Comprehensive Observation Services and the 2-Midnight Rule – Part 2

June 20, 2014

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

- **This information applies to Medicare unless otherwise specified**
Objectives for Part 1

- The participant will be able to:
  
  - Describe key processes a hospital should have in place for Observation Services
    - Entry Point and Order Set
    - Managing Observation Length of Stay (LOS)
    - Observation Start & Stop Time
    - Active Monitoring
    - Beneficiary Consideration
      - Patient Notification
      - Self-Administered Drug policy
      - Application of the ABN
  
  - Apply Condition Code 44 when appropriate
Appropriate Observation Cases

First know what an appropriate observation case is:

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 in less than 2 midnights

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
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 as needed and medical treatment/monitoring

- In all cases, the physician believes that the issue will be stabilized in less than 2 MN (counting the midnight spent in OP such as ED, OR, routine OP....)
Ordering Observation (Overview)

- Provide Observation in a licensed hospital area

- Requires a physician order for the Observation status of care

- Determine and document medical necessity – what are the risks if sent home directly from ED or OR etc..

- Every treatment order must have a documented reason for such – ie – 1 Liter Normal Saline (NS) bolus for dehydration

- All ancillary orders must have a reason for such as is any OP services

- Physician must monitor, assess and document periodically in the medical record
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
  - OP Procedure/Treatment in an IP Bed
  - Medically Monitored Overnight Stay

- “Standing Orders for Observation” is not acceptable
Observation Order

- **Sample Admission Orders:**
  - Admit to inpatient or
  - Admit to Dr. ______ care or
  - Set of orders labeled “Admission Orders”

- **Sample Observation Order**
  - Place patient in Observation in _____ unit for ________ and
  - Refer to Observation services for the following reason(s)

- **Registration clerks are not to proceed** with admission process if the level of care the physician is placing the patient in is not clear.

- 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 a CMS Open Door Forum
The PCP should evaluate the patient whose placement in Observation or IP admission was made via phone discussion and determine if they still agree with the decision.

- If they believe the patient will require 2 MN in the hospital, he/she then:
  - Write an admission order,
  - Documents the medical necessity and
  - Certifies the need for 2 MN stay

- If the decision is to leave the patient in Observation he/she should:
  - Document his/her assessment in the progress note and
  - Discuss plan for the remaining time in Observation (new test or treatment orders and discharge plan)
Managing Observation LOS

- The Care Manager or designee should be available to discuss the physician’s plan as much as possible during the am rounds.

- The Care Manager should:
  - Confer with the day charge nurse before leaving to discuss patient status etc...
  - Touch base with the PCP before leaving for the day and discuss the next step (discharge before midnight or be admitted)
  - Share discussion with the house supervisor or the evening charge nurse to ensure that everybody is on the same page
Managing Observation LOS

- Observation lasting greater than 1 MN when counting midnight spent in OP – Options are:
  - **Discharge** if stable. (Continue workup on a OP basis if needed)  
  - **Continue observation status** if medical necessity is still relevant but plans are to discharge the patient before the second midnight
  - **Admit**. Document medical necessity for the need for greater than 2 MN including midnight spent in OP. Provider to document why the patient cannot be discharged which will lead to medical necessity documentation for admission.) and completes the certification  
  - **Convert to outpatient in a bed (OPIB)** in which case you would stop Observation billing (e.g., patient stable but waiting for a test to be completed) – This should be prevented if at all possible since there are no reimbursement for OPIB.
Observation Start & End Time

Active Monitoring
Observation Start Time

Medicare Claims Processing Manual – Chapter 4, Section 290.2

290.2.2 - Reporting Hours of Observation
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.

Note: If the ED nurse will be initiating the Observation while waiting for a bed or the ED nurse becomes the Med/Surg nurse, she/he should document the time the patient is officially an Observation patient vs ED even if still in ED
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.

