Pt Status: Inpt vs OBS

The Challenges of Coverage and Compliance

Why is it so hard?

Special Olympic's Oath:

- Let me win,
- But if I can not win,
- Let me be brave in the attempt.

Outline of Training

- Patient Status – what is inpt; what is obs
- Updates with OBS – ER to OBS, PP to recovery to OBS, Direct to OBS
- Billable hrs vs hrs in a bed

From the pt: AARP Jan-Feb 2010 issue

- "Hospital Stays are Under Observation"
- Ruth Way fell, was admitted to the hospital for a 6 day stay and then to a SNF for rehab for 6 weeks.
- She is back living indptly but with more than $10,000 in nursing home charges.
- The reason: the hospital says she was never formally admitted as an inpt. A Medicare review board determined that her stay was merely for OBS.
- The decision meant Medicare was off the hook for paying for the SNF as a 3 day inpt stay is required.
- Advocate indicates they hear more of multi-day stays being deemed as OBS, sometime retroactively. Fearful of denial.
- Son: This is gross dereliction of the responsibilities that Medicare should have for our aging citizens.
- CMS Notice: www.medicare.gov/publications/pubs/pdf/11435.pdf - "Are you a hospital inpt or outpt? If you have Medicare – ASK!"

Medicare Patients Sue HHS over Observation Status Bills 2/2012

- Ctr for Medicare Advocacy and the National Sr Citizen Law Center filed a class action lawsuit against HHS. *Bagnall vs Sebelius* – challenging practice of placing hospital pts in obs status , an alternative to admitting them as an inpt
- "Although Obs status can have significant negative consequences for pts, hospitals have financial incentives to use it. And they have been using it increasingly in place of admitting pts, according to the lawsuit." Clarified – loss of an inpt so bill as obs.
- Payment for 1 OBS stay – 8 – 48 hrs = $650 flat fee for the hrs with the loss of the ER E&M. No $ for PP to OBS to APC hospitals.
- Pending legislation/no action – Improving Access to Medicare Coverage Act (HR 1548) ensures time spent under obs would count toward the 3 day SNF qualifying stay.
- Increase in OBS claims- 22% from 2006-2008.
- Increase in stays over 48 hrs – 70% more from 2006-2008

Inpatient vs Observation
Making it Easier

Office of Inspector General/OIG's 2011 Work Plan

- *We will review Medicare payments for OBS services provided during outpt visits in hospitals. Provides for Part B coverage of hospital outpt services and reimbursement for such services under the hospital OPPS. CMS's Medicare Claims Processing Manual, pub 100-04 , Ch 4, provides the billing requirements. We will assess whether and to what extend hospitals' use of observation services affect the care Medicare beneficiaries receive and their ability to pay out-of-pocket expenses for health care services."*

OIG's 2011-12 Work Plan – Risk Areas for Hospitals

- Outpt claims pd greater than charges. (APC methodology)
- Inpt claims pd greater than chgs
- Inpt $ greater $150.000
- Outpt $ greater $25,000
- **One day stays at acute care**
- Major complications /comorb
- Payments for septicemia servs
- **Payments for inpt same day discharges and readmissions**
- Outpt claims billed during the DRG payment window
- Payments for hemophilia
- Payments for outpt surgeries w/units greater than 1
- Inpt and outpt claims /manufacturer credits for replacement of devices
- Post –acute transfers to SNF/HHA/another acute care inpt facility
- SNF/HHA consolidated billing-separate outpt services
- Outpt claims with 59 modifier
- Inpt claims pd greater than chgs

How does the OIG identify hospitals for audit?

- The hospital's past performance on single issue audits
- Where the hospital stands in comparison to PEPPER data
- Whether there was continued poor performance. Patterns where MAC/FI had tried to educate and yet, patterns continued.

RAC HealthDataInsights licenses Milliman Care guidelines

- "HDI has signed a 5 year license with Milliman Care Guidelines. HCI will use the care guidelines content and software to review Medicare claims.
- HDI will use the annually updated evidence based care guidelines products.
- The Care Guidelines promote healthcare quality by providing clinical guidelines based on the best available clinical evidence."
- CMS does not mandate or endorse any specific guidelines or criteria for utilization review."

Feb 25, 2009 "Evidence-based care guidelines will be used to combat waste in Medicare program."

2013 OPPS proposed rule – New direction on defining an Inpt

- Comments thru 9-7 on CMS's ideas
- Defining inpt at a specific period of time
- Along with providing a limit on how long a beneficiary receives obs services.
- Industry chatter:
  - If a 24 hr bright line rule for inpt status is enacted, the overall impact will be beneficial for providers.
  - UR would be highly focused on the 'immediate placement' in a bed –rather than after 24 hrs.
  - Focus of recovery auditors will be on inpt stays less than 24 hrs.

Medicare's Inpt definition

Medicare benefit policy manual chpt 1 10

- An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."

  "However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

  - The severity of the signs and symptoms exhibited by the patient;
- - The **medical predictability of something adverse happening to the patient…"**

What does Severity look like?

- What brought the pt to the hospital?
- Has the pt failed outpt treatment?
- Does the pt's condition require admission to an acute setting?
- Is the pt sick enough to require hospital level of care NOW?
- TIE known risk factors into the reason for inpt admit- today

What does intensity of service look like?

- Clinical documentation tied to the severity of the condition the pt was admitted for.
- What is currently being done for this patient?
- Does this treatment require an inpt level of care?
- Applies to each separate day. (all care givers)

More on what is an inpt?

- Medicare Program Integrity Manual, Chapter 6, Section 6.5.2.
- "*The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can only be safely and effectively treated on an inpt basis.*"

DCS/Region A demand letter

- Outlining rationale for inpt vs obs in decision letter.
- "*Inpt care rather than OBS is required only if the pt's medical condition, safety or health would be significantly and directly threatened if care was provided in a less intensive setting. A pt must demonstrate signs and /or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpt basis." (Dec 2010)*
- The entire record must reflect this definition of an inpt – from the admit note, to progress notes, to nursing's documentation thru discharge.

Physician and Hospital Shared Risk – Pt Status

- **Trailblazer/MAC Jurisdiction 4, 8-30-10 "Inappropriate Hospital Admission vs Outpt Observation"**
- Medicare requirements that the inpt admission begins when the admission order is written. Additionally, all physician orders must have a date and a legible signature.
- Physician's decision to treat the pt as an outpt or inpt are reflected in the physician's orders. The pt's condition, history and current dx test results, along with the physician's medical judgment, availability of treatment modalities and hospital admission policies should be considered when making a decision to provide inpt level of care. If a physician determines additional information is making a medical decision for inpt admission, the physician may elect to place in OBS outpt status.

