The Observation Report

Guidelines and tips for coding the new observation APC

by Carol Dodd, RHIT
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Sincerely,

Kim Raines
Managing Editor

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Managing Editor

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CMS gives separate billing for some observation services

No one, from the federal government on down, ever argued that observation services are not a valid method of determining whether a patient requires admission to a hospital and continuation of care.

The problem CMS identified with the observation process was that it didn’t have good data to analyze. It was impossible to tell whether these services were being used appropriately and effectively, and that they did not overlap with or take the place of more efficient treatment scenarios.

APCs were based on data from claims filed in 1995. Although physicians had been billing observation services for some time, there was little facility-based information available that could serve as a basis for a cost-benefit analysis of the service. Everyone has heard the horror tales about misuse of observation services. These misuses are most likely the exceptions, not the rule. Still, CMS had virtually no data to use to develop an APC for observation service, or the best-practice treatment modalities for a patient in observation.

CMS never refused to pay for observation under APCs and the OPPS rules. Observation services have always been packaged into facility payment for the different initial levels of service that resulted in a patient’s admission to observation, and hospitals continued to collect data on these services. Facilities were encouraged to continue reporting observation services and the charges incurred in the delivery of the service to provide data for future decisions concerning the separate reimbursement.

Coding choices

There are a number of coding choices in CPT-4 physicians use to report observation for their own reimbursement. The codes are based on the documentation of physician cognitive and physical services. Unfortunately, these codes give little to no information about the services rendered by other personnel, or the resources the facility expends to monitor and care for the observation patient.

CMS asked facilities to report observation services by revenue center, leaving open the option to include the CPT-4 codes. It asked that the charges incurred be clearly identified with the observation services.

The data was used to form a more complete picture of how the services were being used, the types of patients most likely to require continued monitoring, and what best-practice treatment modalities and diagnostic monitoring would be required for optimal use of the service.

From this picture, CMS settled on three conditions it felt were most likely to respond favorably to continued treatment and monitoring in an observation setting. The conditions are asthma, congestive heart failure (CHF), and chest pain (which are explained later in this report). CMS clearly defined how the observation APC can be charged, and the amount of payment it felt was appropriate for this new APC.

Diagnostic monitoring

“Frequently, beneficiaries are placed in ‘observation status’ in order to receive treatment or be monitored before making a decision concerning their next placement (that is, admit to the hospital or discharge to home).”—Federal Register, November 30, 2001

In essence, that says it all. Admission to observation services implies that the patient’s condition requires more study and treatment before a final disposition is made. In this statement, CMS clearly precludes the use of observation services for convenience, or as a continuation of surgical services, and disallows payment under the APC when patients are simply waiting for transfer or placement elsewhere.

The statement also implies that after a finite period of time, a decision will be made as to whether the patient is to be admitted or discharged. continued on p. 4
During the comment period before the final rule was adopted, some practitioners argued that the list of eligible diagnoses was too narrow, and CMS has agreed to look at further diagnoses as more data becomes available. Before the final rule was established, CMS did agree to broaden the code ranges for conditions under the list, but for now these three conditions are the only ones that will be paid separately. The question that remains is whether separate payment under the observation APC (0339) will really yield the type of reimbursement that will adequately compensate facilities for services.

It is unlikely that separate payment for observation services will make separate observation units in facilities economically feasible. CMS isn’t concerned about this detail, and reiterates that observation services can take place in any part of the hospital.

As CMS quietly but clearly reminds us, it isn’t as though separate payment under this APC represents any additional monies paid under OPPS. Instead, some dollars will be shaved from the payment rates for other services, most notably those for clinic and ED APCs. This is in keeping with the zero-balance philosophy that CMS has used to adjust other payment rates, most notably those items that were formerly high-ticket passthroughs.

Determining the needs
Facilities must develop strategies to use, document, and bill observation services correctly under the final rule. And they must also collect the necessary data to provide CMS with an evaluation of the rule and their recommendations for revision or expansion.

The APC concept is based on resources and personnel, and on strategies for the correct utilization of facility resources. We stand in a unique position to determine where the real needs lie and to assist with the development of a comprehensive plan to meet those needs. The data collected during the next year on the effectiveness of this new APC are crucial to the development of future policies regarding observation services.

Good documentation and careful utilization of observation services is a crucial step in the justification of Medicare dollars for observation services. Facilities can assist CMS to further study the service, with a possible expansion of services/reimbursement for observation by meticulous recordkeeping and documentation that supports the need for observation as well as correctly billing for the service.

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Identifying the errors
Most of us are well aware of the miscalculations in the November 30, 2001, Federal Register that led to the three-month delay in implementation. There are also many typos in the final rule, including several in the text that dealt with observation services. For example, on p. 59883, there are two glaring errors that caused a great deal of confusion. The first is regarding identification of the HCPCS code that corresponds with APC 0339. Two different codes are identified for billing observation. The correct code is the second code mentioned on p. G0244.

Additionally, CMS had been convinced to add several other codes to the list for congestive heart failure (CHF). The final rule inadvertently listed it under the heading of chest pain. A complete list of all diagnosis codes is found in the back of this report.