- A patient MAY NOT remain in Observation when stable to wait for an OP service such as MRI, CT, Specialty consultation etc....
Observation End Time

- 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, in a CAH, the patient would be discharged from Observation and registered for Same Day Surgery
  - Gets incorporated when in a PPS hospital but counting Observation hours end
  - 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 **End Time**

- Provider documentation with time stamp 12:40 has an order to discharge the 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 notes that the 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

- Patient is stable but will need an MRI which is not available until the following day and patient has no transportation to come back ... Observation time ends when the patient is determine stable
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.
Active Monitoring

- 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
  - Add this method of time calculation in the Observation P&P if this is the route you chose to take
Beneficiary Considerations

Patient Notification for OP Observation Services
Self-Administered Drugs
Notice of Non-Coverage
ABN
Beneficiary Considerations

- The beneficiary in an Observation status is liable for a coinsurance charge equal to 20% of the hospital’s customary charges for the services

  - PPS hospitals are paid under the hospital Outpatient Prospective Payment System (OPPS)

  - PPS hospitals are also subject to the preadmission payment window, a Medicare beneficiary would not be liable for the coinsurance charges for the observation status services when subsequently admitted
Beneficiary Considerations

- Inappropriate use of observation services subjects Medicare beneficiaries to an increased beneficiary coinsurance liability that could have been avoided, had the beneficiary been properly admitted as an inpatient when he/she met criteria.

- Beneficiary should be informed of his / her OP observation status because CMS requires participation in Medicare Part B benefits for this service.
  - See sample form provided with this training.
  - Recommend the following process:
    - The initial form when placed in Observation be given and explained at registration time.
    - The change of status from IP to Observation be given by the Care Manager.
Beneficiary Considerations

- Beneficiary is responsible for a part B yearly deductible and a coinsurance or copayment for all OP services including those provided while in OP Observation
  - Coinsurance or copayment amount the beneficiary pays for an individual service cannot be more than the current amount the beneficiary pays as the Part A IP hospital deductible. However the total copay can exceed inpatient deductible

- Each Fiscal Intermediary (FI) has a list of medications they do not pay for while in Observation but they mostly consist of all PO medication and other self-administered drugs

**Medications that can be self-administered are not covered under Part B.** For safety reasons many hospitals have policies that don’t allow patients to bring prescription or other drugs from home. Facility policy should be clear regarding self-administered drugs.
People with Medicare often need self-administered drugs in hospital outpatient settings, like the emergency department, observation units, surgery centers, or pain clinics.

Medicare Part B does not cover drugs that are usually self-administered by the patient unless the statute provides for such coverage.

The statute explicitly provides coverage, for blood clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, certain oral anti-cancer drugs and anti-emetics used in specific situations.

Drugs not falling into the category listed in the previous sentence, are billable to the patient and do not require an Advanced Beneficiary Notice (ABN). Providers should identify these drugs in order to bill as non covered.
Self-Administered Drugs in OP Setting

- All pharmacy drugs and IV solutions are assigned a revenue code of 250 to 269.
- Providers assign a specific revenue code, (i.e. 259) to all drugs that can be self-administered.

- The CDM is then assigned codes specific to payor including Medicare signifying them that those are non-allowable charges
  - Obtain assistance from CDM consultants to assist in the process as needed

- By assigning one of these revenue codes, facilities can automatically file charges as non-covered on outpatient claims, without reviewing the patients' itemized account.
  - These drugs are covered when provided to an inpatient.
Outpatient or inpatient drugs and biologicals that are put directly into an item of durable medical equipment or a prosthetic device are covered under Medicare (See Benefit Policy Manual Chapter 15 Section 110.3)

Exceptions to outpatient self-administered drugs:
- Insulin provided to a patient in a diabetic coma. Use value code A4 and revenue code 637
- Drugs provided during an outpatient operative session. (i.e., eye drops or ointments provided during cataract surgery)
- Oral anti-emetic drugs, Q0163 . Q0181 (See revenue code 636)
- Oral chemotherapy (see revenue code 636)
- Oral immunosuppressant drugs (see revenue code 636)
- Drugs needed for use of DME or Prosthetic/Orthotic device
Hospitals are expected to bill the patients for drugs that are not covered by Medicare

- Patients should be notified of their responsibility in advance of the service

- Medicare states that for safety reasons, many hospitals have policies that don’t allow patients to bring prescription or other drugs from home but that they still will be billed.