More from Trailblazers

- Scenario 1
- An inpt claim is submitted for medical review
  - The claim is without a written and signed physician order for admission
  - The documentation is without an admit note describing the reason for admission to an inpt level of care/LOC
  - The services rendered could have been rendered in an outpt setting
  - The screening tool indicates the intensity of services and the severity of illness of the pt's condition as documented did not support the medical necessity for inpt LOC
  - Medical review decision: Denied because documentation does not support the medical necessity for an acute level of care
  - IF THE PATIENT'S CONDITION REQUIRES INPT ADMISSION, the physician needs to document an inpt admission order with a progress note describing the medical decision for the inpt admission and the intended treatment plan to address the patient's condition.
  - Internet Only Medicare Manual (IOM) Pub 100-04, Medicare Claims Processing Manual; chapter 1, section 50.3; chapter 3, section 40.2.2.k

Learning from audit denials

- 1) Obs 1st. 1 hr prior to discharge, doctor converts to inpt. CMS denied based on the fact that when the inpt order was written, there was no indication of the need to convert at that time.
- 2) Admit decision: Admit elderly woman to evaluate and treat malignant tumor which would have justified an inpt admission. However, there was no treatment given during her stay. CMS denied : at the time the decision was made to admit the pt to inpt status, the pt was in no acute distress, she was no requiring pain meds, she was able to handle her secretions, her vital signs and oxygen saturation were normal, her lab data revealed normal findings and she was admitted for an outpt workup."
- 3) Pt was placed in inpt with : "given her memory deficits and difficult with ambulation, I will arrange 23-hr admission to the hospital for colonoscopy prep." Pt was wheelchair bound and lives alone. CMS denied stating – inpt care, rather than obs or outpt services, is required only if the medical condition , safety or health would be significantly and directly threatened if care was provided in a less intensive setting.'

- **TAKE AWAYS**: Orders take effect when written..pt's condition must support inpt status AT THE TIME THE ORDER IS WRITTEN. PLUS always speak to and treat the clinical reasons that were addressed when the inpt decision is written and FINALLY, social admits are very hard to justify an inpt admission.

Orders take effect when written. Pt's condition must meet inpt at the time of the order.

- Initial observation order was determined at later point in time to have been inappropriate as patient should have been admitted as an inpatient. Order is written for inpatient care on different date than referral to observation. Since orders cannot be retroactive, the admission date is the date the inpatient order is written, even if patient could have been inpatient when the observation order was written.
- Note: When an admission order is written but the patient status no longer supports the need for inpatient admission, the claim cannot be billed as an inpatient claim.
- Example 1: Patient arrives to ED on 03/28/11. Order is written for observation stay. On 03/29/11, determination is made that patient could have been an inpatient starting on 03/28/11; however, patient no longer requires inpatient services. At this point, an order for inpatient admission could not be valid. The claim cannot be billed as an inpatient claim.
- From: https://www.noridianmedicare.com/provider/updates/docs/InpatientOrders.pdf%3f

More from regs and audit findings

- 42 CFR 482.12 (c) (2) "Patients are admitting to the hospital only on a recommendation of a licensed practitioner permitted by the state to admit pts to the hospital. "
- Medicare State Operations Manual "In no case may a non-physician make a final determination that a pt's stay is not medically necessary or appropriate." Case Mgt protocol can 'recommend' to the providers but only takes effect when the provider has authenticated it.

Two focus points for OBS:

- Pt status – understanding what is OBS? (Ownership: UR and providers)
- Billable hrs – understanding what constitutes billable hrs vs hrs in a bed.. (Ownership: Nursing and providers)
- If only signs and symptoms are present but no confirmed course of tx/dx – think OBS.

Continuous Monitoring: May a hospital report drug adm furnished during the time period when obs services are being reported? CMS FAQ 1-27-10

Deduct the obs hrs and bill the procedures

- "Observation services should **not** be billed concurrently with **diagnostic or therapeutic** services for which active monitoring is a part of the procedure (e.g colonscopy, chemotherapy). " In situations where such a procedure interrupts observation services and results in two of more distinct periods of obs services, hospitals should record for each period of obs services the beginning and ending times during the hospital outpt encounter. Hospitals should add the length of time for the periods of obs services together to determine the total number of units reported on the claims for the hourly obs services under HCPCS code G0378 (hospital obs service, per hr.)
- **Continuous monitoring =billed 1st, then 'earn' OBS hrs**
- Medicare Claims Processing Manual, Pub 100-4. Chpt 6, Section 290.2.2

OPPS July 2011 update (CR7443)

- *"Under the current OPPS policy, obs services should not be billed concurrently with dx or therapeutic services for which active monitoring is a part of the procedure, (eg colonscopy, chemo). CMS is revising billing instructions to state that in situations where such a procedure interrupts obs services, hospitals may determine the most appropriate way to account for this time. For ex, a hospital may record for each period of obs services the beginning and ending times during the hospital outpt encounter and add it up. A hospital may also deduct the AVERAGE length of time of the interrupting procedure from the total duration of time that the pt receives observation services. CMS is updating the Medicare Claims Processing Manual, Pub 100-04, chapter 4, section 290.2.)*
- HINT: Develop standards for how long off the floor services procedures take – like MRI – and auto deduct IF On and OFF the floor is not being consistently documented.

More on continuous monitoring CMS 1-27-10, FAQ

A: The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations , hospitals should check with their Medicare contractors for future information.

If the hospital determined that active monitoring is part of a drug adm service furnished to a particular patient and separately reported, then OBS services should not be reported with HCPCS G0378 for that portion of the drug adm time when active monitoring is provided.

Good News – Hydration FAQ9974

- "It is an unacceptable practice to automatically place a patient in observation for the sole purpose of providing Chemotherapy, or other therapeutic intravenous infusions. If any complex therapeutic intravenous infusions are given during a patient's observation hours these service hours must also be deducted. Hydration is not considered as therapeutic active monitoring." An example: "a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring." (Source: FAQ 9974 active monitoring and drug administration.htm)

New 2011 Physician Supervision – 3 types of supervision outlined

- The final rule exempts CAHs & small, rural w/100 beds or less from this rule thru calendar year 2011. However, CAHs are expected to make the necessary adjustments to comply with the rule in calendar year 2012. (CAH PUT ON HOLD,2012 & proposed regs for 2013)
- Direct supervision – immediately available to furnish assistance and direction throughout the procedure. Does not mean in the room; but CMS makes it clear must be physically present. Available thru phone does not meet the requirement. In a clinic within close proximity, is considered to be immediately available.
- General supervision – services are furnished under the overall direction and control of the physician but his presence is not required during the procedure.
- Personal supervision – physician is present in the room when procedure is performed.

More on 2011 Physician supervision

- For a limited set of nonsurgical extended duration therapeutic services (all types of drug adm, OBS hrs), CMS allows direct supervision followed by general supervision. For those services, direct supervision is required at the initiation of the services; general supervision is required once the attending practitioner deems it safe to move to general supervision.
- Some revision to Direct Supervision. CMS makes it clear that the practitioner must be 'physically present.' The doc must be located close enough they can immediately step in. An ER doc WOULD qualify as long as they are not so busy they cannot be interrupted. A physician, available thru phone or telemedicine, is NOT currently considered immediately available. A physician in a clinic with close proximity to where the outpt therapeutic services is being performed DOES qualify as direct supervision.

