



# Back to Basics - Medicare

Spring Conference

March 13, 2008

Presented by: Steve Thompson

# Agenda

- Observation
- EPO Billing
- ABN's
- Questions

# Observation



# Observation

- Under the Medicare Outpatient Prospective Payment System (OPPS), hospitals are required to bill for observation services if that service is provided.
- 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 to be discharged from the hospital.

# Coverage Requirements

- Observation must be reasonable and necessary
- Only in rare and exceptional cases will observation span more than 48 hours
- Usually the decision to admit or discharge can be made in less than 24 hours (reported units must equal or exceed 8 hours).

# Observation = Requirements

- Determined by physician order and documented medical necessity, not by location.
- Must be based on risk stratification criteria.
- Written order for observation must be clear – preferred “Admit to Observation”
- Physician and staff are expected to routinely monitor the patient, in order to determine if inpatient admission is necessary and/or appropriate.

# Observation – non covered

- Patient or family convenience
- Post operative monitoring during standard recovery
- Standing orders for observation following outpatient surgery
- Inpatient admission converted after the fact to an observation status.
  - Exception – when condition code 44 is applicable

# Observation – Condition Code 44

- Condition Code 44 – Inpatient admission changed to outpatient – For use on an outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet inpatient criteria.
  - The hospital may change the status from IP to OP and submit an OP claim (TOB 13X,85X) for medically necessary Part B services.

# Additional criteria – Condition Code 44

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient in the hospital;
  - The hospital has not submitted a claim to Medicare for the inpatient admission;
  - A physician concurs with the Utilization Review Committees decision; and
  - The physician's concurrence with the Utilization Review Committee's decision is documented in the patient medical record.
- When a hospital determines all of the above criteria are met, they are to bill as an OP as if the IP admit never occurred .

# Observation – Billing

- G0378 – “Hospital outpatient service per hour”. This code captures hourly observation services provided to any Medicare patient admitted to observation status, regardless of the patients medical condition. When using this code, hospitals must bill the observation charges using Rev code 762, with appropriate number of units.
- G0379 – “Direct admission of patient for observation care”. This code captures charges for the initial nursing assessment, the creation of the medical record, the recording and initiation of telephone calls, etc. Revenue code 762 must be used.

# General Billing

- Reporting Hours
  - ✓ Observation begins at the time documented in the medical record which coincides with the time when the patient is placed in the bed. (round to the nearest hour).
  - ✓ Observation time may include medically necessary services % follow-up care provided after the physician discharge order, but before the patient discharge.
  - ✓ Reported observation time would NOT include the time patient remains in the observation area **after** treatment is finished. (For reasons such as waiting for transportation home).
    - ✓ If 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 is the date the patient is admitted to observation.

# General Billing

- The OPPS processing logic will determine if G0378 (observation) is separately payable as APC 0339 or packaged into the payment for other services provided by the hospital in the same encounter.
  - 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 the the observation status.

# General Billing – 5 Criteria for Separate Payment

1. Patient has a specified Chest Pain, Asthma or CHF diagnosis.
2. At least 8 hours of observation.
3. A clinic or ER visit or Critical Care on the day of or day before OR direct admission (G0379).
4. No status indicator “T” procedure the day of or the day before.
5. Documentation requirements.

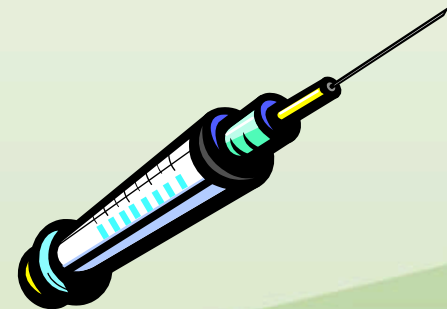
# General Billing

- In order to receive separate payment for a direct admission to observation (APC 0604), the claim must show:
  - Both HCPCS codes G0378 (hourly observation) and G0379 ( Direct admission to observation) with the same date of service;
  - No services with a status indicator T or V or critical care (APC 0620) were provided on the same day of service as HCPCS G0379; and
  - The observation care does not qualify for separate payment under APD 0339.
    - If a bill for “direct Admission” to observation doe NOT meet the above (3) criteria, then payment will be packaged into payments for other separately payable services provided in the same encounter.

# Observation – Payment Information

- Separate payment may be made for observation services for:
  - Asthma
  - Chest pain
  - Congestive Heart failure
- *The list of qualifying ICD-9-CM codes:* [www.cms.hhs.gov/hospitaloutpatientpps](http://www.cms.hhs.gov/hospitaloutpatientpps)
  - The list of ICD-9-CM codes eligible for separate payment is reviewed annually. Any changes are included in the October Quarterly Update of the OPSS and also published in the annual OPSS final rule.
  - “Qualifying” codes must be reported in FL.76 Patient reason for visit or FL. 67 Principal diagnosis or both, in order to receive separate payment for APC 0339
  - Qualifying codes reported in the secondary diagnosis field will not pay separately.

