Observation Unit
Financial Success

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Components of Optimizing Revenue

- Maximize RVUs/patient
  - Physician documentation
  - Coding methodology
- Optimize RVUs/day
  - Appropriate patient selection
  - Census and staffing
- Facility revenue considerations

2014 CPT & CMS Language

Observation care is a well-defined set of specific, clinically appropriate services, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients.

CMS Transmittal 1745, 290.1 - Obs Services Overview

Such services are covered only when provided by order of a physician...

“...The following codes are used to report encounters by the supervising physician...and performance of periodic reassessments” CPT 2014 page 13

General Documentation Requirements

- Timed/dated order to place in observation status
- A short treatment plan regarding the goals of observation
- Clinically appropriate progress notes
  - Asthma different than chest pain
- A discharge summary reviewing the course in observation, findings, and plan

Professional Observation CPT Codes

Same day admit and discharge CPT Codes:
- 99234 – Low severity
  - Low-complexity MDM
- 99235 – Moderate severity
  - Moderate-complexity MDM
- 99236 – High severity
  - High-complexity MDM

CMS 8 Hour Rule

- Medicare requires 8 hours of Obs. on the same calendar date to bill 99234-99236
  - CPT does not define a time threshold
- If the Obs. stay spans 2 calendar days, no time constraints for CMS or CPT payers
Admit and discharge more than one calendar day:

- **Initial Day CPT codes:**
  - 99218 – Low severity
    - Low-complexity MDM
  - 99219 – Moderate severity
    - Moderate-complexity MDM
  - 99220 – High severity
    - High-complexity MDM

**Coding Scenarios Observation Services**

<table>
<thead>
<tr>
<th>Observation Level of Care</th>
<th>Care All on the Same Day</th>
<th>Care Covers Two Calendar Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>99234</td>
<td>99218 + 99217</td>
</tr>
<tr>
<td>2</td>
<td>99235</td>
<td>99219 + 99217</td>
</tr>
<tr>
<td>3</td>
<td>99236</td>
<td>99220 + 99217</td>
</tr>
</tbody>
</table>

**Physician Documentation**

- All but the lowest level Obs require very significant Hx and PE documentation
- Comprehensive Hx and PE:
  - 99219/99220 & 99235/99236
    - HPI: 4 elements
    - PFSHx: 3 areas (Requires Family Hxs)
    - ROS: 10 systems
    - PE: 8 organ systems
  - Obs services typically require a family history
- Beware overuse of macros for ROS and PE

**Cloning Under Scrutiny**

“There are troubling indications that some providers are using EHR technology to game the system, to obtain payments to which they are not entitled. False documentation is illegal. A patient's information must be verified by the provider to ensure accuracy and can not simply be cut and pasted. Law enforcement will take appropriate steps…”

**2014 OIG Report: PROGRAM INTEGRITY PRACTICES TO ADDRESS VULNERABILITIES IN EHRS**

Inappropriate copy-pasting could inflate claims by inserting irrelevant documentation to support billing higher level services.

A single click could produce information suggesting the practitioner performed more comprehensive services than were actually rendered.
**BCBS Accusation of Cloning**

I am writing to provide you with a summary of the findings from the focused medical record review of our practice that was conducted by the PNSL investigation. Identical notations were observed in the electronic medical records for different patients with different presenting problems, raising serious concern about the integrity of the electronic medical record.

In several instances, it appeared that in parts of the electronic medical record for a given patient, the name was simply the same as in an earlier patient's record, rather than being patient-specific with pertinent information for the presenting problem(s) on the actual date of service. Corrected/improved templates were observed primarily in the sections of the medical record labeled "Review of Systems" and "Physical Examination." While templates contained in the database.

Other, some or most of the physical examination information for a given patient was identical to other patient record(s). That is, every patient's physical examination included review of the systems for skin, eyes, ears, nose, mouth and throat, neck, head, heart, lungs, abdomen, extremities, musculoskeletal, and psychiatric issues. However, the type and

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**Summary Documentation Requirements**

<table>
<thead>
<tr>
<th>Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSHx</th>
<th>PE</th>
</tr>
</thead>
<tbody>
<tr>
<td>99234</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>99235</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>99236</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

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**2014 RVU Values for Observation Services**

<table>
<thead>
<tr>
<th>Same Day/Over Midnight Obs</th>
<th>Total RVU</th>
<th>Over Midnight Obs</th>
<th>Total RVU</th>
<th>ED E/M Service</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99234</td>
<td>3.79</td>
<td>99217</td>
<td>2.03</td>
<td>99284</td>
<td>3.30</td>
</tr>
<tr>
<td>99235</td>
<td>4.74</td>
<td>99218</td>
<td>2.78</td>
<td>99285</td>
<td>4.85</td>
</tr>
<tr>
<td>99236</td>
<td>6.12</td>
<td>99219</td>
<td>3.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>99220</td>
<td>5.20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

99217 + 99220 = 7.23 RVUs Total

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**Cost Of Hx and PE Downcodes**

- 2 downcodes: 99236
  - Loose 4.66 RVUs.
  - $166.93
  - 38%

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**Obs Coding Methodology**

- Most ED run Observation units see higher acuity patients
- Chest pain or clinically equivalent complexity is very common
- ED Observation E/M distribution influenced by pre-selected complexity

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**Clinical Benchmarks of Patient Complexity**