Transmittal, 1745/1760 July 2009

- Editorial change to remove references to "admission ' and "observation status' in relation to outpt observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term 'admission' is typically used to denote an inpt admission and inpt hospital services. For payment purposes, there is no payment status called "observation', observation care is an outpt service, ordered by a physician and billed with a HCPC code.
- Revenue code 762 or 760 is acceptable.
- Rounding of hrs. Hospitals should round to the nearest hr. (EX 3:03 to 9:45 = 7 hrs)
- Standing orders for obs services following outpt surgery are not recognized. Recovery room services billed separately (4-6 hrs)
- References: 290.1; 290.2.1; 290.2.2/ Transmittal 1745
- Medicare Claims Processing Manual Chpt 4, 290; Pub 100-02 Medicare Benefit Policy Manual Chpt 6, 29.6

What if the payer wants an inpt billed as observation?

- Why?
  - Some non-Medicare payers certify for observation even when the doctor orders inpt.
  - Some payers have regulations that indicate a patient must stay a minimum # of hours
  - Some payers do not honor physician orders; internal adjudicators change

Fight the Decision or never, ever change the order

- Create: "***Variation from order for non-Medicare payers***"
- SAMPLE: According to Medicaid's regulation- "(*insert actual regulations or pre-cert info),* this account will be billed as an observation even though the physician ordered inpt."
- Document signed by leadership, in med record
- Bus off converts from inpt to obs, revises billing.
- Stats will change: loss of inpt day, possible productivity impact to nursing unit
- Drug adm is billable; but is time charted?

What type of UR Program do you have?

- Place and Chase.
  - Pts are placed in a bed status based on placement orders from the department of the hospital (OR, ER, PACU) or the physician's office.
  - No UR assessment is made prior to the placement decision.
  - Monday morning quarter backing. (Darn-Orders take effect when written.)

OR

Interactive UR involvement PRIOR/DURING placement decisions.

- Bed placement calls are channeled thru UR for initial conversation and review of orders.
- If no 24/7 UR, lead nurses/house supervisors are Quasi - UR

How to grow to UR 24/7? Nursing & the provider are UR's partner

- Expand the usual 8 hr, day shift role of the UR nurse…..if only 1 UR position, assess daily routine to include-
- Focus on the ER. What percentage of admits (OBS and Inpt) come thru the ER? Work aggressively with the ER provider, ER nursing and ER lead nurse to understand pt status and how to ensure 'action oriented orders'. Identify the pivotal event that 'pushed' the pt into either an inpt or an OBS level of care.
- Focus on the daily physician rounds. Round with the provider, clarify the pt's status/plan of action, document all dialogue with the provider.
- Focus on the bedside nurse to identify what status they are charting – inpt vs obs – and look for the order, each shift.

Patient Status/Level of Care

- **Who is the owner of pt status**: Inpt, outpt receiving care in a bed, observation?
- Provider, Case Management/Utilization Review
  - Only a physician/provider can direct pt care
  - UR Committee Membership Requirements
  - Who can make the determination that a patient's status should be changed?
  - Consultation with ordering physician
  - Notification of patient and physician

GOAL OF OBSERVATION -

- Where would the patient rather be – in a hospital (gappy gown, no one to watch cat, care for family issues, etc) or home?
- <u>Reason for Observation</u> – to allow the physician time to make a decision and then RAPIDLY move the patient to the most appropriate setting..
- Observation is not a holding zone

Medicare Guidelines

- **APC regulation (FR 11/30/01, pg 59881)**

  "Observation is an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged."

- **Medicare Hospital Manual (Section 455)**

  "Observation services are those services furnished on a hospital premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible as an inpatient."

Expanded 2006 Fed Reg Info

- **Observation** 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 a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.
- *Note: No significant 2007, 08 ,09 , 10, 11, 12 reg changes*

Observation-Time Guidelines

- Obs time must be documented in the medical records
- A beneficiary's time in observation begins with the bene's admission to an obs bed (or when order is written if the doc is in the care area.).
- Time ends when all clinical or medical intervention has been completed, including f/up care that may occur after the physician has ordered the pt be released. (Pg 68692 Fed Reg 11-10-05)

New Transmittal with 7-09 OPPS update, Transmittal 1745/1760, CR 6492

Clarify a hospital begins billing for observation services at the clock time documented in the pt's medical record which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.

HUGE IMPACT TO Condition Code 44: Bill OBS from point of order

Observation is an Outpatient

- Observation is an outpatient in a bed
- It is billed hourly to the payers
- Each hr must be medically necessary with active physician involvement-as appropriate for each billable hr
- Non-billable hrs occur when – order is up, no new orders, social admit, gaps between orders and physician contact, no transportation, ancillary delays, physician delays, family convenience, not medically necessary, late cases.
- Build in the CDM and track and trend = patterns

Three types of OBS audits focus areas

ER to OBS

- Many hrs are lost while the pt is being 'held in ER pending bed placement." ER is an outpt treatment area. Once the OBS order has been activated by nursing, discontinue the ER documentation and begin OBS documentation. Once the placement has been completed, floor nursing continues the ER/OBS documentation -including drug adm.

PP to recovery to OBS

- This is the most problematic of the 3,
- Bad habits exist where providers are ordering OBS at the same time the procedure is ordered. Can't have an unplanned event BEFORE a scheduled surgery.
- Routine recovery is 'up to 4-6 hrs' anywhere in the hospital - all hrs billable in an outpt setting. (Exception Appendix G/conscious sedation) Recovery must occur //pass prior to movement to a more acute level - OBS or inpt with an updated order.

Direct to OBS

- Majority of these are simply outpts receiving services in an inpt bed.
- Facilities should incorporate a 'pt status' midnight census to help reinforce correct pt status that is documented supports ordered.
- Look for very short LOS as well as outpt procedures/transfusions. No OBS unless there is an adverse event.

Hey, who is inputting OBS charges when the pt is in an inpt unit?

More 2006 Regulations

Observation status is commonly assigned to pts with **unexpectedly** prolonged recovery after surgery and to pts who present to the emergency dept and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. (Fed Reg, 11-10-05, pg 68688)

More on Post procedure to OBS

- **Q30. We have standing orders for observation after surgery; we do not have the patient sign an ABN but bill observation hours knowing that Medicare will not pay, is this accurate?**
- A30. Per IOM 100-04, Chapter 4 Section 290.2.2: "General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services." If a patient needs observation beyond the standard recovery period because of patient status or a complication, a specific order for observation must be written at that time. If no specific order was written, any observation hours on the claim must be billed as non-covered. (Noridian, Q&A, Feb 2010)

Another MAC weights in

- Trailblazer/MAC "Inappropriate Hospital Admission Versus Outpt Observation" 8-30-10
- *Obs or monitoring is a type of service. Planned admission following an elective outpt procedure may be denied for lack of medical necessity when the pt's condition does not warrant an acute inpt stay. The admission must be related to the pt's condition and documentation must provide a rationale for the medical decision to place the pt in an inpt status. In addition, monitoring and observation services following an outpt procedure are not obs services; the recovery, monitoring and medications following the procedures are an inclusive part of the procedure."*

Surgical/Interventional Procedures – Tough Environment

- Each patient individually assessed
- **After** 4-6 hrs routine recovery
- Decide: Safe to go home?
- If not, evaluate:
  - Is it an unplanned outcome?
  - Is it an exacerbation of a condition?
- If not, explore extended recovery.
- If yes, eligible for observation.

