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What is OBSERVATION (OBV) status?
OBV status was introduced by the Centers for Medicare & Medicaid Services (CMS) to deal with patients who do not fulfill CMS criteria for inpatient admission but who the treating physician is not comfortable sending home. The expectation is that OBV patients will stay for fewer than 24 hours during which time a decision will be made to either admit the patient to the hospital or discharge the patient.

Is OBV new? Why has its use increased?
OBV services have been in place for several years, but usage has increased as CMS has emphasized outpatient services as positive alternatives to traditional inpatient admissions of short stay (1-2 days) duration. CMS considers many short stay admissions as medically unnecessary for inpatient reimbursement and has denied payment for them in increasing numbers, especially since the advent of the Recovery Audit Contractors (RAC) who review both hospital and physician professional service claims.

Is an OBV patient an inpatient or an outpatient?
According to CMS, OBV patients are OUTPATIENTS even if they are on a general medical floor.

How long can a patient be in OBV status?
In general, the disposition of OBV patients—admit to inpatient or discharge—should be determined within 24 hours. On occasion this can be extended to 48 hours but such patients will be scrutinized by CMS and other payers. Around the country, hospitals that have developed the ability to manage OBV patients efficiently have average LOS as low as 17 hours; at JSUMC our current average LOS for OBV patients is 36 hours.

What patients are most appropriate for OBV status?
In general there are no specific diagnoses that require OBV status. However, the most common indications for OBV status include:
- Low risk chest pain
- Mild CHF
- TIA/Syncope
- Abdominal Pain
- Hypovolemia/Dehydration
- Mild COPD or Asthma

What is a CDU?
A Clinical Decision Unit or CDU is a physical location within the hospital in which patients placed in OBV status can be managed efficiently. The name derives from the essential purpose of OBV status, that is, to make a clinical decision as to whether the patient can safely go home or whether the patient requires inpatient hospitalization.

Why cohort patients in a CDU rather than have OBV patients intermixed with general medical patients?
There are several advantages to clustering OBV patients. First, clustering patients in a unit where staff understands the imperative to accomplish diagnostic testing quickly will allow the most
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efficient means to arrive at the key decision: does this patient need inpatient hospitalization. Second, the hospital’s reimbursement for OBV patients is limited and excessive Length of Stay (LOS) for this large group of patients could have disastrous consequences to the hospital’s fiscal viability. Finally, the efficiency of physician billing is directly dependent on the correlation of your bills with the patient’s actual status in the hospital. Clustering patients on a single unit will make it more obvious that a particular patient is in OBV status.

Will all OBV patients go to the CDU?
We hope that most patients placed in OBV status will be in the CDU, with a few standing exceptions: TIAs will continue to be managed on the neurosciences unit on NWP 5, Pediatric patients on Pediatrics and Obstetric patients on the Obstetric floor. Obviously when the census is high bed availability may dictate that some OBV patients go wherever the beds are.

What do I do if I am not sure if my patient should be an inpatient or OBV patient?
Case management and our physician advisors can help sort this out. If they are not available it is best to err on the side of placing a patient in OBV. Conversion from OBV to inpatient is expected in a significant percentage of patients—the purpose of OBV is to allow time for an admit or discharge decision—but changing from inpatient status to OBV may be extremely problematic and cause significant billing issues, especially for Medicare patients.

What is Medicare Condition Code 44 and how might a physician be impacted?
In some instances, a physician may order a patient to be admitted as an inpatient, but upon subsequent review by the hospital’s case manager and physician advisor, it is determined that an inpatient level of care does not meet Medicare’s admission criteria.

The hospital’s Utilization Review (UR) representative will contact the physician responsible for the care of the patient (attending) to discuss this conclusion. If the attending agrees, and the patient has not yet left the hospital, the case can be converted to outpatient status and billed with a “Condition Code 44” indicating an allowable conversion for reimbursement.

Remember, in order for you to be reimbursed, your billing must be concordant with the patient’s status in the hospital. Thus, if a Code 44 applies, and this only impacts Medicare patients, all practitioners must bill using the OUTPATIENT Codes, Place of Service Hospital (Code 22). Bills for Inpatient service will be denied. The attending can order observation services for the patient at the time of conversion to outpatient; and then bill using the outpatient observation codes for any subsequent professional services rendered while the patient is still in a hospital bed.

What about status changes for managed care and other private payers?
Again, changing from OBV to inpatient will not be problematic and changing from inpatient to OBV may be less problematic. Indeed, some companies will deny inpatient stays but be willing to reimburse for an OBV level of care. In such cases, you will be contacted and asked to enter an order to place the patient in OBV. Your role here is crucial: billing cannot occur until the OBV order is in place.
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Why do some hospitals require that OBV patients be managed by ED Physicians or Hospitalists?
The regulations promulgated by CMS about OBV status are lengthy and complex. Observation billing cannot be divided among several billing entities. One interpretation of these regulations is that the initial period of OBV requires “Direct Supervision” by the physician placing the patient in OBV. Since many OBV patients arrive when most private physicians are not on-site, many hospitals have determined that only ED physicians or hospitalists who are in-house 24/7 can therefore provide OBV services. Our task force arranged a meeting with Highmark, the fiscal intermediary for CMS, and they assured us that as long as Direct Supervision was available in the hospital, that service could be part of the hospital’s responsibility and the overall physician component could be accomplished and billed by our private physicians.

