Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

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Related Change Request (CR) #: 4259
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Implementation Date: January 3, 2006

January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Observation

Note: This article was updated on April 3, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers billing fiscal intermediaries (FIs) for hospital observation services provided to Medicare beneficiaries and paid under the OPPS

Provider Action Needed

This article is based on Change Request (CR) 4259 which includes changes included in the January 2006 OPPS OCE and the January 2006 OPPS PRICER.

Background

Change Request (CR) 4259 describes changes to coding and payment for hospital observation care paid under the OPPS to be implemented in the January 2006 OPPS update (including OPPS OCE and OPPS PRICER changes). In addition, CR4259 discusses changes to observation care under the OPPS.

Observation Care

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 whether they can be discharged from the hospital.

Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Observation services are covered only when 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. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

For complete details and the specific new instructions regarding observation care, see the revised portions of the *Medicare Claims Processing Manual* attached to CR4259 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R787CP.pdf and to the *Medicare Benefit Policy Manual* attached to CR4259 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R42BP.pdf on the CMS website.

New G-Codes

Beginning January 1, 2006, the following two new G-codes should be reported by hospitals for observation services and direct admission for observation care:

New G-Codes	Descriptor
G0378	Hospital observation services, per hour
G0379	Direct admission of patient for hospital observation care

The OPPS claims processing logic will determine the payment status of the observation and direct admission services, that is, whether they are packaged or separately payable. Thus, hospitals are able to provide consistent coding and billing under all circumstances in which they deliver observation care.

CPT Codes

Beginning January 1, 2006, the following Current Procedural Terminology (CPT) codes should not be reported by hospitals for observation services:

CPR Codes Not Paid Under OPPS	Descriptor
99217	Observation care discharge
99218	Initial observation care, low severity
99219	Initial observation care, moderate severity
99220	Initial observation care, high severity
99234	Obs/Impt. care (incl. admit/discharge), low severity
99235	Obs/Impt. care (incl. admit/discharge), moderate severity
99236	Obs/Impt. care (incl. admit/discharge), high severity

G-Codes

Lastly, the following three G-Codes are discontinued as of January 1, 2006:

Discontinued G-Codes	Descriptor
G0244	Observation care by facility to patient
G0263	Direct Admission with congestive heart failure, chest pain or asthma
G0264	Assessment other than congestive heart failure, chest pain, or asthma

CR4047

CR4047 (Transmittal 763, dated November 25, 2005) explains that some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service.

The MLN Matters article that corresponds to CR4047 can be reviewed at: *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM4047.pdf* on the CMS website.

Unless otherwise noted, the coding and payment policy addressed in CR4259 are effective for services furnished on or after January 1, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R787CP.pdf on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.