Uglies:

- Observation can not be ordered 'before' the procedure
- No standing orders for observation.

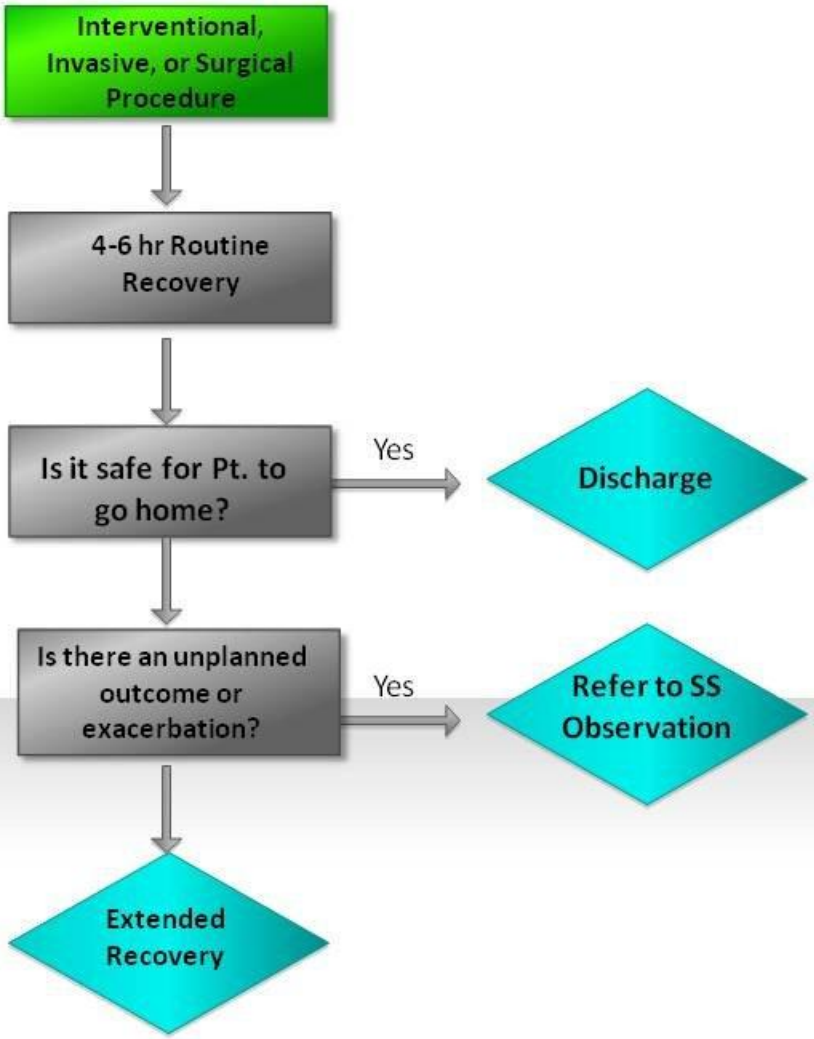
Services Not Covered as Obs

Services that are covered under Part A, such as a medically appropriate inpt admission or as part of another Part B service, such as postoperative monitoring during a standard recovery period (4-6 hrs) which should be billed as recovery room services. Similarly, in the case of pts who under diagnostic testing in a hospital outpt dept, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those dx services. Obs should not be billed concurrently with therapeutic services such as chemotherapy. (Pub 100-02, Ch 6, Sec 70.4)

And then there was Recovery..

- **Routine** – Immediate post procedure up to 4-6 hrs. Not billing for a room, but the service.
- Floor nursing can bill for recovery, extended recovery, as well as observation.
- Explore creating **timed phases:**
  - Phase 1 – immediate post procedure –PACU
  - Phase 2 – less than 1-1 nursing-up to 4-6 hrs-outside PACU
  - Extended recovery – not safe after 4-6 hrs –outside PACU/phase 3
  - Create a R&B choice for: obs, semi, private, extended

OBSERVATION DECISION TREE



Need an updated order

Operational Issues with Observation

- After up to 4-6 hrs of routine recovery, the physician should expect a call to ask the following:
  - Not safe to go home – need updated orders for extended recovery or observation or inpt.
  - Active physician involvement will still be necessary to move the pt to the most appropriate setting
  - Extended recovery option –orders, medically necessary but no unplanned event.
  - Unplanned event severe enough to warrant admit to acute level of care?

Decision Tree Additions

- At any point, the pt's status may deteriorate and an inpt admit is ordered – in recovery, extended recovery or observation.
- At any point, the pt's status may change while in extended, the physician orders observation and the decision-making moves to observation

Unplanned Outcome

- Interqual's example of unplanned outcome:
- IV administration for pain and/or nausea management.
- Lab work that is outside the norm
- Inability to void at end of routine recovery
- Unusual bleeding===move to an obs bed and begin all other obs guidelines

It is all about understanding Pt Status and/or Level of Care

- Daily reconciliation of midnight status-150 pts in a bed; what are they? Recovery, outpt, inpt, OBS, non-covered, extended recovery.
- Just because a pt is in a bed, does not mean they are a)OBS or b) Inpt.
- Ongoing communication with bedside nursing on their 'pt status' is essential.

Attacking Billable Hours vs Hours in a Bed

Expanded 2006 Fed Reg Info

- **Observation** 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 a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.
- *Note: No significant 2007, 08 ,09 , 10, 11 reg changes*

Physician 2006 Additions

- **Pt must** be under the care of a physician….as documented in the medical record by admission, discharge and other appropriate progress notes that are timed, written and signed by the physician.
- The medical record must include documentation that the **physician explicitly assessed** patient risk to determine that the beneficiary would benefit from observation care. (pg 68694)

Key Elements for Covered Observation Stays

- Physician order to place/referral in observation
- Intent in the order
- Medical Necessity for ea billable hr
- Active physician involvement/ongoing assessment and reassessment
- Rapidly move to appropriate setting- home or inpt.

Deduction from hours

- "Gaps between orders'
- Condition code 44 not done correctly
- Beside monitoring/drug adm and no other separate, unique documentation is present = continuous monitoring
- Left the unit
- If no direct supervision for initiation of care

Condition code 44/CMS

- Original transmittal 81 (effective 4-1-04) Updated transmittal 299, dated 9-10-04. (FL 24-30)
- Further clarity on physician review: www.cms.hhs.gov/MLNMattersarticles/downloads/SE0622.pdf Q&A, March 2006
- Use 'when the physician ordered inpt, but upon UR review performed before the claim was originally submitted, the hospital determined that the service did not meet it's inpt criteria.'
- New MLN Matters Q&A – 'UR must consult with the practitioners responsible for the care of the pt and allow them to present their views BEFORE making the determination"
- Review and final decision must be made while the pt is still in the facility.

