



Medicare Hospital and Chargemaster Version LifePoint Custom

KEY CONCEPTS OUTLINE

Module 13: Strategies and Key Issues by Revenue Code: Routine Services and Observation

- I. Accommodation Codes—Room Rates (Revenue Codes 011x–016x)
 - A. Accommodation codes and daily room rates
 1. The billable unit of service for these revenue codes is a “day”.
 - a. The midnight-to-midnight method must be used for Medicare cost reporting, even if you use a different definition of a patient day for statistical purposes. < *Provider Reimbursement Manual*, Part 1, Chapter 22 § 2205>
 - (i) An inpatient at midnight is included in the census of the inpatient care area regardless of the patient’s location at midnight (e.g., in a routine bed, in an ancillary area, etc.), including a patient who has not yet occupied a routine care bed since admission.
 - (ii) If a patient occupies a bed in more than one routine care area in a day, the inpatient day is counted only in the routine area where the patient is located at midnight.
 - (iii) If the patient is in an ancillary area at midnight, the inpatient day is counted in the routine area in which the patient was located before going to the ancillary area.
 - (iv) If the patient has not been located in a routine area since admission, the inpatient day is counted in the routine area the patient is assigned.
 2. The daily room rate for inpatients usually defaults to a standard accommodation code set up by nursing unit or floor.
 3. The daily room rate can have multiple prices per revenue code or department unit, which are typically represented by different accommodation codes in the AR system (e.g., isolation, therapeutic).

- a. Who enters accommodation codes if different from the default?

Example:

Med/Surgical 2 West Cost Center 205611

Accommodation	Price	Rev Code
A Default	\$1500	111
B Isolation	\$2000	111
C Therapeutic	\$2500	111
D Iso/Therapeutic	\$3000	111

Procedure:

- Order for inpatient admission and placement in room & bed on unit = Default Accommodation (A).
- Order for isolation precautions—Workflow changes Accommodation to B. Discharge of isolation precaution changes Accommodation back to A.
- Order for specialty mattresses or BMI > 40—Workflow changes Accommodation to C.

Note: Another option is unit secretaries changing accommodation codes.

- b. How are accommodation codes monitored for accuracy?
- c. Ensure different room rates by revenue code are all included in managed care contracts.
- (i) Best practice is to ensure revenue codes are represented. The hospital can have as many room rates as it chooses if CMS' *Provider Reimbursement Manual (PRM)* Part 1 instructions are followed.

B. Nursery levels (017x)

1. The levels of care for nursery/neonatal ICU (NICU) are associated with revenue codes.
 - a. 0171 – Level I (routine newborn care)
 - b. 0172 – Level II (low birth weight or moderately ill requiring more nursing)
 - c. 0173 – Level III (intermediate care, <32 weeks gestational age <1500g requiring 6-12 hours of nursing care per day)

- d. 0174 – Level IV (intensive care, constant nursing, continuous cardiopulmonary, and other support for illness)
- 2. Caution: NICU preauthorizations/certifications are often required to be by level through UR/case management.
 - a. How does the unit know which accommodation code (i.e., level) to charge per the authorization?
- 3. The hospital should have policies that define the levels of care.

Tip: Ensure documentation of daily assessments is retained in the medical record and ties to the NICU level charged.

Use the NUBC referenced guidelines develop a template for the daily assessment documentation to be retained in the medical record.

C. SCUs/ICUs

- 1. SCUs/ICUs are defined in the *PRM* Part 1, Chapter 22, Section 2202.7.
- 2. Revenue codes 020x–021x.
- 3. In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (§ 2202.7), then the cost of such service cannot be included in a separate cost center but must be included in the general routine service cost center. <*Provider Reimbursement Manual* Part 1, Chapter 22, Section 2202.6 Routine Services>
- 4. Requirements to qualify as a SCU:
 - a. The unit must be in a hospital;
 - b. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis (extraordinary care incorporates extensive life-saving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units);
 - c. Special life-saving equipment should be routinely available in the unit;
 - d. The unit must be physically identifiable as separate from general care areas, and the unit's nursing personnel must not be integrated with the

general care nursing personnel (they must be specially trained to serve in such areas); and

- e. There must be specific written policies for each of such designated units, which include (but are not limited to) burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms or maternity labor rooms. <Provider Reimbursement Manual Part 1, Chapter 22, Section 2202.7>
- f. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment unless the above requirements are met. <Provider Reimbursement Manual Part 1, Chapter 22, Section 2202.7>
- g. The hospital must have policies that address overflow patients (i.e., patients that require a medical-surgical level of care that must be cared for in the ICU due to bed availability). The room rate that is charged must reflect the level of care so that the level of care variation in cost can be tracked for cost-reporting purposes.