- If no attempt to charge the patient as per policy for any patient billable services, it is not appropriate to add the cost to the cost report
Self-Administered Drugs in OP Setting

- Hospitals are recommended to give pamphlets to patients on this subject such as the following:
  
  
  - [http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf)

- These are designed as handouts to explain self-administered drug requirements. It is advised that providers print these and have them handy for customer service, financial counseling and others to provide patients with requirements for self-administered meds.
Many hospitals choose to write off self-administrable drugs, but if they participate in uncompensated care pools, then they run the risk of an OIG audit, since they adjust off some services unilaterally and apply other adjustments to charitable care, uncompensated care etc.

Stroudwater cautions against a policy that writes off all self-administered meds automatically. If hospitals get audited then their policies will be subject to OIG interpretation and they could be at risk. It is even more problematic from a compliance perspective if a facility only adjusts Medicare recipients self-administered drugs.
Self-Administered Drugs in OP Setting

- **Take home drugs from All Facilities for Medicare Beneficiaries**
  - Revenue code 253 is not covered by Medicare. If drugs are dispensed to an outpatient for use at home - the beneficiary is responsible for the charges.

- **Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services.**

- **However, if the drug or biological is deemed medically necessary to permit or facilitate the patient’s departure from the hospital, and a limited supply is required until the patient can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service.** These drugs should be billed under 250.
Medicare drug plans (Part D) may provide some limited reimbursement for self-administered drugs.

Generally, Medicare Part D plans will only be able to provide in-network reimbursement for self-administered prescription drugs that meet the following criteria:

- Drugs covered on the Part D plan’s formulary (or covered by an exception).
- Drugs aren’t routinely obtained from out-of-network providers, such as the hospital or emergency department.
- They couldn’t have been reasonably obtained through an in-network pharmacy.
- They are supported by receipts and documentation.
Hospitals must choose a consistent process, write a P&P and communicate with the staff:

✓ Notify the patient of their responsibility for self-administered drugs as described earlier

✓ If hospitals allow for patients to bring self-administered drugs in, the P&P should include the following:
  - What is the process to ensure medication safety
    - Medication in the original container
    - Who will review content - ? Pharmacist and what to do when not on duty – house supervisor, Hospitalist, ED physician?

✓ What do we do if the patient does not bring medication in original container? Do we still allow them to self-administer their own medication and have the responsible party sign a release of liability form? Or do we refuse to have that occur?
Informing The Patient

- Patient’s should be clearly notified of their responsibilities:
  - Consider the following:
    - Create a special consent form for Observation which would be signed by the patient/responsible party.
      - Explain that Observation is an OP service and whether they will be responsible for payment based on payor
      - As for any OP services, they are responsible for self administered drugs such as.....and explain their options – may give the Notice of Medicare Exclusion as discussed earlier
      - Have a bullet for them to sign that they are taking responsibility if they choose to bring their own meds in
    - Have a form to sign when the patient is changed from IP to Observation (condition code 44)
    - Give notice of non-coverage for IP or an ABN for Observation when not meeting either IP or Observation
What needs to be discussed as a hospital is whether they can bring their own medications and agree in what form such has – must be in the original pharmacy container...