# Erythropoieses Stimulating Agents



# Erythropoieses Stimulating Agents

- Reporting of Hematocrit or Hemoglobin levels on all claims
- Effective date January 1, 2008
- Implementation date April 7, 2008
- Hematocrit or Hemoglobin readings are already required for ESRD claims for administration of an ESA

# Instructions to Providers and suppliers

- Effective January 1, 2008, all claims for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent Hematocrit or Hemoglobin reading.
- Institutional claim, the Hemoglobin reading is reported with a value code 48 in box 39 and a Hematocrit code is reported with a value code 49 in box 39. If these codes are missing, the claim will be returned.

# Rationale for change

- Recently published data regarding the use of ESAs have raised concerns.
- In light of the health and safety factors and the Tax Relief and Health Care Act of 2006, effective January 1, 2008 the CMS is implementing an expanded reporting requirement for all claims billing for the administration of an ESA.

# Claims Returns

- When Medicare returns a claim for ESA's with HCPCS codes J0881, J0882, J0885, J0886 or Q4081 for failure to report the most recent Hemaglobin or Hematocrit test results, it will include:
  - Claim Adjustment Reason Code 16, and
  - Remittance Advice Code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

# Non ESRD ESA Claims

- Effective January 1, 2008, claims billing HCPCS J0881 and J0885 must begin reporting one (**and only one**) of the following three modifiers on the same line as the ESA HCPCS
  - EA: ESA, anemia, chemo induced
  - EB: ESA, anemia, radio-induced
  - EC: ESA, anemia, non chemo/radio
- Non-ESRD ESA claims that do not report one of the above modifiers along with HCPCS J0881 or J0885 will be returned to the provider

# Non-ESRD Non ESA

- Effective January 1, 2008, all non ESRD, non ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self administered must report the most recent Hematocrit or Hemaglobin reading.
  - Institutional claims that do not report the most recent Hematocrit or Hemaglobin reading will be returned to the provider.

ABN



# Using the ABN

- The ABN allows the beneficiary to better participate in his or her own health care treatment decisions by making informed consumer decisions.
- If the patient chooses to have the services or tests performed, they need to understand they are **personally and fully responsible** for the payment. Payment will be a complete out of pocket expense.

# Using the ABN

- If the patient does not choose to be billed, they are to be given the option of refusing the service or discussing alternatives with their physician.
- A provider should not present a beneficiary with an ABN unless the provider has some genuine doubt about the likelihood of Medicare payment.  
**Blanket ABN's** is not an acceptable practice.

# Advanced Beneficiary Notice (ABN)

- An ABN is a written notice from a provider to a Medicare Beneficiary before items or services are performed, when the provider believes that Medicare will probably not or certainly will not pay for some or all of the services to be provided.
- Examples of exclusions:
  - Custodial Care
  - Pap Smear
  - Pelvic Exam
  - Prostate Cancer Screening
  - Colorectal Cancer Screening

# Delivery of an ABN

- Delivery of an ABN occurs when the beneficiary or authorized representative, has received the notice and can comprehend its contents.
- The provider is to hand deliver the ABN to the beneficiary or authorized representative. If the beneficiary alleges non receipt and the provider cannot show that notice was received by the beneficiary, the FI could hold the provider responsible and not allow provider to collect the denied services from the beneficiary.

# Delivery of ABN

- If the ABN is obtained by someone other than the party billing the service (physician), the signed ABN is to be provided to the provider who will be billing the services rendered.
- As much as possible, it is recommended that the beneficiary be provided with a legible copy of the signed document.
- A telephone notice to a beneficiary or authorized representative, is not considered sufficient evidence of proper notification.
- A beneficiary or authorized representative must be able to fully comprehend the reason for the ABN.

# Special Rules

- Exception for repetitive notices:
  - A single ABN covering an extended course of treatment is acceptable provided the ABN identifies all items and services for the provider believes Medicare will not pay.
- When an ABN is to be given for a standing order, the provider must specify in the Items or services box, the pertinent facts (example, Frequency and duration). One year is the limit for use of a single ABN.

# Reference Source

- MLN Matters:
  - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5699.pdf>
- Official instruction (CR5699)
  - <http://www.cms.hhs.gov/Transmittals/downloads/R14212CP.pdf>

# Questions?



# Contact Information

- Steve Thompson
  - 415 925 7516
  - [Thompsst@sutterhealth.org](mailto:Thompsst@sutterhealth.org)