

Billing and Coding Guidelines

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Number

05101, 05201, 05301, 05401,
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Title

Billing and Coding Guidelines for Acute Inpatient Services versus Observation (Outpatient) Services (HOSP-001)

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Excerpt from CMS internet only Manual (IOM): Publication 100-2, Chapter 6, §220.5

A. Outpatient Observation Services Defined

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Hospitals may bill for patients who are “direct admissions” to observation. A “direct admission” occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED). Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly admitted for observation services.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §290, at for billing and payment instructions for outpatient observation services.

B. Coverage of Outpatient Observation Services

When a physician orders that a patient be placed under observation, the patient’s status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an

inpatient (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, §10 “Covered Inpatient Hospital Services Covered Under Part A.

C. Notification of Beneficiary *All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare, and hospitals receive OPPS payments for such observation services. A separate APC payment is made for outpatient observation services involving three specific conditions: chest pain, asthma, and congestive heart failure (see the Medicare Claims Processing Manual, §290.4.2) for additional criteria which must be met. Payments for all other reasonable and necessary observation services are packaged into the payments for other separately payable services provided to the patient on the same day. An ABN should not be issued in the context of reasonable and necessary observation services, whether packaged or paid separately.*

If a hospital intends to place or retain a beneficiary in observation for a noncovered service, it must give the beneficiary proper written advance notice of noncoverage under limitation on liability procedures (see Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, “Financial Liability Protections,” §20, at <http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf> for information regarding Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed). “Noncovered,” in this context, refers to such services as those listed in paragraph D, below.

D. Services That Are Not Covered as Outpatient Observation

The following types of services are not covered as outpatient observation services:

- *Services that are not reasonable or necessary for the diagnosis or treatment of the patient.*
- *Services that 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).*
- *Services that are covered under Part A, such as a medically appropriate inpatient admission, or 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 payment for those diagnostic services. Observation should not be billed concurrently with therapeutic services such as chemotherapy.*
- *Standing orders for observation following outpatient surgery.*

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Claims for the preceding services are to be denied as not reasonable and necessary, under [§1862\(a\)\(1\)\(A\)](#) of the Act.

Billing and Coding Guidelines

Inpatient

Acute, inpatient care is reimbursed under a diagnosis-related groups (DRGs) system. DRGs are classifications of diagnoses and procedures in which patients demonstrate similar resource consumption and length-of-stay patterns. A payment rate is set for each DRG and the hospital’s Medicare

reimbursement for an inpatient stay is based on that rate. Length of stay is not a factor and the hospital receives the same DRG payment whether the patient stays one day or several days.

Medical necessity for inpatient care is based upon and determined by the physician's assessment of the patient's history and physical (H & P) and specific risk factors that are inherent to the beneficiaries' condition at the time of admission.

3-Day Window Payment

3-payment window includes all outpatient diagnostic services and non-diagnostic services "related" to the inpatient stay

- On the date of inpatient admission, or
- 3 days immediately preceding the date of admission

Unless "the hospital demonstrates that such services are not related to such admission"

- Statute does not change the billing of diagnostic services
- Hospitals are able to bill correctly for admission-related outpatient non-diagnostic services without modifying dates on the inpatient claim bundle services on the inpatient hospital claim

ICD-9-CM procedure code dates for non-diagnostic services will be allowed

Inpatient Changed to Outpatient

The hospital Conditions of Participation (CoP) at *42 CFR §482.30* and (CoP) at *42 C.F.R. §482.12(c)*. require hospitals to have a utilization review (UR) plan.

A UR plan is defined as a formal evaluation of the coverage, medical necessity, efficiency, or appropriateness of health care services and treatment plans for an individual patient.

Hospital must ensure all the UR requirements are fulfilled
Hospital UR committees consist of two or more practitioners.