- Remember that as the patient gets more savvy the more they will insists on bringing their own meds

- Meet with administration and pharmacists to develop an acceptable plan such as pharmacist to review medication before initial administration or ED MD and PDR comparison after hours

- Ensure clear P&P for new process
Informing The Patient

- Also consider providing community education using:
  - Framed sign explaining Medicare's rule and post it in ED and OP procedure areas.
  - Others are creating a simple pamphlet to notify patients of their Observation status and responsibility
    • Pamphlet is provided with ED visits to educate the community
    • It also instructs the Medicare beneficiaries to bring in their home meds...
  - Don't forget to have educational material to the point, short, large print, clear and who can they ask if they have any questions.
Notice of Exclusion

- For services that are not paid under the OPPS, but do not require an ABN such as providing drugs to the beneficiary that are usually self-administered, providers may use the Notice of Exclusion from Medicare Benefits to advise beneficiaries of any potential liability.

- See the following website for Exclusion form
    - See next slide for samples of “Notice of Exclusion from Medicare Benefits”
    - Can be given to the patient when applicable before OP services **though not mandatory** since the information is contained in their Medicare Handbook
Notice of Exclusion from Medicare Benefits

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.

- When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

**Before you make a decision about your options, you should read this entire notice carefully.**

- Ask us to explain, if you don’t understand why Medicare won’t pay.
- Ask us how much these items or services will cost you (Estimated Cost: $______________)

Medicare will not pay for:
Advance Beneficiary Notice (ABN)

- The purpose of an ABN is to provide prior notice to a beneficiary (or his or her representative, in the event that the beneficiary is not competent) when the provider believes that Medicare will not pay for certain Part B outpatient services because limitation on liability applies.

- Limitation on liability applies when Part B outpatient services fall within one of three categories:
  - The services do not meet Medicare’s medical necessity guidelines for a patient’s condition;
  - The frequency of a screening service exceeds Medicare coverage for that benefit; or
  - The services are custodial
Do we need to give an ABN?

- The intent of the ABN form is to explain to patients that a provider anticipates Medicare will not pay for certain services.
  - Patients will be responsible for payment to providers when they (or their representatives) opt to receive these services.

- Use of the ABN form is more common in outpatient settings, hence appropriate to be issued with Observation which is an OP service
  - For example, an observation patient who refuses to leave the hospital may receive an ABN form that explains Medicare will not pay for custodial care
  - The hospital must give proper notice to the beneficiary in advance of any custodial care provided in order to charge the beneficiary for the custodial care.

- CMS introduced a new ABN effective November 1, 2011
  - ABN forms with a March 2008 release date issued on or after November 1, 2011 will be invalid.
  - [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html)
  - [https://www.cms.gov/BNI/02_ABN.asp](https://www.cms.gov/BNI/02_ABN.asp)
Do we need to give an ABN?

- See part of new ABN below

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**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn't pay for D. ___________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have a good reason to think you need. We expect Medicare may not pay for the D. ___________ below.

<table>
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<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
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**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. ___________ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.
Changing Services from IP to OP and OP to IP

See Medlearn Matter re: CMS SE0622

Condition Code 44 (From IP to OP)

- Note: Condition Code 44 still applies with the 2 MN rule

- Know the reasons to report condition code 44

- In some instances, a physician may order an inpatient admission, but upon subsequent review, staff members determine that the inpatient level of care does not meet the hospital’s admission criteria.

- The National Uniform Billing Committee issued condition code 44 to identify cases when this scenario occurs and hospitals must change the patient’s status from inpatient to outpatient.

- Providers should use this code on outpatient claims only

- Condition code 44 allows hospitals to treat the entire episode of care as an outpatient encounter and to receive payment under the outpatient prospective payment system.
CMS set the policy for the use of condition code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager/UR is on duty to offer guidance.

Providers should not use code 44 as a “catch-all” solution at the end of short stays when medical necessity is subsequently deemed unjustified after a patient is discharged.

