Table Attachment
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Guidelines for Observation Services

The determination of an inpatient or outpatient status for any given patient is specifically reserved for the attending physician. The decision must be based on the physician's expectation of the care that the patient will require. An inpatient admission, for patients who are expected to need hospital care for 24 hours or longer, should be ordered. 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. Those patients for whom it is reasonable to expect safe discharge in less than 24 hours should be treated on an outpatient basis. In many institutions there is no difference between the actual medical services provided in an inpatient setting versus an outpatient observation setting. In such cases, the designation still serves to assign patients to an appropriate billing category.

A person is considered an inpatient if he/she 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 is still appropriate. The justification for the admission, then, is based on the information available at the time of admission.

When the admitting physician orders observation services, the patient is considered an outpatient. While specific medical necessity for both inpatient admissions and outpatient observation is always determined on a case-by-case basis, certain diagnoses and procedures generally do not support an inpatient admission, and fall within the definitions of outpatient observation. Uncomplicated presentations of chest pain (rule out MI), mild asthma/COPD, mild CHF, syncope and decreased responsiveness, atrial arrhythmias and renal colic are all frequently associated with the expectation of a brief (less than 24-hour) stay unless serious pathology is uncovered. Routine diagnostic cardiac catheterization, electrophysiological mapping, and renal dialysis are usually performed with a similar short stay expectation and are thus usually outpatient procedures.

Observation services can be provided in any location within a facility, whether in a specific observation unit or on a hospital floor. Observation services should be patient-specific and are not part of the facility's standard operating procedure or protocol for a given diagnosis or service; observation determinations made by protocol without consideration of the applicability to the specific patient are not clinically appropriate.

Observation services begin at the time the professional provider writes the order for outpatient observation. If the observation stay results in an inpatient admission, the inpatient admission begins at the time of the admission for observation services. The inpatient claim should include all charges incurred during the stay. No separate observation claim is to be filed.

Coding Guidelines

Initial observation services performed by the primary care physician (i.e., physician of record) are reported using the initial observation care codes (new or established patient) 99218-99220.

Evaluation and management services performed by the supervising practitioner and provided on the same date and in sites that are related to the initiation of observation care are not separately reported.

Consultation services requested of other physicians while the patient is in observation care are reported with codes 99241-99245.

Observation services initiated on the same date as the patient’s discharge are reported by the primary care physician as observation care codes 99234-99236.

Observation discharge service is reported using code 99217 if the discharge is on other than the initial date of observation care. Procedure code 99217 includes all services provided to a patient on the day of discharge from observation status.

For patients receiving observation services who are admitted to hospital inpatient status on the same date, the primary care physician should report only the initial hospital care codes 99221-99223.

It is not appropriate to report a discharge from observation care (99217) when a patient is admitted to hospital inpatient status on the same day.

Subsequent observation care is reported per day using codes 99224-99226. These codes include review of the medical record, results of diagnostic studies and response to change in patient status since the previous physician assessment.

Hospital observation services should be billed with HCPCS codes G0378 (Hospital Observation Services, Per Hour) and G0379 (Direct Admission of Patient for Hospital Observation Services).

Report code G0379 with only one unit of service. G0379 must be billed in conjunction with G0378.

HCPCS code G0379 is used when a patient is referred directly to observation care after being seen by a physician in the community and without an associated Emergency Room (ER) visit, hospital outpatient clinic visit or critical care service on the day of initiation of observation services.

Observation time for direct referrals begins after the patient arrives at the facility and it is documented in the medical record that observation time has started.

The units of service billed for G0378 must equal the number of hours that the patient is in observation status. Hospitals should round to the nearest hour when reporting observation care; however the total time should exclude any “carved out” time (e.g., diagnostic or therapeutic services).

Hospitals should not report the procedure codes for physician observation when reporting hospital observation services.

Observation services are considered an outpatient service and generally do not exceed 24 hours.

Although some patients may require a second day of observation, it is rare for medically necessary observation services to span more than 48 hours. Observation services (G0378) are limited to 48 hours or 48 units of service.