CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 787

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: DECEMBER 16, 2005

Change Request 4259

SUBJECT: January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Observation

I. SUMMARY OF CHANGES: This transmittal updates language found in the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, Section 290 and reflects changes included in the January 2006 OPPS OCE and the January 2006 OPPS PRICER.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 01, 2006

IMPLEMENTATION DATE: January 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	4/Table of Contents
R	4/290.1/Observation Services Overview
R	4/290.2/General Billing Requirements for Observation Services
N	4/290.2.1/Revenue Code Reporting
N	4/290.2.2/Reporting Hours of Observation
R	4/290.3/Billing and Payment for Observation Services Furnished Prior to January 1, 2006
N	4/290.3.1/ Billing and Payment for Packaged Observation Services Furnished Between August 1, 2000 and December 31, 2005

N	4/290.3.2/ Billing and Payment for Separately Payable Observation Services Furnished Between April 1, 2002 and December 31, 2005
N	4/290.3.3/Billing and Payment for Direct Admission to Observation Services Furnished Between January 1, 2003 and December 31, 2005
R	4/290.4/Billing and Payment for Observation Services Furnished On or After January 1, 2006
N	4/290.4.1/Billing and Payment for All Hospital Observation Services Furnished on or After January 1, 2006
N	4/290.4.2/Separate and Package Payment for Direct Admission to Observation
N	4/290.4.3/Separate and Package Payments for Observation
R	4/290.5/Services Not Covered as Observation Services

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 787	Date: December 16, 2005	Change Request 4259

SUBJECT: January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Observation

I. GENERAL INFORMATION

A. Background: This manual section describes changes to coding and payment for observation for hospitals paid under the OPPS, to be implemented in the January 2006 OPPS update. The January 2006 OPPS OCE and OPPS PRICER reflect the changes identified in the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, Section 290. The instruction to install the January 2006 OPPS PRICER is provided in Change Request 4250, Transmittal 786, dated December 16, 2005. The instruction to install the January 2006 OPPS OCE is provided in Change Request 4238, Transmittal 784, dated December 16, 2005. Unless otherwise noted, the coding and payment policy addressed in this manual revision are effective for services furnished on or after January 1, 2006.

B. Policy: Beginning January 1, 2006, two new G-codes (G0378 & G0379) are to be used to report observation services and direct admission for observation care. The OPPS claims processing logic will determine the payment status of the observation and direct admission services, that is, whether they are packaged or separately payable. Thus, hospitals are able to provide consistent coding and billing under all circumstances in which they deliver observation care.

Beginning January 1, 2006, hospitals should not report CPT codes 99217-99220 or 99234-99236 for observation services. In addition, G0244, G0263, and G0264 are discontinued as of January 1, 2006.

Change Request 4047, issued on November 25, 2005 (Transmittal 763), explains that some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service.

If a hospital provides non-covered services such as custodial care (see the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6, for further explanation of non-covered services), it must give proper notice to the beneficiary in advance of any custodial care provided in order to charge the beneficiary for the custodial care. The hospital should bill for the period of medically necessary observation and should also submit non-covered services.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4259.1	Contractors shall be in compliance with the manual instruction in Publication 100-04, Chapter 4, Section 290.	X								
4259.2	Contractors shall be in compliance with the manual instruction in Publication 100-02, Chapter 6, Section 20.5.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4259.3	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Chuck Braver at (410) 786-6719 for policy payment issues Antoinette Johnson at (410) 786-9326 for Part B claims processing **Post-Implementation Contact(s):** Chuck Braver at (410) 786-6719 for policy payment issues Antoinette Johnson at (410) 786-9326 for Part B claims processing	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev.787, 12-16-05)

Crosswalk to Old Manuals

290.1 - Observation Services Overview

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being 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 services.

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. 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.

A separate Ambulatory Payment Classification (APC) payment is made for outpatient observation services involving three specific conditions: chest pain, asthma, and congestive heart failure (see §290.4.3 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 Advanced Beneficiary Notice (ABN) should not be issued for reasonable and necessary observation services, whether packaged or paid separately.