More CMS clarity on CC 44

FAQ (questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_aip)

- Q: May a hospital change a patient's status using CC 44 when a physician changes the patient's status without UR committee involvement?
- A: No, the policy for changing a patient's status using CC44 requires that the determination to change a pt's status be made by the UR committee with physician concurrence. The hospital may not change a pt's status from inpt to outpt/OBS without UR committee involvement. The conditions for use of CC 44require physician concurrence with the UR committee decision. For CC 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 inpt admission is not medically necessary. (cont)

More Clarity on CC 44 (cont)

- This physician member of the UR committee must be a different person than the concurring physician for CC 44 use who is the physician responsible for the care of the pt.

Noridan/MAC states in their FAQ:

Q37: If the attending physician AGREES with the status change from INPT to Outpt/OBS , do we need to involve the UR physician also? Or is it only required with the attending does not agree?

A37: In order to change the beneficiary's status from inpt to outpt/OBS , the attending physician must concur with the UR committee.

More clarity on Condition Code 44 – Patient impact

- Palmetto/MAC, issued "Observation and CC 44 Discussion Items." Power Q&A as a result from NC work group, 4th Q 2009.
- Q: *A Medicare pt is admitted as an inpt. Case Mgt/UR does not believe meets inpt/Interqual requirements. The physician agrees. The pt status is changed back to OBS; however, the hospital failed to inform the pt of the status change. How is this situation billed? Should the pt remain an inpt and not be charged OBS?*
- *A: Should the pt's status change at any time during the hospital stay, it is imperative that the pt be notified of this change in a timely manner (prior to discharge.). In this particular situation, this notification should have occurred at the point when the pt was identified as not being eligible..*

More CC 44 news…

..for an inpt stay they could have been entitled to information regarding the change in status and impact to coinsurance. According to Medicare Claims Processing Manual , Publication 100-04, Chapter 30, Section 20: " When the beneficiary did not know or could not have reasonably expected to know that the items or services were not covered, but the provider knew or could have been expected to know, of the exclusion of the items or services, the liability for the charges for the denied items or services rests with the provider."

..Because the pt was not notified of his/her change in status, the provider will be required to bill the claim AS AN INPT type of bill (11x) in spite of the fact that the stay does not meet inpt criteria. The claim should be filed as a "no pay"..

Final CC 44 Issues

..type of bill (110) with all days and charges as non-covered. Since the beneficiary was not given a notice of non-coverage before discharge, the stay should be billed as provider liability using a M1 occurrence span code in form locator 35 or 36. This will cause the claim to process in FISS as non-covered with no payment and no pt liablity reports on the remittance advice or the beneficiary's Medicare Summary Notice (MSN).

..After the no pay claim (TOB 110) is processed, you may then file an inpt ancillary claim (TOB 12x) to seek payment for the eligible ancillary provided during the stay. The eligible ancillary services are outlined in Medicare Claims Processing Manual , publication 100-04, chapter 4, section 240.1.

WOW! Transmittal 1803, CR 6626 -billable hrs with CC 44

- Numerous MACs are submitting clarifications regarding billable hrs when changing from inpt to OBS under CC 44 provisions.
- Per Noridian/MAC –training update sent 9-24-09

"When a hospital has determined that it may submit an outpt claim according to CC 44, the entire episode should be billed as an outpt episode of care with outpt services that were ordered and furnished billed.

Because there was no order for obs at the time the pt was admitted, providers may not being counting obs hrs until such time as an order for obs is given.

EX) Pt A is admitted at noon on Sun. On Mon afternoon, it was determined that the pt didn't meet inpt criteria, the physician concurred, and the status was changed back to outpt OBS. The outpt status considered to have begun at noon on Sun. However, OBS hrs cannot be billed until the physician has written an order for obs. If the order is written at 2:00 pm on Mon, the hospital would begin the OBS hrs at that time. No obs hrs would be charged between noon on Sun and 2:00 pm on Mon."

RAC ISSUE: What did the physician bill? Inpt or Obs?

Urban Myth – 'get 24 hrs of OBS"

- www.rgbagov.com/publications/lcd/lcd-files/080-01a.html (gone!! Cahaba has taken over as the MAC)
- **Guideline**: If the physician 'believes' the condition will resolve itself within 24 hours –with results, indicators, etc. completed – order observation.
- **Guideline**: If the physician has doubt that the patient meets criteria for inpatient, then admit to observation, aggressively manage, move to inpatient or safely discharge home.
- **Guideline:** If the physician's original INTENT/order is inpatient, but the patient recovers soon (<24 hrs), inpatient is still billed.

This policy represents a compilation of Medicare regulations that bear on outpatient observation and brief inpatient admissions, and summarizes their impact as it applies to correct billing. It provides clarification regarding both coverage and billing issues, and also defines the interpretation of both the intermediary and the PRO with respect to ambiguities in the manual. As such it represents a joint policy statement that reflects the views of all entities. A Carrier review found no inconsistencies with Carrier instructions to the physicians regarding the fundamental decision to admit.

The basis for this policy is MIM BILL REVIEW [13-3-3604 Fl. 42 code 76x] which states that "Payer should establish written guidelines which identify coverage of observation services", and PRO 1010 which instructs the PRO to "identify and seek correction of situations that if continued, would result in violations under §1156 of the Act. [PRO 19-1010.C]

The Least You Need to Know

The determination of an inpatient or outpatient status for any given patient is specifically reserved to the admitting physician, although that physician has Medicare guidelines he is expected to follow. The decision must be based on the physician's expectation of the care that the patient will require. The general rule is that the physician should order an inpatient admission for patients who are expected to need hospital care for 24 hours or longer and treat other patients on an outpatient basis. An inpatient admission is not covered when the care can be provided in a less intensive setting without significantly and indirectly threatening the patient's safety or health. Although in many institutions there is no difference between the actual medical services provided in inpatient and observation settings, in such cases the designation still serves to assign patients to an appropriate billing category. The correct physician application of Medicare patient status guidelines is therefore always critically important.

Observation services require the use of a bed and periodic monitoring to evaluate an outpatient condition or determine the need for possible inpatient admission. Observation may not be used as a substitute for a medically necessary inpatient admission, nor may it be used solely for the convenience of a patient, physician or facility. Observation generally does not exceed 24 hours and never (practically speaking) exceeds 48 hours.

Treatment room services are not synonymous with observation and are used to reimburse for facility usage associated with minor procedures where those facility services are not otherwise reimbursed or bundled.

A person is considered an inpatient if he is formally admitted based on the physician's expectation of a need for an appropriate inpatient stay. If the patient dies, is transferred, leaves AMA or recovers in a shorter period of time, an inpatient admission should still be billed. The justification for the admission, then, is based on the information available at the time of admission. Subsequent information may support a physician's "hunch" that the patient needed inpatient care, but never serves to refute that original determination.