The inclusion of the rheumatic codes and the combination codes make perfect sense to most coders, from the standpoint of data capture. There will certainly be many instances in which the three main codes originally proposed by CMS (428.0, 428.1 and 428.9) will not be listed according to correct coding guidelines, while CHF may be present.

Chest pain
It is estimated that each year 11,000 people are sent home from ED visits with a misdiagnosed myocardial infarction. This unfortunate statistic includes a higher death rate (25%) for those individuals who are not hospitalized and treated in this immediate period while the infarct evolves.

It is equally unfortunate that the signs and symptoms do not always correlate with positive laboratory results during the one to two hours of the typical ED visit. This is the rationale that supports separate payment for observation services for patients who are experiencing chest pain.

While the patient is observed, further documentation must depict the process by which a definitive diagnosis is made. CMS requires further diagnostic tests to be performed during the observation period to validate that the patient is truly being observed for a worsening condition, and not simply waiting for an inpatient bed.

CMS has stated that it will develop the software capability to identify whether the testing took place as part of the ED visit or during the observation period. This is crucial.

During the observation period, at least two sets of cardiac enzymes and two electrocardiograms (EKGs) must be documented to ensure that the patient has continued to receive diagnostic services. Thus a set of cardiac enzymes, drawn and read during the ED visit, will not be considered a valid part of the observation protocol.

CHF
The Merck Manual asserts that “no definition of CHF is entirely satisfactory.” There are so many etiologies, and so many complications associated with the disease, that a careful assessment of patient status is critical, as well as continued monitoring to ensure that symptoms are under control. Since CHF is largely a symptom, rather than a disease, the initial response to treatment is not always predictive of the long-term outcome.

When a patient is admitted to observation services for CHF, CMS requires that a chest x-ray, pulse oximetry, and an EKG be used to monitor the patient’s progress. These should be documented on the observation record, noting the time each test was performed, to differentiate these from earlier ED or clinic testing.

Asthma
Although asthma presents less of a diagnostic challenge to the physician than either CHF or chest pain, it often proves refractory to initial treatment and this factor is what makes asthma a prime candidate for observation services. Physicians monitor not only the causes and etiologies involved, but also the patient’s response to treatment modalities.
Initially, CMS required nebulizer treatments as part of the observation scenario for asthma patients. It reversed this decision in the November 30, 2001, Federal Register, when clinicians argued that nebulizer treatments were not diagnostic procedures. It is likely that the initial rule had intended to monitor the patient's response to treatment as much as diagnostic efforts.

In the revised directions, CMS requires documentation of the peak expiratory flow rate (PEFR) using code 94010, or 94760, pulse oximetry.

There is some argument about using the code 94760, status indicator N, which isn't billed by many hospitals. In truth, this code should always be reported when the procedure is performed, since status indicator N codes can be used to validate transitional and outlier payments even though they are packaged into the E/M level of service for the visit. Facilities should update their chargemasters to reflect this procedure, as well as other CPT codes with status N indicators.

The importance of time reporting
Amid considerable argument from commenters, CMS stuck to its guns and insisted that an eight-hour period is the minimum acceptable for separate payment under APC 0339. Observation periods that do not meet the time criteria are packaged into the E/M level of service from the ED clinic as they have always been since the August 2000 implementation of OPPS.

There is some method to this madness. CMS sets these time requirements in accordance with its estimation of what is appropriate utilization for observation cases.

In effect, CMS feels that observation should appropriately last approximately eight to 24 hours, and that data supports this. So that is what they're going to pay for. If you cannot meet the time criterion, anything less will be paid by the original ED or clinic E/M, and anything over 24 hours will be packaged into the observation APC payment.

Many commenters have argued that even a high-end E/M level doesn't begin to cover the resources expended and personnel who attend to a patient who must be observed for any additional period of time. The same is true for longer periods of observation. For example, for an 18-hour stay, the separate reimbursement will be insufficient to cover the costs of prolonged observation. All clinical arguments to the benefits of shorter or longer periods of time were firmly denied.

Meeting the criteria for observation time
There are no guidelines in the final rule to determine how hourly increments should be rounded, although the Medicare Hospital Manual states in Section 455 that observation hours should be rounded to the nearest hour. Charges for a portion of a “final hour” of observation should be pro-rated appropriately. This would give a much better assessment of the actual resources used. Don’t let the eighth hour of observation services be rounded up to meet the minimum requirement, however.

Some leeway is granted to facilities in that the termination of observation time occurs when the nurse picks up the doctor’s order to discharge the patient. Facilities should develop an observation documentation form that records both of these times clearly. This may become part of an audit criteria for observation reporting, and it seems likely that huge discrepancies in the two times will be addressed by CMS in future versions of the rule.

Some patients just don’t need eight hours
CMS reiterated that observation periods of fewer than eight hours’ time would be packaged into the E/M level for the ED or clinic visit as they have been since August of 2000. Does that mean that these services should not be reported? Absolutely not.

