital
- Email me any questions you may have along with questions you want to make sure I address during the next section - mguyot@stroudwater.com
  - I have access to Revenue Cycle consultants at Stroudwater
  - Do refer to this webinar if you send me a question.
- Mark your calendar to participate in part 2 of the Observation webinar – **next Friday, September 14** , same time (11:30 CT)
- Thank you and have a great weekend.