Some hospitals may also feel that their medical staffs would not cooperate in assigning the correct status to patients. Ultimately CMS requires an order by the attending physician to either admit a patient or place a patient in OBV status. It is imperative that this be done in a manner consistent with accepted guidelines. We have every confidence that our medical staff will help us “get this right.”

What is the role of the APNs in the CDU?
APNs will assist in the admission process, may write an H & P, will communicate with you to coordinate the evaluation and management plan, keep you informed of test results, help facilitate expedited testing, track results, and assist in the discharge process.

Can APN documentation support my billing?
NO! Unlike resident entries which, if properly linked to your note, can be used to support a higher billing level, chart entries by APNs who are not employed by you cannot support your billing. You may, after verifying their findings, find it helpful to refer to their H&P or progress notes as you dictate your H&P or enter your progress note.

How do I know if my patient is an inpatient, outpatient or OBV patient?
OBV status is indicated on the printed census report; we are working to make sure this is updated in real time.

In Invision, Observation status also appears on the Action screen:

In Soarian, the closed census list will show that the patient is an outpatient; a “walking” stick figure will appear on the patient’s information line. Not all outpatients are Observation patients; the Observation status will be delineated on the patient’s screen header as seen here:
How should primary care physicians bill for OBV services?

1. CMS will pay for initial OBV care billed by only the physician who ordered hospital OBV services and was responsible for the patient during his/her observation care [Note: the order may be entered on your behalf by a resident or entered as a verbal order from you to an APN or RN].

2. For the physician to bill initial OBV services there must be a medical record which contains dated and timed physician orders regarding the OBV services the patient is to receive, nursing notes and progress notes prepared by the physician while the patient received OBV services.

3. When a patient receives OBV services for less than 8 hours on the same calendar date, the Initial OBV Care, from CPT code range 99218-99220, shall be reported by the physician. The OBV Care Discharge Services, CPT code 99217, shall not be reported for this scenario.

4. When a patient receives OBV care for a minimum of 8 hours, but less than 24 hours and is discharged on the same calendar date, the physician is to report CPT code 99234-99236. You cannot also use discharge code 99217.

5. When a patient is admitted for OBV care and is then discharged on a different calendar date, the physician shall report Initial Observation Care, CPT 99218-99220, and CPT Observation Care Discharge code 99217.

6. In what should be a rare event that a patient remains in OBV status for more than 2 calendar dates, the physician shall bill a visit furnished before the discharge date using the codes for subsequent OBV care: 99224-99226.

7. If a patient is Placed in OBV and then a decision to admit is made on the same calendar day, bill only Initial Hospital Care Codes 99221-99223. Do not use the OBV codes.

8. If an OBV patient is admitted to inpatient status by the same practitioner on a subsequent day, the practitioner may bill Day 1: Initial OBV Care 99218-99220 and on Day 2: Initial Hospital Care 99221-99223.

How should consultants bill for OBV services?

Consultants use outpatient codes whenever a patient is OBV status. The place of service should be OUTPATIENT HOSPITAL (Code 22) except for Horizon patients where, in accordance to their recent policy update, the place of service should be Emergency Department (Code 23) [Horizon’s policy is available at: https://services5.horizon-bcbsonj.com/eprise/main/horizon/content/homepage/GeneralMsgnew/gen_2011.8.09_11.40.12].

The consultation codes used by consulting physicians will vary if they have examined the patient in the preceding 3 years. An example of the current Medicare reimbursement amounts for OUTPATIENT HOSPITAL (Code 22) is illustrated below (These examples are current as of
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October 2011 and should be used for informational purposes only as the data is subject to change.

<table>
<thead>
<tr>
<th></th>
<th>99201</th>
<th>99211</th>
<th>99202</th>
<th>99212</th>
<th>99203</th>
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<th>99214</th>
<th>99205</th>
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<tbody>
<tr>
<td>Outpatient: Initial Day (patient NOT seen by group within 3 years)</td>
<td>$27.45</td>
<td>$9.73</td>
<td>$51.96</td>
<td>$26.69</td>
<td>$79.33</td>
<td>$52.21</td>
<td>$134.06</td>
<td>$80.28</td>
<td>$172.14</td>
<td>$113.44</td>
</tr>
</tbody>
</table>

Outpatient: Follow Up or Initial Day (patient seen by group within 3 years)

How will OBV affect reimbursement?
An example of the current Medicare reimbursement fee schedule amounts is illustrated below (These examples are current as of October 2011 and should be used for informational purposes only as the data is subject to change).