Up until the implementation of the new observation APC, hospitals were instructed to report observation charges on a separate line on the UB-92, using revenue code 762. No CPT code is necessary, but the number of hours of observation must be stipulated
as well as the charges incurred. The appropriate emergency or clinic E/M level must be reported in addition to the observation.

There will be no separate reimbursement for these services, but the information is critically important if CMS is to evaluate whether to change the time requirement for observation reimbursement. This is especially true in the case of observation for asthma, where many commenters had criticized the eight-hour requirement. In the final rule CMS states

“However, we will closely monitor the impact of the 8-hour time requirement and, if appropriate, consider changes for a future proposed rule.”

The only way they’re going to be able to do this is with data.

There is also a chance that the additional charges may qualify the facility for some outlier payments, especially if these episodes occur frequently. Be sure to capture all ancillary procedures performed during this period as well, whether they have their own APCs. In order to improve the reimbursement picture for observation, we must prove both the costs and the efficacy of the services rendered.

CMS hopes the eight-hour time requirement will help facilities develop protocols for the correct use of observation services and improve clinical utilization. This information is critical to the facility as well as to CMS. Accurate reporting of resources and charges will be easily identified and retrieved for analysis by medical staff and the APC committee, to determine best-practice initiatives.

Physician and nursing attendance requirements
CMS also requires that a patient in observation receive further diagnostic workup and nursing care and monitoring during the observation period. This clearly differentiates the observation patient from one who is admitted overnight as a matter of course, where, to quote the final rule: “they are placed in a bed on a nursing unit, with vital signs taken every 4 hours. This is not a service we recognize as observation.”

The use and documentation of more aggressive monitoring and treatment is paramount to validating the use of observation services. Facilities should develop standards of care for each type of observation patient and documentation tools to prove that these measures have been taken.

Observation forms should be designed to verify the following:

- Risk stratification forms used to determine the patient’s need for observation services (discussed in a later section of this report)
- Physician documentation forms
- Nursing documentation forms

Physician requirements:
Physicians are required to provide an admission note and a discharge note for all observation patients. These should be timed and signed by the attending physician and there should be room for progress notes on the patient’s condition where appropriate.

A section of these forms should provide space where physicians can report the results of each testing requirement for the conditions for which observation services have been implemented. The form should also allow room for comments, where appropriate, on the results of these tests and how they have affected decision making.

Nursing documentation
The nursing documentation should reflect active monitoring of the patient’s condition. More important, it should contain the admission and discharge times, by which observation time reporting is actually based.

Separate forms should be provided for both physicians and nurses, although, arguably, standard nursing notes or flow sheets may be adequate. But if observation is to be seen and paid as a separate entity, the appropriate data should be clearly identifiable to coders and billers to simplify verification of the claim, and will easily stand up to audit in the future.

The next story, “Documentation requirements,” should help to illustrate why a separate set of observation forms could be a very good idea.
Diagnosis-A note for coders
With only three conditions approved for observation services, there are many codes available that qualify for separate reimbursement. But as every coder knows, sometimes a serious sign or symptom such as chest pain is transformed into another diagnosis after study. What to do when the chest pain is later found out to be gastroesophageal reflux disease (GERD)?

If the coder follows correct coding guidelines, the GERD must be listed as the principle diagnosis for the visit. Fortunately, CMS doesn’t require that the condition that initiated the observation services be the principle diagnosis on the bill. Chest pain is a valid secondary diagnosis in the outpatient setting, and should be coded in addition to the GERD. It is also correct to list the chest pain in the admitting diagnosis field where appropriate. This meets the requirement for “medical necessity” for observation. Physician query is always appropriate when a diagnosis is unclear, but it cannot be used simply to validate the need for observation services. No matter what the final diagnosis indicates, the claim will be denied unless one of the approved diagnoses appear on the bill.

Documentation of ancillary procedures
One of the benefits of having space on the observation document for ancillary tests is that it can be clearly demonstrated that 1) these tests were performed during the observation period, and 2) that they were used to determine the patient’s need for further treatment or to clear the patient for discharge. This information is what CMS will be looking for when it gets around to auditing these episodes in the coming months. The physician document for observation should contain space where each of these tests can be checked off, with space for comments as to how they affected patient care and medical decision-making.

Admission requirements and notes
Every time a patient is admitted to observation, an APC for an ED visit or a clinic visit (APCs 0610, 0611, 0612, 0600, 0601, and 0602) must accompany APC 0339 on the same bill. This means that a physician must be on hand to validate the need for observation each time a patient is admitted to the service.

Facilities that permitted direct admission for observation from a provider’s office in the past must examine this policy and find the means to comply with the new requirements. Hospitals may require that all observation patients be processed through the emergency room or clinic first if they wish to continue to provide observation services for outside providers, or require that the attending physician be physically present at the hospital when a patient presents for direct admission to observation. A hospitalist or house physician might be assigned to meet the patient and perform a low-level assessment so that the E/M can be billed along with the observation services. But however it is done, a physician must be on hand to check the patient in, and this must be reflected in the facility charges.

A dated and timed admission note must be written for each observation episode, and appropriate tests must be ordered, as well as instructions given for monitoring the patient during observation.