A patient with a known diagnosis entering the hospital for a minor procedure or treatment that is expected to require a short stay (less than 24 hours) is considered an outpatient regardless of the time of arrival or the use of a bed and regardless of whether or not the stay spans two actual calendar days. Conversely a patient should be admitted for a minor procedure if comorbidity suggests that a 24-hour stay will be medically necessary. Thus, in general, expected stays of less than 24 hours should be outpatient while expected stays of greater than 24 hours should be inpatient. Note that this decision is the physician's. based on his initial expectation, and is not a fa6ility determination based on the actual length of stay.

Observation is appropriate if a serious condition can probably be ruled out in less than 24 hours or if an identified medical condition is likely to abate with less than 24 hours of therapy. If observation is associated with another outp4ent service (procedure or ER evaluation), there should be a clear event or decision point that triggers an order or physical transfer to mark the beginning of the observation period. There must be medical necessity for observation beyond the usual recovery period, as hours of the usual recovery time associated with the procedure are already reimbursed with the procedure. Brief observation stays following emergency room evaluation are not covered if those services are normally provided within the time frames and facilities of an emergency visit.

Aggressive operational "new thoughts"

- **Dedicated OBS bed or unit**: medical, post procedure, OB, Tele (ideas)
- Super trained nursing to 'actively move the pt" as well as "active physician involvement."
- **New action oriented pre-printed physician order form**.
- *HINT: Use for all outside PACU recovery, late case procedures, etc.*

S

SAMPLE

SHORT STAY OBSERVATION ORDERS

DATE: _____ **TIME:**_____ **ADMIT TO: SHORT STAY OBSERVATION**

DIAGNOSES: _____

_____

CONDITION: _____ **Undetermined** _____ **Serious** _____ **Fair** _____**Good**

LICENSED INDEPENDENT PRACTITIONER'S (LIP) INTENT: Document why the patient needs to be in an observation bed.

_____

LIP ORDERS: What are your goals for care & what are the triggers that will indicate your orders have been met? Please make these measurable and goal oriented ie. IV _____**cc. times** _____**hours with what goal**_____

Vital Signs: _____

IV:_____

Lab/Radiology:_____

Other:_____

_____

_____

_____

_____

_____

LICENSED INDEPENDENT PRACTITIONER'S SIGNATURE:

SSB Physician Orders (2/04)

PLACE NAME LABEL HERE

Making it Happen

- Physician must order 'observation.'
- Order clearly indicates status: Inpatient versus Observation
- Initial order clearly indicates **intent**:
  why the patient needs assessed
  what is the goal for the care
  what are the 'triggers' that will indicate to the care team-order met, contact the physician.

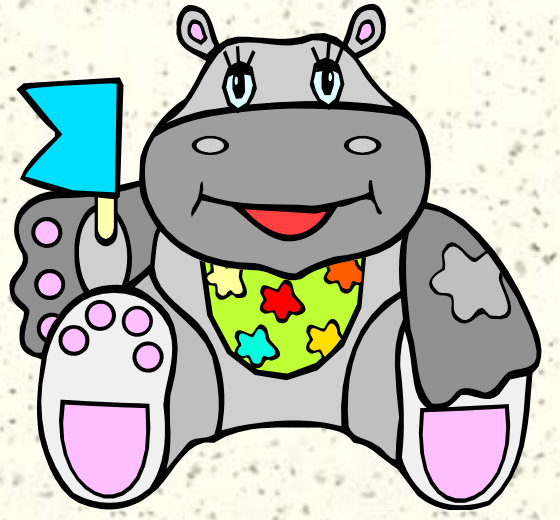
Physician Order Sample- Action Oriented w/triggers

- **Place in Observation**
- **Dx**: "Dehydration"
- **Treatment**: "2 Liters IV fluid bolus over 2 hours followed by 150cc/hr"
- **Monitor for** "hypotension, diarrhea, vomiting, urine output, etc.."
- **Notify physician when:** Patient urinates or 3 liters have been infused

- Each hour needs tied to the physician's orders.
- Billable time is finished when the orders are met.
- Nursing develops internal 'triggers' to aggressively monitor all orders.
  - color coded observation charts
  - white board -room # w/trigger times
  - update new trigger times with updated orders
  - 24 hr board – use colors to identify OBS orders due/room could also use for recovery phase 2 is done/6 hr mark

Physician and Nursing - Partners

- **Active physician involvement** = charting indicates condition update w/corresponding orders, changes documented with all timed and signed by the physician.
- **Who keeps the physician 'updated' so the above can occur?**



Ideas to Explore and Resolve

- **ER**:
  - New space = observation unit
  - Physicians more actively involved with ongoing obs care/orders once moved to the floor
  - Internal changes to accomplish

Additional Opportunities

- **Hospitalist**
  - Role in assisting the primary physician in ongoing orders, interventions, after hrs, etc.
  - Financial impact
  - Coordination of pt care with the FPs and the surgeons

Charge Capture Ideas

- Explore front loading the 1st hr, where the majority of costs occur
- Explore different rate for different levels of acuity, i.e. care areas: medical, post procedure, OB, telemetry
- Each subsequent hr significantly less
- Create non-billable CDM entries
  - Non-billable not medically necessary
  - Non-billable community benefit
  - Stats only, but allows for tracking/trending

More Charge Capture Ideas

- Don't forget to look for outpatient services being done in Observation
- New Drug Administration CPTs for infusion and injections/9xxx; blood tx/36430
- Outpatient procedures done (0-69999 CPTs)
- Nonbillable/$0 entries

Drug Administration Uglies

- Initial/primary reason for visit
- Use 9xxxx for all payers. Only 1 C/pump for Medicare
- Once determined, initial/primary visit code (hydration, therapeutic, chemo)- then use subsequent CPTs for additional services
- All outpt areas are impacted: ER, observation, Hospital based clinics
- May be unrealistic for nursing/care areas to chart and charge.
- **IDEA**: Nursing takes ownership for charting 'start and stop' times per CPT.
- **IDEA:** Create charge Capture Analyst position

"Time" Charting Ideas

- Create a stamp for Drug adm start and stop times. (Could do recovery & 02 as they are timed charges)
- Use the stamp for billable time
- IV Hydration Infusion

_____ _____ _____ _____ _____ (multiple lines)
Start Stop Date Dept Initials

- IV Therapeutic Infusion

_____ _____ _____ _____ _____ (multiple lines)
Start Stop Date Dept Initials

Remember – time continues from ER to observation/outpt areas

Creating an Observation Attack Team

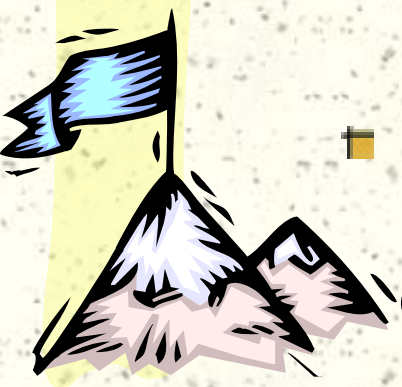
- If opportunities are found for improvement, create an internal, cross functional team to begin the rollout/improvement process.
- Follow the **CQI: FOCUS PDA** process.
- Find (F) an opportunity to improve.
- Organize (O) a team
- Clarify (C) the current process
- Understand (U) the variation
- Select (S) the process(es) to improve
- Plan, Do, Act