290.2- General Billing *Requirements* for Observation Services

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

290.2.1. - Revenue Code Reporting

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Hospitals are required to report observation charges under the following revenue codes:

Revenue Code	*Subcategory*
0760	*General Classification category*
0762	*Observation Room*

Ancillary services performed while the patient is in observation status are reported using appropriate revenue codes and HCPCS codes as applicable.

290.2.2 - Reporting Hours of Observation

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses' notes and discharged to home at 9:45 p.m. should have a "7" placed in the units field of the reported observation HCPCS code. Observation time ends when the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. 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.

If a period of observation spans more than one calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date the patient is admitted to observation.

290. 3- Billing and Payment for Observation Services Furnished Prior to January 1, 2006

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

290.3.1 - Billing and Payment for Packaged Observation Services Furnished Between August 1, 2000 and December 31, 2005

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

In the beginning of the OPPS, all observation services were packaged services. No separate payment was made for observation services, as the payment for observation was included in the APC payment for the procedure or visit with which it was furnished.

Packaged observation services furnished on or after August 1, 2000, through December 31, 2005, were reported using CPT codes 99217 through 99220 and 99234 through 99236.

290.3.2 - Billing and Payment for Separately Payable Observation Services Furnished Between April 1, 2002, and December 31, 2005

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Although observation services continued to be packaged in most situations, a separate APC payment was made for observation that was provided under certain specific

conditions. This separate APC payment through APC 0339 (Observation) for observation services was effective for services furnished on or after April 1, 2002.

A hospital billing a 13X bill type could receive a separate APC payment for observation services for patients with diagnoses of chest pain, asthma, or congestive heart failure, when certain additional criteria were met according to §290.4.3. In addition, certain additional requirements for diagnostic testing associated with the observation encounter were required for separate observation payment from April 1, 2002, through December 31, 2004. Hospitals billed G0244 (Observation care provided by a facility to a patient with congestive heart failure, chest pain, or asthma, minimum eight hours) on bill type 13X with the units of G0244 reflecting the number of hours of observation care provided and received payment for one unit of APC 0339 if all criteria were met. So long as each observation episode of care met the observation criteria for separate payment, more than one non-overlapping observation episode of care was allowed on a single claim and each observation encounter was paid separately.

290.3.3 - Billing and Payment for Direct Admission to Observation Services Furnished Between January 1, 2003 and December 31, 2005

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

When a patient was a "direct admission" to observation, defined as a patient referred by a community physician to the hospital for observation without receiving hospital clinic, emergency room, or critical care services on the day of initiation of observation care, hospitals billed:

- *G0263 – Direct admission of patient with diagnosis of congestive heart failure, chest pain, or asthma for observation services that meet all criteria for G0244; or*
- *G0264 – Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma when the observation stay does not qualify for G0244.*

Hospitals received separate payment for G0264 through a payment for APC 0600 (Low Level Clinic Visits), whereas payment for G0263 was packaged into the separate payment for observation care provided through APC 0339.

290.4 - Billing and Payment for Observation Services Furnished On or After *January 1, 2006*

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

290.4.1 - Billing and Payment for All Hospital Observation Services Furnished On or After January 1, 2006

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Beginning January 1, 2006, two new G-codes are to be used to report observation services and direct admission for observation care. The OPPS claims processing logic will determine the payment status of the observation and direct admission services, that is, whether they are packaged or separately payable. Thus, hospitals are able to provide consistent coding and billing under all circumstances in which they deliver observation care.

Beginning January 1, 2006, hospitals should not report CPT codes 99217-99220 or 99234-99236 for observation services. In addition, the following HCPCS codes are discontinued as of January 1, 2006: G0244 (Observation care by facility to patient), G0263 (Direct Admission with congestive heart failure, chest pain or asthma), and G0264 (Assessment other than congestive heart failure, chest pain, or asthma).

The three discontinued G-codes and the CPT codes that are no longer recognized are replaced by two new G-codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct admission for observation care, whether separately payable or packaged:

- *G0378- Hospital observation services, per hour; and*
- *G0379- Direct admission of patient for hospital observation care.*

The OPPS claims processing logic will determine whether observation services billed as units of G0378 are separately payable under APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter. Therefore, hospitals should bill HCPCS code G0378 when observation services are provided to any patient in "observation status," regardless of the patient's condition. The units of service should equal the number of hours the patient is in observation status.