Interim progress notes
CMS backed off somewhat on its stance that progress notes should be written for observation patients. In the November 30, 2001, final rule, CMS amended its requirements to read:

“With regard to writing progress notes, we wish to emphasize that the requirement is only to write ‘appropriate’ progress notes.”

The rule goes on to say CMS is aware that sometimes only an admission or discharge note is really necessary, but adds that changes in the patient’s condition, and more important, the “length and complexity of care provided,” require further documentation.

This last statement can be viewed as the proverbial...
word to the wise. It seems clear that the lack of a progress note for a patient who is pushing the envelope of the approved time period for observation care (24 hours or more), will be an instantaneous red flag to an auditor.

Discharge notes
Discharge notes should summarize the patient’s progress and be dated and timed appropriately. If no progress notes have been written, this summary should be as comprehensive as possible.

The observation period ends when the nurse has removed the order for discharge from the chart. Nursing documentation should clearly indicate the time and date at which the order was removed, either by countersigning the physician’s document, or on a separate nurse’s note.

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Risk stratification

"With regard to documenting the use of risk stratification, we did not mean to require any extra documentation in the medical record. We just wish to put physicians and hospitals on notice as to what type of medical record evidence reviewers will use when reviewing claims for observation."—Federal Register, November 30, 2001

The Federal Register goes on to say that the manner in which risk stratification documentation is made is entirely at the physician’s discretion. Unfortunately, the big hole in this premise lies in the understanding that physicians are in agreement as to what type of documentation is necessary, and that all physicians naturally document everything they think and do.

Any coder can tell you this is an unlikely scenario. Consequently, as CMS notifies us that reviewers will be looking for this evidence, facilities must decide whether to develop risk stratification guidelines, adopt those that are commercially available, or simply to “wing it” and hope for the best.

What is risk stratification?
Risk stratification is a set of criteria by which a physician can calculate at how much risk a patient would be if he or she was treated and released without further monitoring and treatment. These criteria are similar to the “severity of illness criteria” with which most health information professionals and clinicians are familiar.

Risk stratification is widely used by managed care organizations to estimate costs of future treatment for certain subsets of patients. Managed care targets preventive services to these patients, in the hope of offsetting future costly illnesses. Risk stratification also determines best-practice models or protocols, in essence, those methods of treatment that are most effective in treating certain diseases.

Managed care has used risk stratification to develop means of dealing with chronic illnesses. At the level of primary care, the physician assesses factors such as patient history, environmental and social situation, race and ethnicity, age, sex, and other factors to project how the course of a chronic illness will run. These criteria take thousands of patients into account, and use elaborate software modeling techniques to determine how likely a patient is to respond to certain treatment modalities, and what life changes the primary care physician can suggest/implement that may prevent the illness from worsening. For instance, a risk stratification model for prevention of acute exacerbation of a chronic CHF might include the following factors:

- Over 65 years old
- Obesity
- Hypertension with diastolic dysfunction
- Noncompliance with medications
- Poor dietary habits

Similar factors can be used to determine risk stratification for patients for whom observation services are being considered, with the continued on p. 10
inclusion of the diagnostic factors indicating the severity of the disease episode and patient's response (or lack thereof) to current treatment modalities.

Developing risk stratification guidelines
CMS did not clearly define risk stratification as a requirement for OPPS observation services in 2002. Therefore, the use of risk stratification criteria is very much like the situation used to develop facility leveling guidelines as defined by the April 7, 2000, Federal Register, in which the onus for developing these guidelines was left to the individual facility. This means there is going to be a wide variation in criteria used to determine the need for observation services.

Facilities have been given two choices: They can adopt commercial risk stratification products (CMS points to those developed by QualCare) or they can develop criteria independently. Commercial products come with a cost, and it may be equally effective for the facility to develop its own criteria, which can be ratified and adopted by medical staff and the APC committee, and filed for use in the emergency room, clinic, or with the hospitalist.

Although CMS states it does not require separate documentation of risk stratification, the facility may wish to develop a checklist that can be quickly filled in, signed and dated, and attached to the patient’s chart (see the end of this section for an example). This document serves as proof-positive to the reviewer that risk stratification criteria were used, and defend the billing of the code when all other criteria are met.

A job for the APC task force
Who should be involved in this process? Certainly, this is a job for the ongoing APC task force, which should include clinicians and nurses as well as health information and financial personnel.

Clinical support
It is likely that medical staff from your ED and other outpatient areas, as well as emergency and clinic nurses, are already represented on your APC task force. For this project, it will also be necessary to invite cardiology and pulmonary specialists, as well as nurses from whatever units your observation patients are likely to be transferred. You will need their expert advice on the criteria that you will choose.

The first determination will be to decide whether to adopt a commercial product or develop in-house standards. (Your state peer review organization may be able to provide some guidelines.) If you decide to develop your own guidelines, the clinicians must decide what types of criteria to measure and how this will be done. You can use a point system, similar to those that are sometimes used to determine facility level of service, although the factors measured will be different to a large extent. In the case of risk stratification criteria, these factors will measure the risk at which a patient is placed:

- Demographic factors, such as age, sex, ethnicity, life style, etc.
- Patient history
- Presenting signs and symptoms
- Diagnostic testing results
- Response to treatment

Clinicians may wish to weight certain criteria at a higher risk level than others.

