HMI Corporation

CODING & BILLING FOR PROSPECTIVE PAYMENT SYSTEMS

First Quarter February 17, 2003

## Updated Billing and Payment Requirements for Observation Services

The Centers for Medicare and Medicaid Services (CMS) released a more comprehensive explanation of the appropriate use of Observation HCPCS codes for 2003. In addition to revisiting the billing requirements for packaged observation services, CMS further defined the new *Direct Admit Observation* codes listed below:

**G0263 – Direct admission of patient w/diagnosis of CHF, chest pain, or asthma for observation services that meet all criteria for G0244.**

**G0264 – Initial nursing assessment of patient directly admitted to observation w/diagnosis other than CHF, chest pain, or asthma, or patient directly admitted to observation w/diagnosis of CHF, chest pain, or asthma that does not meet all of the criteria for G0244.**

> *Note: G0264 would now be reported for every Medicare direct admit observation patient that did not qualify for G0263.*
>
> *Note: A manual process may be required by some facilities to appropriately identify and bill for paid observation services, and an initial 100% audit of this patient type is recommended.*

The following guidelines should assist facilities in determining how observation HCPCS codes be reported:

G0263

1. This code must always be reported with G0244 (It indicates paid observation for chest pain, CHF or asthma, but direct admitted, bypassing the ED or Clinic).
2. This code must always be reported with modifier 25.
3. This code is reported with revenue code 762.
4. This code is status indicator “N” and is treated as a packaged service (no separate payment is made).
5. This code is not reported in hourly increments, and should be reported only once.

G0264

1. This code must be reported on all Medicare direct admit observation patients not qualifying for G0263.
2. This code should never be billed with G0244.
3. This code is assigned an APC, and is paid the same as a low level Evaluation and Management (E&M) visit.
4. This code is not reported in hourly increments, and should be reported only once.
5. This code is reported with revenue code 762.

G0244

1. This code is reported for patients presenting to the ED or Clinic with a diagnosis of chest pain, CHF, or asthma.
2. This code must be reported with certain diagnostic tests based on diagnosis (see Program Memorandum (PM) A-02-129).
3. This code must be reported with an ED, Clinic or critical care visit, or G0263, with modifier 25 attached.
4. This code must be reported in hourly increments, with a minimum of 8 hours and a maximum of 48 hours.

5. This code is assigned to an APC (based on an 8 to 24 hour period), and is paid the same regardless of the amount of hours between 8 and 48 reported.
6. Effective October 1, 2002, new ICD-9 codes have been added to the required diagnoses list for CHF (see PM A-02-129).
7. If the period of observation spans more than one calendar day, "hospitals should include all of the hours for the entire period of observation on a single line and enter as the date of service for that line the date the patient is admitted to observation".
8. This code is reported with revenue code 762.

99217-99220 or 99234-99236

1. These codes should be reported for all observation services not meeting any of the above criteria.
2. These codes are packaged, and no additional payment is made.
3. These codes are reported with revenue code 762, and can be "hard-coded" by the chargemaster or "soft-coded" by HIM. CMS does not require that the HCPCS codes be reported, but many FI's require them.
4. These codes are reported in hourly increments.

CMS created these new temporary codes based on the number of comments they received from hospitals about the number of patients reporting to their facilities from physicians' offices. CMS will be tracking this data for future reimbursement considerations for observation services. All hospitals should ensure that the proper mechanisms are in place to accurately report these codes.

## Latest CMS Updates

CMS recently published the following updates:

- **PM AB-03-021** – Additional Documentation Requests (ADR) Requirements for Order Providers of Laboratory Services
- **PM AB-03-013** - 3-Day Payment Window Refinements Under the Short-Term Hospital Inpatient Prospective Payment System

The above listed program memorandums can be found at:
http://cms.hhs.gov/manuals/memos/comm_date_dsc.asp

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