Hospitals should report G0379 when observation services are the result of a direct admission to "observation status" without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community (see §290.4.2 below)

Change Request 4047, issued on November 25, 2005, (Transmittal 763), explains that some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service. It is vitally important that all of the charges that pertain to a non-repetitive, separately paid procedure or service be reported on the same claim with that procedure or service. It should also be emphasized that this relaxation of same day billing requirements for some non-repetitive services does not apply to non-repetitive services provided on the same day as either direct admission to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including diagnostic tests, lab services, hospital clinic visits, emergency department visits, critical care services, and

``T'' status procedures, are reported on the same claim. Additional guidance can be found in the Change Request cited above.

290.4.2 - Separate and Packaged Payment for Direct Admission to Observation

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

In order to receive separate payment for a direct admission to observation (APC 0600), the claim must show:

1. *Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service;*
2. *That no services with a status indicator ``T'' or ``V'' or Critical care (APC 0620) were provided on the same day of service as HCPCS code G0379; and*
3. *The observation care does not qualify for separate payment under APC 0339.*

Only direct admission to observation services billed on a 13X bill type may be considered for a separate APC payment.

Payment is not allowed for HCPCS code G0379, direct admission to observation care, when billed with the same date of service as a hospital clinic visit, emergency room visit, critical care service, or "T" status procedure.

If a bill for direct admission to observation does not meet the 3 requirements listed above, then payment for the direct admission service will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.4.3- Separate and Packaged Payment for Observation

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Separate payment may be made for observation services provided to a patient with congestive heart failure, chest pain, or asthma. The list of ICD-9-CM diagnosis codes eligible for separate payment is reviewed annually. Any changes in applicable ICD-9-CM diagnosis codes are included in the October quarterly update of the OPPS and also published in the annual OPPS Final Rule. The list of qualifying ICD-9-CM diagnosis codes is also published on the OPPS Web page.

All of the following requirements must be met in order for a hospital to receive a separate APC payment for observation services through APC 0339:

1. Diagnosis Requirements

a. *The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.*

b. Qualifying ICD-9-CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

2. Observation Time

a. Observation time must be documented in the medical record.

b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- *An emergency department visit (APC 0610, 0611, or 0612) or*
- *A clinic visit (APC 0600, 0601, or 0602); or*
- *Critical care (APC 0620); or*
- *Direct admission to observation reported with HCPCS code G0379 (APC 0600).*

b. No procedure with a ``T'' status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Only observation services that are billed on a 13X bill type may be considered for a separate APC payment.

Hospitals should bill all of the other services associated with the observation care, including direct admission to observation, hospital clinic visits, emergency room visits, critical care services, and "T" status procedures, on the same claim so that the claims processing logic may appropriately determine the payment status (either packaged or separately payable) of HCPCS codes G0378 and G0379.

If a bill for observation care does not meet all of the requirements listed above, then payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5 - Services Not Covered as Observation Services

(Rev.787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

If a hospital provides non-covered services such as custodial care (see the Medicare Benefit Policy Manual, Pub 100-02, Chapter 6, for further explanation of non-covered services), it must give proper notice to the beneficiary in advance of any custodial care provided in order to charge the beneficiary for the custodial care. The hospital should bill for the period of medically necessary observation and should also submit non-covered services according to billing instructions in the Medicare Claims Processing Manual, Pub 100-04, Chapter 1, §60.1.2. Hospitals should submit a non-covered charge amount equal to the total charge for each service and should use modifier -GY or condition code 21 as appropriate. For services that are not paid under the OPPS, but do not require an ABN such as providing drugs to the beneficiary that are usually self-administered, providers may use the Notice of Exclusion from Medicare Benefits to advise beneficiaries of any potential liability.

An ABN should not be issued for reasonable and necessary observation services, whether packaged or paid separately. Hospitals should not confuse packaged payment with non-coverage.