Demographic factors
In prevention or long-term treatment of a chronic disease, demographic factors play a greater role than they do in the emergency situation. Some of these factors do, however, indicate the need for increased concern and may specify a need for further surveillance, especially when multiple factors exist.

For example, in the case of asthma, African Americans have an 11% prevalence of acute asthma, and Hispanic/Puerto Ricans have a 6% prevalence. These factors, coupled with smoking history, age, and sex, might indicate a higher-risk patient than a Caucasian (3% prevalence) with no smoking history, who is male, and between the ages of 18–54, during which fewer males are afflicted with acute episodes of
asthma than females. Other social factors, such as socio-
economic information, or whether a patient lives alone,
may be important in this area of risk definition.

Patient history
A thorough patient history is needed to complete
the picture of the risk. The number of hospital visits
a year for the same symptoms may indicate a re-
fractory condition. Factors, such as the duration of
time between hospitalizations and whether a patient
has ever been intubated, contribute information nec-
essary in the assessment of risk. Additionally, the pre-
ence or absence of other chronic diseases may indicate
a higher or lower risk factor for a particular patient.
Chronic obstructive pulmonary disease, sarcoidosis,
HIV, cystic fibrosis, or a history of heart disease can
be used to justify increased risk in our asthma exam-
ple. Medication compliance, animal exposure, weather
extremes, recent asthma medication use, steroid
use, and current symptom duration all factor into
the risk assessment picture.

Presentation of symptoms
The initial clinical assessment provides immediate
indication of risk, in that it will qualify and quantify
observable symptoms. The degree of dyspnea and
the ability of the patient to speak are clear indicators
disease severity. Other symptoms that may be
present, such as chest pain, are notably important.
These factors are likely to be noted in the physical
examination portion of the patient’s record, but if a
separate document is used for risk stratification, any
number of symptom combinations substantiate the
need for further treatment. Clinicians may choose to
weight the presenting signs and symptoms higher
than demographic or historical data.

Diagnostic testing results
Again, using asthma as an example, testing reinforc-
es the diagnostic picture, and the results of those
tests should be noted for reference. They may be
weighted, as above, to reflect a higher level of risk
than social and environmental factors. Pulse oximetry
tests should show whether the patient is hypoxic, and
also the level of hypoxia can be weighted for risk,
with more severe states weighted higher. Arterial
blood gas may indicate hypoxemia or hypercarbia,
and these should be documented. Peak expiratory
flow is one of the tests that CMS has deemed defin-
itive, and should be repeated during the observa-
tion period, but in the ED, or upon admission to
observation, an initial reading should be taken.

Remember, peak flow is effort-dependent, so the re-
sults are somewhat suspect. To be completely accurate,
a baseline reading should be available. The risk
stratification criteria should note whether baseline
readings are available, and also that efforts have
been made to locate previous medical records for
comparison when this is appropriate. Chest x-rays
may provide further data, and an EKG can indicate
tachycardia or other evidence of strain on the car-
diovascular system.

Response to treatment
Although this is probably going to be documented in
the ED record or by the hospitalist or clinic physician,
a narrative section on the risk stratification checklist
may be a helpful reminder to physicians and a good
defense in an audit. The patient’s response to med-
ications and treatments should be noted in detail,
and a brief summary of current status leading to the
decision to admit to observation is the facility’s best
proof of the effective use of the criteria. The docu-
mentation checklist on p. 12 is a sample of what a
risk stratification checklist might look like. The weight-
ing values and numerical assignment of points are
purely arbitrary, and the clinicians on your task
force should be the final arbiters of how the check-
list should be applied.

Risk stratification and chest pain
Risk stratification in the patient with chest pain differs
from that of a patient with asthma because no true
diagnosis may have been defined when the patient
is admitted for observation services. Chest pain is a
symptom rather than a diagnosis and may indicate
any number of different conditions with varying
degrees of severity and threat to life. In general, risk
stratification for chest pain endeavors to determine
the probability of cardiac involvement as a cause for
the pain. The social/historical factors weigh higher
than in the case of the asthma patient in determining
the need for further observation for
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some type of cardiac event. When the EKG and laboratory results can confirm a diagnosis, the patient is admitted or transferred for further care.

In many cases, facilities have chest pain protocols in place based on best practice models that have proven effective in the diagnostic process as well as early management of the cardiovascular event. In cases where certain risk factors are present, however, and there is no definitive information provided by EKG and laboratory data, the following risk stratification can be used to indicate the need for further observation services.

Many common laboratory indicators for myocardial infarction do not show definitive changes until the event has evolved over a period of several hours. Levels for creatinine phosphokinase fractionation and for Troponin 1 require three to four hours to rise to levels that can be considered definitive. Since any single assay is only sensitive to about 34%, observation may be indicated on symptomatic and historical data alone.