Physician Professional Billing Codes Related to Services to Patients in Observation Status (October 2011)

<table>
<thead>
<tr>
<th>(1) Regular Hospital Admission: Initial Day</th>
<th>(2) Subsequent Day Of Care: Inpatient</th>
<th>(3) Observation Service: Initial Day</th>
<th>(4) Observation: Subsequent Day(s)</th>
<th>(5) Observation Patient: Day Of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>99231</td>
<td>99218</td>
<td>99224</td>
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<td>99233</td>
<td>99220</td>
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<tr>
<td>(6) Observation &amp; Discharge On Same Day</td>
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<td>99234</td>
<td>$139.39</td>
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<td>99236</td>
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<td></td>
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</tr>
</tbody>
</table>

(1) 99221-99223 = Inpatient hospital care, Initial Day, evaluation & management, 3 levels. Effective the first full day the patient is in “inpatient” status.

(2) 99231-99233 = Inpatient hospital care, Subsequent Days, 3 levels. Cannot be billed on the same day as a discharge code.

(3) 99218-99220 = Observation care, Initial Day for E&M of patient, 3 levels. (An exception to this is for Empire Blue Cross (EBC) patients, where these codes should be used to bill for subsequent days of care in Observation status pending EBC’s finalization of a “subsequent day” observation service code.)
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(4) **99224-99226** = Observation subsequent day(s). This code should be used when the patient is still being treated in Observation care and a decision has not been made to either admit or discharge the patient.

(5) **99217** = Use to report all services provided to a patient on discharge from “observation status” if the discharge is on other than the initial date of “observation status”.

(6) **99234-99236** = Use to report observation services for patients admitted and discharged from observation on the same calendar day.

Case Examples

- **Example 1** – Patient T presents at Emergency Room at 10:00 am complaining of chest pain. ER physician discusses case with patient’s attending physician, who orders placement of patient in Clinical Decision Unit (CDU) for observation at 11:00 am. Attending physician examines patients in CDU at 2:00 pm, and requests continued observation services. Patient released from CDU at 9:00 pm after 10:00 hours and goes home. Physician bills code 99234 - 99236 for services to patient depending on level of care.

- **Example 2** – Patient R presents to the ED with chest pain. The ED doctor examines patient and phones her primary care physician. PCP verbally orders observation at 6:00 pm Monday. PCP arrives later that evening and confirms orders. Patient remains in observation for 37 hours and is discharged to home at 7:00 am on Wednesday. PCP can bill 99219-99220 (depends on level of care) for first day, and 99224-99226 for Tuesday, and 99217 for Wednesday.

- **Example 3** – Patient Y presents to the ED with chest pain on Monday. The ED doctor examines patient and phone her PCP, Dr. Smith. PCP verbally order observation at 6:00 pm and arrives later to examine patient and confirm orders. On Tuesday, Dr. Smith requests a cardiology consult from Dr. Green, a cardiologist. Patient Y has never been seen by Dr. Green or anyone in his group. Patient Y is in observation for 36 hours and discharged home at 6:00 am on Wednesday.
  - Dr Smith, PCP, can bill code: 99218- 99220 (depends on level of care) for Monday; 99225 for Tuesday; and 99217 for Wednesday if he examines patient that day.
  - Dr. Green, cardiologist, can bill code: 99201-99215 depending on level of care for Tuesday service.

What concerns will my patients and families have?

OBV patients are outpatients from a CMS perspective. Whereas, a single co-pay may apply to an inpatient stay, each test ordered during an OBV stay will have a co-pay. For patients with supplemental policies this may not be a major issue; for those who do not this may be quite significant.
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The second most important impact for your patients is that OBV days do not “count” toward the three day hospitalization requirement that allows for Medicare to pay for extended care facilities.

Where can I get more information?

- If you have questions related to patient care, contact the Case Manager on the unit or the Case Management Department at 732-776-4245.
- If your questions relate to Part B physician billing codes, call Meridian Health Resources at 732-643-4315.
- Contact Information –Part A
  - Provider Customer Contact Center and Interactive Voice Response (IVR)
    - 1-877-235-8048
    - [https://www.highmarkmedicareservices.com/selfservice/index.html](https://www.highmarkmedicareservices.com/selfservice/index.html)
  - Patient / Medicare Beneficiary
    - 1-800-MEDICARE (1-800-633-4227)
- Contact Information –Part B
  - Provider Customer Contact Center and Interactive Voice Response (IVR)
    - 1-877-235-8073
    - [https://www.highmarkmedicareservices.com/selfservice/index.html](https://www.highmarkmedicareservices.com/selfservice/index.html)
  - Patient / Medicare Beneficiary
    - 1-800-MEDICARE (1-800-633-4227).

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