Code 44 Process for Inpatient Turned to Outpatient

1. The determination that an admission or continued stay is not medically necessary may be made by one member of the UR committee, provided the practitioner responsible for the care of the patient either concurs with the determination or fails to present his or her view when afforded the opportunity.
2. In all other cases two members of the UR committee must determine that the inpatient admission is not medically necessary. If two physician members of the UR committee determine the patient's stay is not medically necessary, their decision becomes final
3. CMS has determined that only those licensed practitioners, authorized under state law to admit patient's to the hospital have the authority to change a Medicare patient's status from inpatient to outpatient.
4. The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views before making the determination

- 5 If the UR committee determines the admission is not medically necessary, the committee must give written notification, no later than 2 days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.
- 6 It is the hospital UR committee that changes the beneficiary's status from inpatient to outpatient

Use of Condition Code 44

Condition Code 44 is used when a decision to change a patient's status from inpatient to outpatient has been made. Condition Code 44 requires all of the following components are met:

- 3.4 The change of status is made prior to discharge and while still the patient is still in the hospital.
- 3.5 The hospital has not submitted an inpatient claim for the services.
- 3.6 A physician agrees with the UR committee's decision, and that physician is either the attending physician or the second member of the UR Committee.
- 3.7 The physician's concurrence is documented in the patient's medical record.

Condition Code 44 is not a substitute for adequate staffing or continued education of hospital existing policies and admission protocols that include review of medical necessity admissions and continued stays. Review of admissions may be performed before, at, or after hospital admission

Excerpt from CR 6626, CMS Pub 100-04, Chapter 1, Section 50.3.1:

Patients are admitted to the hospital as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. For more detail, see the hospital Conditions of Participation (CoP) at 42 C.F.R. §482.12(c). In some instances, a physician may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital's utilization review (UR) committee determines that an inpatient level of care does not meet the hospital's admission criteria.

The hospital CoP s require all hospitals to have a UR plan. The hospital must ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stays are fulfilled as described in 42 CFR §482.30. The CoP standards in 42 C.F.R. §482.30 of the regulations are comprehensive and broadly applicable with regard to the medical necessity of admissions to the hospital and continued inpatient stays. The conditions for the use of Condition Code 44, as stated in section 50.3.2 below, require physician concurrence with the UR committee decision. For Condition Code 44 decisions, in accordance with 42 CFR §482.30(d)(1), one physician member of the UR committee may make the determination for the committee that the inpatient admission is not medically necessary. This physician member of the UR committee must be a different person from the concurring physician, who is the physician responsible for the care of the patient."

Excerpt from CMS Publication IOM 100-04, the Medicare Claims Processing Manual, Chapter 1, Section 50.3.2:

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. *The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;*
2. *The hospital has not submitted a claim to Medicare for the inpatient admission;*
3. *A physician concurs with the utilization review committee's decision; and*
4. *The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.*

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x bill type and outpatient services that were ordered and furnished should be billed as appropriate.”

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim.”

One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in 42 C.F.R. § 482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status

**Excerpt from CMS internet only Manual (IOM)
CMS Publication 100-08, Chapter 6, Section 6.5.3
DRG Validation Review**

The contractor shall perform DRG validation on PPS, as appropriate, reviewing the medical record for medical necessity and DRG validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and

reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

NOTE: For PPS waived/excluded areas, review shall be performed appropriate to your area.

Excerpt from CMS internet only Manual (IOM)

CMS Publication 100-08, Chapter 6, Section 6.5.1

Screening Instruments

The reviewer shall use a screening tool as part of their medical review of acute IPPS and LTCH claims. CMS does not require that you use a specific criteria set. In all cases, in addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.

The following shall be utilized as applicable, for each case:

- *Admission criteria;*

- *Invasive procedure criteria;*

- *CMS coverage guidelines;*

- *Published CMS criteria*

- *DRG validation guidelines;*

- *Coding guidelines; and*

- *Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community)*

Who Can Bill for Observation Status:

Only the physician admitting the patient to outpatient observation care (or a member of the same group with the same specialty) may bill the observation CPT procedure codes. This includes the admission (99218 - 99220), subsequent observation (99224 - 99226), and discharge from observation (99217) CPT procedure codes. Anyone else seeing the patient while in observation care would bill using an office or other outpatient procedure code 99201 - 99215 as appropriate. The Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 12, Section 30.6.8 discusses observation care. It does not mention the new subsequent observation care codes. It does state, "*All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient services must bill the appropriate outpatient service codes.*"

Conditions of Participation (CoP) at 42 C.F.R. §482.12(c).

Code 44 CoP in 42 C.F.R. § 482.30 (d

Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10 UR plan see CR 6626, CMS Pub 100-04, Chapter 1, Section 50.3.1:

Revision History Number/Explanation