CHF and risk stratification

Assessment of risk in patients with CHF presents a different challenge from either asthma or chest pain. Observation for asthma is targeted toward monitoring the patient’s progress during the attack and improving the outcome without the necessity of further hospitalization. In chest pain, the clinician seeks to determine whether the pain is a symptom of an evolving cardiac event or is due to some other non-life-threatening cause. CHF is a symptom of many different disease processes; however, the episode of heart failure is life-threatening in itself. Physicians will be monitoring care and working to improve the outcome of the attack and, at the same time, to define the cause of the failure and identify those factors that are exacerbating the condition.

The morbidity and mortality associated with CHF is high. It is listed as a cause of death (primary or secondary) in approximately 250,000 patients per year. The incidence of heart failure increases dramatically with age. It is the most common diagnosis among hospitalized patients over the age of 65. Some of the causes of CHF are reversible or treatable, and a basic history and physical examination will reveal risk factors or precipitants. One of the indicators that will probably be the most widely used to determine the need for further observation among patients with CHF (as opposed to direct admission) will be the patient’s response to diuretic medications. Document these factors to define the level of risk and the need for observation.
Billing for observation services

Billing for G0244
Reconciling the method for coding and billing observation services in a way that is consistent with coding and billing for other payers presents a challenge for facilities working to comply with the OPPS rule. In general, facilities must develop this method to accurately reflect observation utilization.

Billing by the hour may be the optimal method for facilities with a special observation unit handling a variety of medical conditions besides those approved by OPPS.

This will permit a consistency of charges that can be billed to any payer as needed. For those facilities that use observation services on an as-needed basis, and that may observe patients in a variety of departments within the facility, billing in a lump sum by cost center may be more efficient.

Hourly billing requires an update of chargemaster codes with charges attached by the hour. Most charges are incurred during the first hour the patient is observed. This hour is billed at the highest level, with an hourly monitoring charge for each hour afterward at a lower level.

The amount billed in an eight-hour observation period, for example, may be equal to or greater than the total amount that OPPS will pay. As we are all aware, the amount billed is often greater than the amount that is eventually paid. However, unless we furnish CMS with current data that accurately assess the resources used, we may expect little to no adjustment of fees in the future.

Hourly billing for observation under OPPS produces the following CDM entries:

<table>
<thead>
<tr>
<th>Cost center</th>
<th>HCPCS</th>
<th>Description of services</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>762</td>
<td>G0244</td>
<td>Observation 1st hour</td>
<td>$150</td>
</tr>
<tr>
<td>762</td>
<td>G0244</td>
<td>Observation 2nd hour</td>
<td>90</td>
</tr>
<tr>
<td>762</td>
<td>G0244</td>
<td>Observation 3rd hour</td>
<td>90</td>
</tr>
</tbody>
</table>

Risk stratification checklist
Congestive heart failure

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Presence</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender/Age</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Aged 70 or older</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Aged 60–69 year</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ages 40–59 years</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medical history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous cardiovascular disease</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Previous episode of CHF documented</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Recorded left ventricular dysfunction</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Renal insufficiency</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Social factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>History of smoking</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sedentary lifestyle</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Inadequate social support for outpatient treatment</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Non-compliance with medical treatment</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Presenting symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspnea</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Orthopnea</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Reduced exercise tolerance</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lethargy/fatigue</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nocturnal cough</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ankle swelling</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Anorexia</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Physical examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tachycardia</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Elevated jugular venous pressure</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Crepitations or wheeze</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Third heart sound</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Arrhythmias</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hypotension</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Objective testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG, evidence of arrhythmia/damage</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Chest x-ray, infiltrate</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Results of diuretic treatment (note drug and dosage)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Admit to observation
Date: _______ Time: ______ Signature: ____________________

The Observation Report
The Observation Report

<table>
<thead>
<tr>
<th>Cost center</th>
<th>Description of services</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>762 G0244</td>
<td>Observation 4th hour</td>
<td>90</td>
</tr>
<tr>
<td>762 G0244</td>
<td>Observation 5th hour</td>
<td>90</td>
</tr>
<tr>
<td>762 G0244</td>
<td>Observation 6th hour</td>
<td>90</td>
</tr>
<tr>
<td>762 G0244</td>
<td>Observation 7th hour</td>
<td>90</td>
</tr>
<tr>
<td>762 G0244</td>
<td>Observation 8th hour</td>
<td>90</td>
</tr>
<tr>
<td>762 G0244</td>
<td>Observation</td>
<td>$780</td>
</tr>
</tbody>
</table>

APC 0339  G0244  Medicare assignment:  $348.69

Other charges, including an ED or clinic E/M level, and required observation testing, would be billed along with the observation charges.

