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Ordering and billing observation services: A simple service with complex regulations

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Ever since the Centers for Medicare and Medicaid Services (CMS) created observation as a billable service that can be provided to Medicare beneficiaries, confusion has been the rule and not the exception. This begins with the decision about the proper use of observation. Prior to the Two-Midnight Rule, the decision of whether a patient warranted observation services or inpatient admission was a clinical decision made by the physician, based on the severity of the signs and symptoms of the patient and the medical predictability of an adverse event.[1] The Two-Midnight Rule, established in the 2014 Inpatient Prospective Payment Final Rule, made the decision a somewhat simpler one, based on the expected time the patient would require in the hospital, with observation indicated for patients who have an expectation of under two midnights and inpatient admission for those whose hospital care is expected to require more than two midnights. But four years later, most physicians still rely on utilization review staff to guide them to the right status.

What is observation?

CMS has defined observation as a well-defined set of specific, clinically appropriate services, including ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether the patient will require further treatment as a hospital inpatient or will be discharged from the hospital.[2] CMS also indicated that "observation services must also be reasonable and necessary to be covered by Medicare."

When initially introduced,[3] observation could only be used for three conditions: asthma, chest pain, and congestive heart failure. In 2006, CMS allowed observation billing on any diagnosis. Hospital coding for observation services also changed with the establishment of specific G codes. The Ambulatory Payment Classification (APC) to which observation services were attached also changed several times.[4] In 2015, CMS established the concept of comprehensive APCs (C-APC)[5] and included observation services as a C-APC in 2016.[6] And when CMS changed the APC designation, they also changed the qualifying visit levels, initially requiring a high-level emergency department (ED) or clinic visit and then broadening the qualifying visit to any ED or clinic visit or a direct referral from a community physician.

Observation itself is billed using Healthcare Common Procedure Coding System (HCPCS) code G0378, with the number of units indicating the number of medically necessary observation hours that were provided to the patient. Although it would seem straightforward to be able to calculate the number of hours, there are several nuances to consider.