When an internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances, it would be appropriate to use condition code 44 if all other criteria are met.
Condition Code 44 (From IP to OP)

Even if a physician orders that a patient be admitted to a hospital as an IP, CMS authorizes UR to change patient’s status from IP to OP if:

- The change is made while the patient is in the hospital
- The hospital has not yet made a claim to Medicare for IP admission
- A physician member of the UR committee determines the medical necessity (Medical UR may be outsourced or through arrangements with a Medical UR from a hospital external to yours)
- The physician’s concurrence is documented in the patient’s medical records
- The patient is notified of the change in level of care
A utilization review (UR) committee (i.e., two or more practitioners or a QIO) must determine whether admission criteria have been met once the clinical documentation improvement or case management team raises the question of whether the inpatient admission was appropriate.

The UR committee may review the medical record for inpatient admission criteria before, during, or after hospital admission but while the patient is still hospitalized.
Condition Code 44 (From IP to OP)

- At least two members of the committee must be MDs or DOs in cases where a second review is required because the treating PCP does not concur.

- When the UR committee determines that the admission is not medically necessary, it must give written notification—within two days of the determination—to the hospital, the patient, and the practitioner responsible for the patient’s care.

- The Medical Reviewer of Physician Advisor (PA) is/are responsible for secondary review when admission criteria not met.

- PA uses physician judgment and applies Medicare guidelines for admission, not InterQual criteria. (UR staff applies InterQual or other criteria.)
The practitioner(s) responsible for the care of the patient must concur with the hospital’s finding that inpatient admission criteria are not met.

- This prerequisite for use of condition code 44 is consistent with the requirements in the CoP at §482.30 (d) of the regulations.
- The practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary.
- It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the attending does not respond, or does not contest then the findings are final.

If the attending contests, at least one other physician member of the committee must review the case. If two physician members agree that inpatient is not medically necessary, the decision is final.
May a hospital change a patient's status using Condition Code 44 when a physician changes the patient's status without utilization review (UR) committee involvement?

No, the policy for changing a patient's status using Condition Code 44 requires that the determination to change a patient's status be made by the UR committee with physician concurrence. – This role may be based on a relationship with an affiliated hospital or outsourced.

This physician member of the UR committee must be a different person from the concurring physician for Condition Code 44 use, who is the physician responsible for the care of the patient. For more information, see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.3.2 (When an Inpatient Admission May Be Changed to Outpatient Status).
Condition Code 44

- **Other examples of why Condition Code 44 is not met are:**
  - No Medical UR review was performed
  - No documentation that primary provider concurred with Medical UR review
  - Patient was not notified of the change of status

- **Note: If the patient has left by the time UR identifies that the patient did not meet IP criteria,**
  - The CC 44 was not met since patient is no longer an IP
  - There is no Observation services to bill since there was no order for Observation while the patient was still an IP
  - In this case, all you can bill for is the part B services such as Lab, imaging, therapy if the order for such justified the part B services
Condition Code 44

- UR determines that the patient did not meet neither IP nor Observation criteria and the patient is still at the hospital – what now?
  - Give letter of non-coverage - follow CMS instruction
  - If they appeal, do notify them that they will be responsible for the cost if they insist on staying at the hospital
  - Submit the claim as non-covered
  - Wait for a denial of payment
  - Resubmit a part B claim, and include all OP that would normally have been covered had the IP never existed

- UR determines that the patient did not meet neither IP nor Observation criteria after the patient has been discharged
  - Submit the claim as non-covered
  - Presently cannot bill for Part B services either since the patient has left
Q: How should the change in patient status from inpatient to outpatient be reported in the patient’s medical record? Can the hospital just discard the inpatient record?

A: Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient’s status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient’s status.
Plans for Part 3 – Thursday 7/26/14
Agenda Topics

- Staff documentation
- Calculating Observation Hours and Billing for Such
- Billing for change of status (IP to OP or OP to IP)
- Physician part B billing
- Time for Action Planning

PLEASE take this week to email questions you have – do let me know that the question is for the 7/26 webinar
It takes a team ...............