Non-Medicare observation

A second set of observation codes can be entered into the chargemaster and keyed to the non-Medicare payer:

<table>
<thead>
<tr>
<th>Cost center</th>
<th>HCPCS</th>
<th>Description of services</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>762 99217</td>
<td>Observation 1st hour</td>
<td>$90</td>
<td></td>
</tr>
<tr>
<td>762 99217</td>
<td>Observation 2nd hour</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>762 99217</td>
<td>Observation 3rd hour</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>762 99217</td>
<td>Observation 4th hour</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>762 99217</td>
<td>Observation 5th hour</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>762 99217</td>
<td>Observation 6th hour</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>762 99217</td>
<td>Observation 7th hour</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>762 99218</td>
<td>Observation 8th hour</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>762 99217</td>
<td>Observation discharge</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total charge</td>
<td>$780</td>
<td></td>
</tr>
</tbody>
</table>

Billing for Medicare patients who do not meet the eight-hour criteria or for those with diagnoses other than the three approved by CMS for separate payment, can and should appear on the patient's UB-92, even though they will elicit a line-item denial.

This data will give CMS additional information needed to either approve additional diagnoses for coverage under APC 0339, adjust the fee schedule, or evaluate the effectiveness of the time period requirements.

For these cases, follow the directions given in calendar year 2001 when CMS was collecting information about observation charges. The HCPCS code was not required:

Cost center  Description of services  Charges
762 G0244 Observation 10 hours  $840

Again, those charges for the ED or clinic E/M, as well as the required tests, must also appear on the same bill along with the observation. The same theory applies for those observation cases that don’t meet the Medicare separate payment criteria. And again, the HCPCS code need not be recorded:

Cost center  Description of services  Charges
762 Observation 5 hours  $420

Naturally, your organization will not be paid separately for this; payment will be included in the clinic ED visit.

Billing by cost center

Facilities with special observation units have an accurate assessment of the total charges for a patient with a particular diagnosis who is observed for a specified period of time. They may choose to bill the charges in a lump sum, which may or may not be adjusted for varying time periods, but may also be billed consistently to all payers. A second set of chargemaster entries must be made to define Medicare observation services, keyed to the approved diagnosis codes, and billed only when the criteria for length of time is met.

Cost center  HCPCS  Description of services  Charges
762 G0244 Observation 10 hours  $840

This is a great deal of programming for those who add and delete charges and codes from the CDM. A facility may not wish to do this much reprogramming. The solution may be to “soft code” observation services in the HIM department instead of hard-coding the charges in duplicate. They can be passed to the billing system through coding data entry.

Soft coding observation also ensures that the documentation requirements for observation are met, and that all the necessary testing and time requirements have been met before observation is billed. Be sure to involve the health information manager in your APC task force meetings on observation services.

The Observation Report
Final thoughts

It is incumbent on us, as facilities offering observation services, to provide the CMS committee on observation services with the data necessary to improve and fine-tune the observation process. Even in its third calendar year, OPPS is still a work in progress. It will not evolve into a completely fair and cost-effective system without the input of those on the frontline of patient care.

Will separate observation reimbursement for these three diagnoses net hospitals the kind of reimbursement that accurately reflects the time spent and the resources used for the service? The question remains to be answered through the data collected during the first year of the implementation of this APC. It should be noted, once again, that the OPPS program is still a work in progress.

Will maintaining a separate observation unit benefit facilities? It is much less likely that the reimbursement from the three diagnoses allowed will be enough to offset the overhead of keeping a separate observation unit open and staffed.

Private payers may make up some of the deficit, but it seems unrealistic to believe that monies from Medicare will make this type of unit a worthwhile use of the facility’s health care dollars. Since CMS assures us it doesn’t matter where in the hospital the patient receives observation care, it seems that CMS thinks the specialized unit is irrelevant.

Facilities must develop strategies to use, document, and bill observation services correctly under the final rule. Facilities must also collect the data necessary to provide CMS with an evaluation of the rule and its recommendations for revision or expansion.

Even when the time constraints haven’t been met for the three diagnoses allowed, or when another clinical scenario warrants the use of observation services, those services should appear on the UB-92 along with the charges accrued under the proper revenue code. There might even be a chance of getting paid for some of these services.

According to Program Memorandum A-01-133, dated November 20, 2001, “If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPS) as well as for future rate setting.”

Since observation that does not fall under APC 0339 is considered packaged into the ED or outpatient department visit, the costs reported on the claim may be eligible for some reimbursement. At the very least, the data can be used to research the need for the expansion of the observation diagnosis list, the time requirements, or adjustments in the reimbursement rate. Facilities should be prepared to submit documentation of the reasons for observation, the services rendered, and the outcome, upon request by CMS.

The APC concept is based on resources and personnel and on strategies for the correct utilization of facility resources. We stand in a unique position to determine where the real needs lie, and to assist with the development of a comprehensive plan to meet those needs. The data collected during the next year about the effectiveness of this new APC are crucial to the development of future policies regarding observation services. Facilities that take an active role in this process will have a better chance of helping to determine the future of this vital service.

Illustration by Dave Harbaugh

“The final rule from the Federal Register is number one on the best-seller list. If you order a copy they’ll throw in a tape of the Survivor series.”
Jugna Shah, MPH, is president of Nimitt Consulting, St. Paul, MN (www.nimitt.com), and contributing editor to HCPro’s family of APC publications. She recommends that you have the following in your APC tool kit.

