



Observation – Is Our Service Medicare Compliant – Part 1

Wednesday May 2 (1:30 – 2:30)

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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.

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What is Observation

- A hospital-based OP
- A physician's order is a MUST
- Observation services = "Ongoing short-term treatment, assessment, and reassessment" to decide on inpatient or discharge
- Documentation must include progress notes to give a patient snap shot in time, vital responses to treatment, well being, not so well being...
- Used when the patient presents to the emergency department and the physician is:
 - Unsure of the diagnosis
 - Unsure of the possible course
 - Will the patient remain stable after treatment?
 - Or, are in need of unexpectedly prolonged recovery after outpatient surgery

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Is CMS looking at Observation differently?

- Charts who's physicians' signatures are not legible are denied
- History as a valid source for review documentation (cannot be implied)
- Records from the treating physician insufficient or not submitted - used to be able to look at the whole record
- Medical records from the treating physician did not substantiate what was billed - used to be able to apply judgment
- Missing evidence of the treating physician's intent to order diagnostic tests – unsigned used to be ok
- Reviewer used to be able to go to history to base the level of care – now must be specifically documented

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Findings Across the Country

- Case managers are telling the physicians "when in doubt place the patient in Observation and we will take care of it later"
 - Missed opportunities for IP vs OP Observation
- Patients being admitted when not meeting criteria
- Patients who met criteria for IP and spent 3 days in an Observation bed
- Patients who could have met criteria but the medical necessity for an IP level of care was not documented by the physician
- RAC denials
- Multiple areas out of compliance.....

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Findings Across the Country

- Compliance issues such as:
 - Patient in the wrong level of care
 - Patient not meeting criteria for any level of care yet Medicare is charged
 - Medical necessity documentation lacking
 - Overage in Observation hours billed
 - Medicare billed for patients' self-administered drugs
 - Hospitals using retroactive timing for Observation start time
 - Nursing documentation no different than IP
 - Etc...

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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

- 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
 - What "in their judgment" warrants an IP stay
- R/O diagnosis or symptoms are never acceptable for an IP

Medicare monitors other conditions

- 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

Medicare monitors other conditions

Percent of Participating Hospitals Reporting the MS-DRG for Medically Unnecessary and all other Complex Denials With the Largest Financial Impact, 4th Quarter 2011

Survey participants were asked to identify top MS-DRGs, according to dollars impacted.

Medical Necessity Denials			All Other Complex Denials		
MS-DRG	Description	% of Total Denials	MS-DRG	Description	% of Total Denials
312	SYNCOPE & COLLAPSE	21%	312	SYNCOPE & COLLAPSE	7%
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	14%	166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	5%
313	CHEST PAIN	8%	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	4%
69	TRANSIENT ISCHEMIA	8%	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4%
249	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	4%	247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	4%

- The physician should use a 24-hour period as a benchmark
- CMS recommends that physicians document when services were attempted in an outpatient setting and failed.

Medicare IP Admit vs OP Observation

- A physician must document:
 - 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 the case 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, regardless of the hospital size as well as a 24 hr backup process is a must.

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 this will be 8+ hours of observation)
- Psychiatric crisis intervention / stabilization with observation every 15 minutes
- Refer to InterQual/McKesson or Milliman for more specifics but remember that these are guidelines only
 - Guidelines are "black & white"
 - Physician thorough documentation as to why they meet criteria can make the difference even when they do not meet InterQual criteria as is.

Appropriate Observation Cases

- 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)
- Conditions requiring further monitoring and evaluation to determine the appropriate diagnosis and the need for admission
- Diagnosed cases likely to respond to limited treatment

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 laborexists	Possible overdose	Nausea and vomiting	Possible infectious process

Appropriate Observation

Post Surgery/Procedures

- ❖ 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

- Abnormal postoperative bleeding
- Poor pain management
- Intractable vomiting
- Exceptionally long delay from anesthesia recovery

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

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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.
- Can not be because it's after hours and patient recovers in Med/Surg vs in recovery room
- 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

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NOT OP Observation services when

- ⊗ Services are not reasonable or necessary for the diagnosis or treatment of the patient.
- ⊗ 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

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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)

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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.

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Observation Entry Points

- 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.
- 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
- Patient may not be placed in Observation directly from home or nursing home without being seen by the physician

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

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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 the patient is observed**
- The order should include 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.

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Observation Start Time *Medicare Claims Processing Manual Chapter 4, Section 290.2 (07-01-09)*

Observation services

Observation time **begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated (nurse's notes) in accordance with a physician's order.**

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

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Observation End Time

Medicare Claims Processing Manual Chapter 4, Section 290.2 (07-01-09)

Observation services

Observation care **ends** when all medically necessary **services** related to observation care are **completed** ... Alternatively the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

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Observation End Time

- 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.
 - This could be 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
 - However, 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.

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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**

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Track Active Monitoring Time

- 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.

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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
 - All other services defined by facility as requiring active monitoring such as ECG, RT treatment, MRI/CT Scan, push drugs....
- CMS states that observation hours should not be reported while services requiring active monitoring are being performed.

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Active Monitoring

- CMS does not define active monitoring, so facilities must establish their own guidelines based on their scope of practice.
- The recommendation is that the facility assign a coder and a case management team member who are each thoroughly versed in all CMS Observation guidelines, as well as those for at least the top commercial payors.
- This small team should be responsible for all encounter review/completion for Observation stays.
- 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.

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Tracking Observation Time

❖ Provider-friendly change to tracking observation hours

- In the July OPSS 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
- This would apply to Active Monitoring procedures

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Tracking Observation Time

- ❖ **Re-think how you are calculating Observation hours for billing purpose**
- Develop an Observation encounter form like you have for ED or IV Infusion department, SDS etc..
 - Include all potential scenario for IV push, infusion etc..
- Nursing staff training regarding documentation
- Patient's nurse to complete to the best of her ability
- Chart to be reviewed for completion (what was done was charged and vice versa – maybe night shift)
- Determine who calculated the hours
- Coder has a final review for coding purpose

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Beneficiary considerations

- The beneficiary is liable for a coinsurance charge equal to 20 percent of the hospital's customary charges for the services
- 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 should be informed of his / her OP observation status because CMS requires participation in Medicare Part B benefits for this service

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Beneficiary considerations

Medications that can be self-administered are not covered under Part B.

What is your policy to address this issue?

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Self-Administered Drugs in OP Setting

- 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.

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Self-Administered Drugs in OP Setting

- It is recommended that providers assign a specific revenue code, 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,

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Self-Administered Drugs in OP Setting

- 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

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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.

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Self-Administered Drugs in OP Setting

- 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:
 - They're covered on the Part D plan's formulary (or covered by an exception).
 - They 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're supported by receipts and documentation.

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Self-Administered Drugs in OP Setting

- 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
 - see website below for sample CMS patient information material on the subject
 - <http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf>
 - ✓ If patient chooses to bring his own, 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 patient does not bring medication in original container? Do we still let him/her self-administer their own medication and have him/her/responsible party sign a release of liability form?

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