D. Incidental nursing—023x

1. This revenue center is used for extraordinary nursing procedures provided or supported by the nursing unit staff for inpatients billed to Medicare and Medicaid if there is not a specific revenue code exclusively for the specific service.
 - a. Examples of bedside procedures that may be billed in this revenue center include:
 - (i) Debridements
 - (ii) Foley insertions
 - (iii) Thoracentesis
 - (iv) Incision and drainage
 - (v) Negative pressure wound therapy
 - (vi) Chest tube insertion
 - (vii) Lumbar puncture
 - (viii) Bedside scope procedures

- b. Examples of services with specific revenue codes that should be used for both inpatients and outpatients include:
 - (i) Blood administration (0391)
 - (ii) Chemotherapy (0331, 0335)
 - (iii) Cell and Gene Therapies (087x)
 - c. The supply items may be packaged in the procedure charge (e.g., lumbar puncture).
 - d. The facility should have a policy that includes a definition of what the standard room rate includes for each nursing unit.
 - (i) This addresses concerns of unbundling because what is extraordinary is different and should be defined per unit.
 - e. Can often be identified based on nursing documentation and supplies (e.g., lumbar puncture, PICC line insertion).
 - f. Who captures?
2. Commercial payers may deny charges billed under the incidental nursing revenue code 023x. Determine why, and address through contracting if possible.
 3. Carve out bedside procedures at the beginning of a fiscal year. One strategy is to not increase the room rates by the full percentage increase and instead use prior year revenue statistics to “carve out” the additional services and begin reporting them. The change should be accompanied by a new policy and definition of standard room rates per unit.

II. Outpatients in Beds

A. Observation services

1. What are observation services?
 - a. “Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.” <Medicare Benefit Policy Manual, Chapter 6, § 20.6A>

- (i) An observation patient is considered to be an outpatient for Medicare purposes < *Medicare Benefit Policy Manual*, Chapter 6, § 20.6B >
2. Order requirement:
 - a. Observation services must be provided "by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests." < *Medicare Benefit Policy Manual*, Chapter 6, § 20.6A >
 3. Documentation requirements:
 - a. The beneficiary must be in the care of a physician as documented in the medical record by "outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician." < 72 FR 66812, *Medicare Claims Processing Manual*, Chapter 4, § 290.5.3 >
 4. Observation services may not be reported separately as observation services if they are part of another Part B service, such as:
 - a. Observation provided concurrently with diagnostic or therapeutic services for which active monitoring is already part of the service; or
 - b. Routine preparation for and recovery from diagnostic tests; or
 - c. Postoperative monitoring during a standard recovery period (e.g., 4–6 hours) < *Medicare Claims Processing Manual*, Chapter 4, § 290.2.2 >
 5. Standing orders for observation following outpatient surgery are not recognized. < *Medicare Claims Processing Manual*, Chapter 4, § 290.2.2 >
 6. Observation is reported with revenue code 0762, and each hour of observation is reported with G0378 for Medicare. Non-Medicare payers may use 99221-99239 for reporting observation.
 - a. When carving out time for concurrent services, deduct the average length of time of the interrupting procedure from the total duration of time that the patient receives observation services." < *Medicare Claims Processing Manual*, Chapter 4, Section 290.2.2 >

- b. Consider defining average time by charge transaction code for non-timed codes such as ECG or x-rays. Develop an IT routine where each Medicare observation account transaction is checked against the time and “carve out” time is summarized.

Sample process for observation “carve out”

<u>CDM</u>	<u>Description</u>	<u>Time</u>
12345	CT	45 min
23456	PT inter eval	60 min
34782	EKG	20 min

Patient acct # & total observation time
784567123 Total obs time = 26 hours

IT routine on acct 784567123

Found CDM 12345, 23456 & 34782
Carve-out time = 125 minutes
Bill 24 hours covered

- B. Direct admission to observation from a non-hospital department location is reported with G0379.
1. Emergency department patients who are subsequently admitted to a bed for observation services during the same encounter receive one of the emergency department CPT® codes (99281–99285, 99291).
 2. Hospital provider-based clinic patients who are subsequently admitted to a bed for observation services during the same encounter receive the HCPCS code for clinic visit (G0463).
- C. Postoperative patients
1. Hourly charges for nursing care after a procedure that does not qualify as observation services should be reported as postoperative care. It is common to charge hourly recovery at the same hourly rate as observation services billed with revenue code 0710 or 0762. Another term for this is “extended recovery.”

- a. Caution: 0710 will create a mismatch for cost reporting purposes, with the revenue going to the recovery area but the routine care area providing the services (i.e., taking the expense), and reclassification should be considered.

D. Patients receiving outpatient procedures (e.g., blood transfusion, outpatient chemotherapy)

- 1. Hourly charges can be reported as outpatient specialty services (0760) with no HCPCS code as long as the costs represented by the hourly charges are not already included in the procedure code to ensure there is no duplication of charges.
 - a. Caution: 0760 revenue code matches to the clinic cost center, so ensure revenue is reclassified to the observation cost center.