Working on the Process

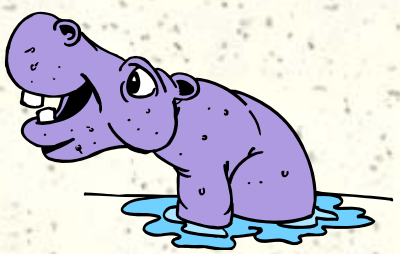
- **Observation Attack Team develops a rollout**
- *1st*: pull hx data: by dx, by care area, by doctor, by payer + hrs
- *2nd*: perform a benchmark chart review- identifying 'broken processes'. Compile data
- *3rd*: perform financial review –identifying $ at risk, summarizing reasons for non-billable
- *4th*: develop training material – including findings from audit, new tools, interventions.
- **FOCUS: Observation made easy!!**

An Observation Attack Team

- Team members: HIM, UR, case mgrs/care team leaders, PFS, Compliance, nursing
- Daily process:
  - Review observation charts, and complete chart review form
  - Complete manual charge ticket: billable and non-billable
  - Using non-billable statistics, evaluate patterns, by dx, by physician, by care area
  - Continue to evaluate improvement to the process: ed, sharing of data, new tools, accountability



Internal Processes



- Daily the Observation Attack team reviews each record
- Complete an internal **chart review** form with the required elements for coverage: order, intent, medical necessity for each billable hr, charted times, non-billable time

- Manually, complete the charge ticket:
- Example: 20 hr LOS

55112 1st hr 1 unit $250 762

55113 sub hrs 15 hrs $270 762

55114 Non-billable-not medically necessary 4 hrs

Daily Charge Capture Process

- Daily, Observation Attack Team completes:
  - Audit of observation accounts
  - Determines non vs billable hours
  - Completes charge ticket with non & billable items
  - Billable divided into first hr, each subsequent hour
  - Drug administration &/or procedure chg

Observation Attack Team ……

- Functions as **Charge Capture Analyst** for:
  - Identifying billable vs non-billable hrs
  - Identifying type of drug administration with start and stop times - include admits from ER as well as direct admits
  - Identifying bedside procedures and bill
  - ER to OBS = complete drug adm charge ticket at OBS d/c; not in ER
  - Reports non-billable items due to missing/incomplete documentation.

DAILY AUDIT TOOL SAMPLES

OBSERVATION CHART AUDIT TOOL

UR#_____DR_____ DOS_____ Time_____ (On face sheet)

MEDICARE REQUIREMENTS

Physician initial orders

- Dated _____
- Timed _____
- Clearly states: Observation (Chart Findings)

Intent in the physician order -Why did the physician want the patient in a bed? (Chart Findings)

- Orders for each hour? (Chart Findings)

Appropriate level of service to be in a bed continues to be met. (Chart Findings)

Active Physician Involvement -Is there documented communication between both the physician and nursing? (Chart Findings)

Patient arrival on unit (Nursing documentation)
Date
Time _____(in a bed / nursing notes)

-Signature Y N (Circle One)

Other? (Chart Findings)

Was medical necessity met for each billable hour?
Hours billed equals _____

Billable time_____ Non billable time _____

Summary of At Risk: (Chart Findings)

SAINT JOSEPH'S HOSPITAL OF ATLANTA
OBSERVATION CHART AUDIT TOOL

Patient Name _____ Dr. _____
Patient Account Number_____
DOS _____ Time _____(on face sheet)

PATIENT PROFILE (FROM H&P)

MEDICARE REQUIREMENTS

1. INITIAL PHYSICIAN ORDERS:

- Clearly states: Observation (Chart Findings) Y / N (If No, complete 1 and proceed to 7)
- Was the order consistent with CMS instructions to Physicians? Y / N
- Dated: Y / N _____
- Timed: Y / N _____

2. INTENT IN THE PHYSICIAN ORDER:

- Why did the physician want the patient in Observation Status? (Chart Findings)
- Orders for each hour? (Chart findings)
- Is the level of service appropriate for Observation Status? (Chart findings)

3. ACTIVE PHYSICIAN INVOLVEMENT

- Is there documented communication between both the physician and nursing? (Chart Findings)

4. OBS. TREATMENT INITIATION

Location:
Date:
Time: (in Obs. / nursing notes)

Nursing Signature Y / N

Others? (Chart Findings)

OBS. ENDING/DISCHARGE

Location:
Date:
Time: (in Obs. / nursing notes)

Date:	Date:	Date:
00:00 12 AM	00:00 12 AM	00:00 12 AM
01:00 1 AM	01:00 1 AM	01:00 1 AM
02:00 2 AM	02:00 2 AM	02:00 2 AM
03:00 3 AM	03:00 3 AM	03:00 3 AM
04:00 4 AM	04:00 4 AM	04:00 4 AM
05:00 5 AM	05:00 5 AM	05:00 5 AM
06:00 6 AM	06:00 6 AM	06:00 6 AM
07:00 7 AM	07:00 7 AM	07:00 7 AM
08:00 8 AM	08:00 8 AM	08:00 8 AM
09:00 9 AM	09:00 9 AM	09:00 9 AM
10:00 10 AM	10:00 10 AM	10:00 10 AM
11:00 11 AM	11:00 11 AM	11:00 11 AM
12:00 12 PM	12:00 12 PM	12:00 12 PM
13:00 1 PM	13:00 1 PM	13:00 1 PM
14:00 2 PM	14:00 2 PM	14:00 2 PM
15:00 3 PM	15:00 3 PM	15:00 3 PM
16:00 4 PM	16:00 4 PM	16:00 4 PM
17:00 5 PM	17:00 5 PM	17:00 5 PM
18:00 6 PM	18:00 6 PM	18:00 6 PM
19:00 7 PM	19:00 7 PM	19:00 7 PM
20:00 8 PM	20:00 8 PM	20:00 8 PM
21:00 9 PM	21:00 9 PM	21:00 9 PM
22:00 10 PM	22:00 10 PM	22:00 10 PM
23:00 11 PM	23:00 11 PM	23:00 11 PM

SAINT JOSEPH'S

Observation ATTACK Team
Charge Audit Tool

Date of Audit: _____
Clinical Area of Observation Charges: _____

Patient Name _____
Account Number _____
Date(s) of Service: _____
Physician: _____

Audit Performed By:
- Clinical Area _____
- Case Management _____
- Business Office _____
- HIM _____
- Other _____

Total Hours in Observation Status: _____

Billable Observation Hours	Original Amount Charged	New Amount Audit	Add Hours	Subtract Hours	Charge Code
1st Hour of Observation	Qty	Qty			60000003
Additional Hour of Observation	Qty	Qty			60000004
Direct Admit Observation Charge	Qty 0	Qty			60000010

Non-Billable Observation Hours Statistical	Original Amount Charged	New Amount Audit	Add Hours	Charge Code
Lack of Documentation	Qty 0	Qty		17500964
Physician / Patient Conveience	Qty 0	Qty		17500965
Social Reason / Community Benefit	Qty 0	Qty		17500966
Other	Qty 0	Qty		17500967

Does Account Require Charges to be Adjusted?