**Relevant Federal Registers:**
- March 1, 2002, Federal Register and Addenda: www.access.gpo.gov/su_docs/fedreg/a020301c.html
- November 30, 2001, Federal Register: www.access.gpo.gov/su_docs/fedreg/a011130c.html
- November 13, 2000, Federal Register: www.access.gpo.gov/su_docs/fedreg/a001113c.html
- April 7, 2000, Federal Register: www.access.gpo.gov/su_docs/fedreg/a000407c.html

**Official program memos, manuals, and documents from CMS**
- For the Hospital Manual (#10): www.hcfa.gov/pubforms/program.htm
- For Program Memos (PM) list: www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm
- Pull down all PMs for 2002 (A-02-025 and A-02-026 are critical), plus all relevant ones for 2001 and 2000 listed: www.hcfa.gov/medlearn/refopps.htm
- For Blue Cross/Blue Shield initial training manual on OPPS: www.hcfa.gov/medlearn/oppstraining.htm
- APC Advisory panel meeting minutes and agenda: www.hcfa.gov/medicare/apcover.htm

**Important Web sites**
- www.hcfa.gov/medlearn/refopps.htm (one-stop reference for all information related to OPPS since the beginning)
- www.hcfa.gov or www.cms.gov
- Federal Register: www.gpo.gov/su_docs/aces/aces140.html (scroll down to browse the whole list of Federal Registers by year)
- Local Medical Review Policies (LMRP): www.lmrp.net
- Society of Nuclear Medicine (list of radiopharmaceuticals): www.snm.org
- Food and Drug Administration: www.fda.gov

**Coding resources (CDM, HIM/MR, Clinical Departments)**
- CPT-4 Professional and CPT Assistant
- HCPCS coding manual
- ICD-9 coding manual and Coding Clinic
- Hospital Manual #10 (link listed above)
- Fiscal Intermediary Manual
- LMRPs
- All relevant PMs since the beginning of OPPS (link listed above)
- Addenda from latest OPPS rules (listed above)
- National Correct Coding Resources and Web links for your APC/OPPS tool kit continued on p. 4
Resources continued from p. 16

Initiative Edits (order from NTIS)
- OCE editor in the APC Grouper (order from NTIS)

• Billing resources
  - Hospital Manual #10 (link listed above)
  - All relevant PMs (link listed above)
  - PC Print Software
  - Other OPPS software (either CMS public domain or commercial)
  - LMRPs
  - National Correct Coding Initiative Edits (order from NTIS)
  - OCE editor in the APC Grouper (order from NTIS)

6. E-mail list serves
  - APC Monitor: www.himinfo.com/apcezine/index_new.cfm
  - OPPS list serve from CMS: OP-PPS-L@LIST.NIH.GOV

• Publications/Newsletters from HCPro (find online at www.himinfo.com)
  - Briefings on APcs
  - APC Answer Letter
  - APCs Weekly Monitor

• APC audioconferences
  - HCPro’s audioconferences keep your whole task force up to date. Go to www.hcpro.com/audio.cfm for upcoming audioconferences or to purchase tapes of past programs.
  - CMS audioconferences—straight from the source
Diagnosis codes by condition required to bill the observation APC

Asthma diagnosis codes
• 493.01 Extrinsic asthma with status asthmaticus
• 493.02 Extrinsic asthma with acute exacerbation
• 493.11 Intrinsic asthma with status asthmaticus
• 493.12 Intrinsic asthma with acute exacerbation
• 493.21 Chronic obstructive asthma with status asthmaticus
• 493.22 Chronic obstructive asthma with acute exacerbation
• 493.91 Asthma, unspecified with status asthmaticus
• 493.92 Asthma, unspecified with acute exacerbation

Chest pain diagnosis codes
• 411.1 Intermediate coronary syndrome
• 411.81 Coronary occlusion w/o myocardial infarct
• 411.0 Postmyocardial infarction syndrome
• 411.89 Other acute ischemic heart disease
• 413.0 Angina decubitus
• 413.1 Prinzmetal angina
• 413.9 Other/unspecified angina pectoris
• 786.05 Shortness of breath
• 786.50 Chest pain, unspecified

CHF diagnosis codes
• 391.8 Other acute rheumatic heart disease
• 398.91 Rheumatic heart failure (congestive)
• 402.01 Malignant hypertensive heart disease with congestive heart failure
• 402.11 Benign hypertensive heart disease with congestive heart failure
• 402.91 Unspecified hypertensive heart disease with congestive heart failure
• 404.01 Malignant hypertensive heart and renal disease w/CHF
• 404.03 Malignant hypertensive heart disease and renal disease w/CHF and renal failure
• 404.11 Benign hypertensive heart and renal disease w/CHF
• 404.13 Benign hypertensive heart and renal disease w/CHF and renal failure
• 404.91 Unspecified hypertensive heart and renal disease w/CHF
• 404.93 Unspecified hypertensive heart and renal disease w/CHF and renal failure
• 428.0 Congestive heart failure
• 428.1 Left heart failure
• 428.9 Heart failure, unspecified