III. Caution regarding the 3-day/1-day payment window and CMS' billing instructions for observation services

- 1. Edits are applied by line-item date of service (LIDOS)
 - a. The payment window applies to outpatient services within three calendar days (or one calendar day for non-IPPS hospitals) prior to the patient's inpatient admission, even if the services are part of a continuous outpatient encounter that began prior to the payment window. <Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>
 - (i) CMS pre-admission packaging edits are applied by line-item dates of service (LIDOS) for each service and not the "from" and "through" date of a claim. <Medicare Claims Processing Manual, Chapter 3 § 40.3 B and D>
 - (ii) Application to observation services
 - (a) Observation services are billed with the LIDOS that they began, rather than the date they are rendered. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
 - (b) Observation services with a LIDOS prior to the payment window will not trigger pre-admission packaging edits, even though some of the services may occur within the payment window and are presumably subject to packaging if they are related to the inpatient admission. <Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>

IV. Medicare Payment for Observation Services

- A. There are three ways Medicare pays for covered observation services. <Medicare Claims Processing Manual, Chapter 4 §§ 290.5.1, 290.5.2, and 290.5.3; 80 Fed. Reg. 70335-336>

Observation services have no separate payment rate under OPPS.

For payment purposes, they are:

- Packaged into/paid as part of the C-APC for comprehensive observation services (8011);
- Packaged into a visit APC for direct referral for observation; or
- Packaged into/paid as part of other services on the claim

B. Comprehensive-APC (C-APC) for comprehensive observation services

1. The C-APC for comprehensive observation services (C-APC 8011) makes a single payment for all services provided during an encounter that includes at least eight hours of observation and meets other criteria. <80 Fed. Reg. 70335-336; Medicare Claims Processing Manual, Chapter 4 § 290.5.3>
2. Criteria for payment of C-APC 8011
 - a. An assessment visit, assigned status indicator J2, with a date of service on the day of or the day before observation services:
 - (i) A clinic visit billed with G0463; or
 - (ii) A Type A ED visit billed with 99281–99285; or
 - (iii) A Type B ED (urgent care) visit billed with G0380–G0384; or
 - (iv) A critical care visit billed with 99291; or
 - (v) Direct referral for observation billed with G0379 <80 Fed. Reg. 70335-336; Medicare Claims Processing Manual, Chapter 4 § 290.5.3>
 - b. At least eight hours of observation care billed with G0378. <80 Fed. Reg. 70335-336; Medicare Claims Processing Manual, Chapter 4 § 290.5.3>
 - (i) Note: Each covered hour of observation should be billed, and the IOCE checks if the units of G0378 are 8 or more. This is the reason all hours are billed on one line.

- c. No surgical procedure assigned status indicator T or J1 reported on the same claim as the observation services. <80 *Fed. Reg.* 70335-336; *Medicare Claims Processing Manual*, Chapter 4 § 290.5.3>
3. If all criteria for C-APC 8011 are not met, the observation will be packaged into the other services on the claim and no additional payment will be made for the observation. <*Medicare Claims Processing Manual*, Chapter 4 § 290.5.3>
 - a. Any other separately payable HCPCS codes (i.e., the clinic visit, ER visit, etc.) will be paid separately according to their “usual associated” APCs. <*Medicare Claims Processing Manual*, Chapter 4 § 290.5.3>
- C. Payment for direct referral for observation
1. Separate payment is available for direct referral for observation (G0379) if the following criteria are met:
 - a. The services on the claim do not qualify for payment under C-APC 8011;
 - b. No service with status indicator T, J1, or V (visit) is billed on the same claim <*IOCE Specifications*, Appendix L, *Medicare Claims Processing Manual*, Chapter 4 § 290.5.2>
 2. Payment is made under APC 5025, “Level 5 Type A ED Visit” <*IOCE Specifications*, Appendix L, OPSS Addendum A>
- D. Packaged observation services
1. Covered observation services that do not qualify for payment as part of the C-APC for comprehensive observation services or direct referral for observation are packaged to other separately payable services. <*Medicare Claims Processing Manual*, Chapter 4 § 290.5.1>

Examples of packaged observation services (i.e., no additional payment for observation is made), include

- *Observation services provided during an encounter with a surgical procedure (i.e., services with status indicators T or J1)*
- *Observation stays of less than 8 hours, unless they are the result of a direct referral for observation*

V. Key General Ledger and Finance Concepts

- A. Each nursing unit is a separate cost/expense department.
- B. Is productivity of the unit/nurses tracked by days? Do hours of outpatients in beds need to be tracked?

VI. Charge Capture Considerations

- A. Ensure ICU/CCU correctly uses accommodation codes for patients that cannot be transferred to med/surg beds due to availability.
- B. Unit secretaries generally enter accommodation codes but consider also giving access to UR/case management for NICU levels.
- C. EMR charge capture linked to orders/accommodation codes.