No ☐
Yes ☐

Adjusted Charge Entry information

Date of Charge Entry for Audited Results: _____
Employee That Performed Charge Entry of Audited Results: _____

Another Crazy idea for APC hospitals - Medicare

- APC payment is based on a minimum of 8 hrs (up to 48 hrs)
- If after assessment of the OBS hrs, a minimum of 8 hrs is 'left as billable' –the facility could just bill 8 hr, receive the APC payment without consideration for additional billable hrs.
- Revenue will not reflect all hrs; payment will be the same once 8 hrs is billed.
- Hrly rate should be assessed

Operational Ideas

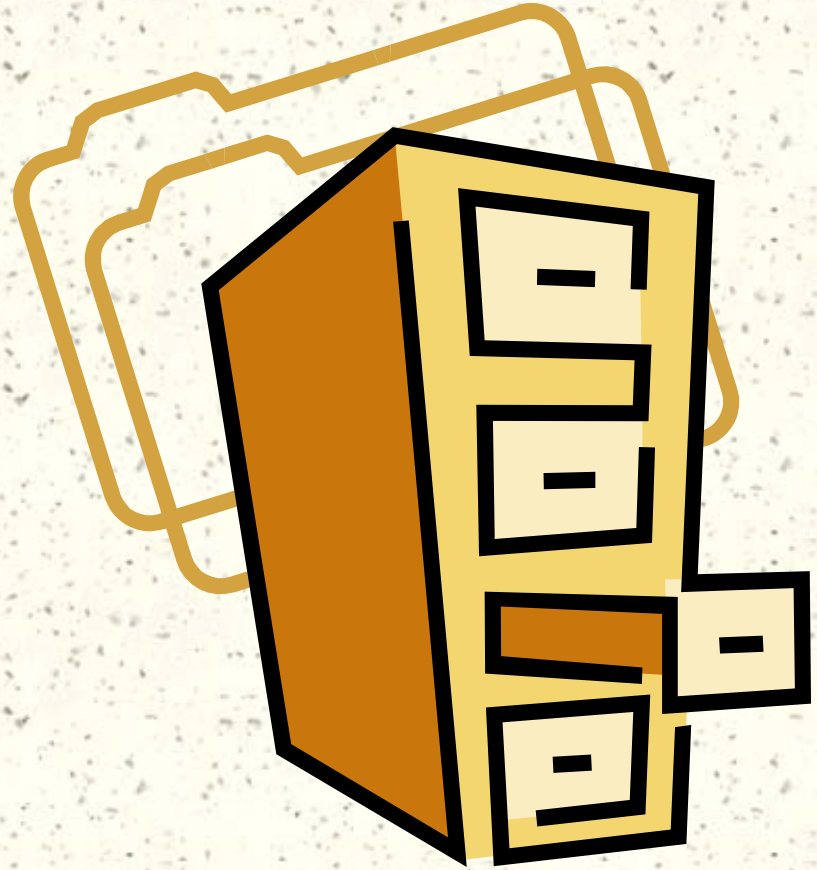
- Can ancillary areas 'see' the order is for observation vs inpatient?
- Ensure there is a **cost benefit of OT** vs having the pt stay in non-billable hrs
- How does the nurse bed-side case manager 'see' the interprets are complete? How does the physician know they are ready to be acted on ?

Celebrate the baby steps

- Determine objectives –compliance, revenue, patient satisfaction. (Where does the patient want to be??)
- Determine if current billing should continue or if a break during corrective action plan.
- Determine how to continue to share the message after the initial kick off plan.
- Celebrate as each area: nursing, physician, administration –live the message.

Roll out Key Elements

- Use 'real life' examples for ed.
- Determine timeline to start Attack Team
- Determine timelines for ed, daily process, ongoing process.



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Thanks for joining us!

Understanding the Medicare Payment System

Observation – Composite APCs

2008

2008 Composite APCs

- What is it? "Composite APCs provide a single payment for two or more major procedures that are commonly performed together in order to promote efficiency by increasing the size of the payment bundle."
- 5 Composites were created. 2 are dedicated to Obs.

Significant 2008 Changes

- Composite APC (CAPC) –two new ones for observation:
  - APC 8002 (level I extended assessment and management component. Direct admit)
  - APC 8003 (level II extended assessment and management component. ER admit)
  - Certain conditions must be met for a separate payment. Otherwise, observation will be packaged.
  - Patients with any diagnosis will trigger CAPC

CAPC 8002 requirements/Direct

- G0378, per hr (over 8 hrs) must be reported on the same day as:
  - G0379/direct admit or
    - 99205 /office or other outpt visit for E&M of a new pt (level 5) or
    - 99215 /office or other outpt visit for E&M of an established pt.
    - Pt w/any dx will trigger payment
    - Payment: $351.04

Understanding CAPC 8002-Direct

G0378	Hosp obs per hr / 8 U	N
G0379	Direct Admit	$50.66
(Q status)		
90760	Hydrat 1st hr	$114.64
90761	Hydrat ea add (8 U)	$201.04

Eligible for CAPC 8002 payment of $351.04. G0379 's $ of $50.66 is replaced with the CAPC 8002 $ of $351.04. Increase in payment

CAPC 8003 Requirements/ED

- G0378 (8hr or more) must be reported with:
  - 99284 or
  - 99285 or
  - 99291
  - Pts w/any diagnosis will trigger a payment.
  - Payment $638.66

Seeing CAPC 8003 Work-ER

- 99284 /Q ER level 4 Dx: CHF $209.99
- G0378 Hospital obs per hr (9 hrs) but it has met criteria to have
- CAPC 8003. 2007 = $442.81/APC 339. In 2008, replace 99284 as it is a Q when done with Obs. Now the payment is $638.66 for 99284 & G0378.
  - TOTAL 2007: E&M + APC 339/covd dx = $652.80
  - TOTAL 2008: Loose E&M + CAPC 8003/any dx = $638.66

- Interesting as the 3 prior covered dx (CHF, chest pain, asthma) will actually result in a loss of payment under CAPC 8003

No payment in these situations

- If a T status/procedure is done on the day of or day before, no CAPC 8002 or 8003 will be paid.
- Lower level of ER & HBC visits will not generate a CAPC payment (ER:1-3; HBC: 1-4)
- Less than 8 hrs will not generate a CAPC payment.