- No AMA CPT Appendix C Obs code vignettes
- CMS RUC data base vignettes
- 99234: 19 y.o. pregnant patient (9 weeks gestation) presents to the ED with vomiting X 2 days. The patient is admitted for observation and discharged later on the same day.
- 99235: 48-year-old presents with an asthma exacerbation in moderate distress.
- 99236: 52-year-old patient comes to the ED because of chest pain.
### CMS Benchmark Data: Patient Complexity

#### 2013 Medicare RUC Claims Data

<table>
<thead>
<tr>
<th>Code</th>
<th>Total Reporting</th>
<th>E Med Reporting %</th>
<th># E Med Patients</th>
<th>E Med Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>99234</td>
<td>53,624</td>
<td>4.45%</td>
<td>2,386</td>
<td>10.9%</td>
</tr>
<tr>
<td>99235</td>
<td>143,673</td>
<td>4.16%</td>
<td>5,977</td>
<td>27.3%</td>
</tr>
<tr>
<td>99236</td>
<td>164,691</td>
<td>8.20%</td>
<td>13,504</td>
<td>61.8%</td>
</tr>
</tbody>
</table>

### CMS E Med Obs E/M Distribution

#### 2013 Medicare E Med Obs Codes Reported

![Distribution Chart]

### Obs E/M Modeling

![Distribution Chart]

### Patient Selection

**A Driver of Financial Success**

- Current
- Appropriate

### RVU Analysis

- Annual Obs Volume: 5,500
- Annual Lost RVUs: 6,050
- Per Visit Increase in Collections: $39.41

### Who Should Be In Obs?

Which Obs patients will an ED group be successful with?

- Select patients with diagnoses that have clinical protocols
- Expedite throughput
- Achieve decreased length of stay
- Reach a successful clinical endpoint
- Prolonged stays drag down RVU efficiency

### The Spectrum of Complexity

**Easier**
- Chest pain
- Abdominal pain
- Headache
- Cellulitis
- Pyelonephritis
- Asthma
- Dehydration
- Renal colic
- Hypoglycemia
- Allergic reaction
- Pharyngitis

**Harder**
- Closed head injury
- Vertigo
- Hematuria
- Pancreatitis
- SOB
- CHF/COPD
- Back pain (non ambulatory)
- Extremes of age
- Mental Health
- Substance abuse
RVU Modelling: LOS and Bed Use

- CHF 3 day stay
  - Htn, Creat. 2.3 & BS 385
- Monday placed in CDU
- Tuesday slow diuresis
  - BS, K⁺ abnormal, BP
- Home late Wednesday
- Alternative bed use
- Day 1 - Chest pain patient
  - 15 hour LOS
- Day 2 - pyelonephritis
  - Stays overnight
  - Dc’d in the AM
- Day 3 Chest pain
  - 15 hour LOS

RVU Modelling: Patient Selection & LOS

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LOS</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF 3 Day</td>
<td>RVUs</td>
<td>5.20</td>
<td>2.03</td>
<td>2.03</td>
</tr>
<tr>
<td>CP, Pyelo, CP</td>
<td>RVUs</td>
<td>6.12</td>
<td>5.20</td>
<td>6.12 + 2.03</td>
</tr>
</tbody>
</table>

Controlling Bed Flow to Maximize RVUs

How Many Patients?

- Varies by department acuity and your Obs protocols
  - How wide you cast the net
- Basic benchmarks
  - Typically 5% - 10% for many groups
  - 1 out of 3 admissions
  - Chest pain most common…typically a third
- Most groups have a 10% - 20% failure rate
  - Converted to inpatient

Minimum Number of Beds and Volume

- Minimum size for an early profitable dedicated unit: 6 beds
  - Fixed cost and nursing FTEs
- Typical Obs LOS 14 hours
- Max 1.3 bed turns per day.
- Obs volume is 8 per day
- ED volume requirement to generate 8 Obs patients:
  - 8% qualify for Obs…ED daily census of 100
  - 36,500 patients per year

Optimizing Unit Size for Profit

- Typical nurse to patient ratio 1:5
- Physician coverage 1:12
- Basic midsize unit requirements
  - Fixed costs: Bed space, secretary, medication administration
  - Profitability starts to optimize at steady census of 12 daily
  - Adjust your protocols to creep census up
- 50k ED…137/day…34 admits…want 12 for obs
  - 5 chest pain + 2 GU (colic & pyelo)
  - Need 5: dehydration/Abd pain/Asthma
**Who Mans The Unit**

**OPPS 2011**
- Direct supervision: during the initiation of observation
- General Supervision: once the patient is deemed stable
- CMS further stated: the provider could be an MD or NP/PA

**Observation Unit Staffing for Profit**
- 10 bed unit...turned 1.3 times daily
  - Blend of moderate and high...5.7 RVUs per case
  - Cost: salary, benefits, overhead...rough to cover costs

**Innovative Profit Solutions**
- MD coverage in the morning and evening
  - New admits and discharges
    - 10hrs X $140 = $1400
- PA/NP interim coverage
  - 12hrs X $70 = $840
  - Protocol driven at night
- Creep up volume to be profitable
  - Expand beyond chest pain to include protocol driven complaints such as Dehydration, Pyelonephritis, Asthma, Cellulitis

**Obs Indirect Facility Revenue**
- Risks: underuse of observation
  - Inappropriate inpatient admissions...RAC target
  - Short inpatient stays:
    - Decrease CMI
    - Hospital payment denials
  - Decreased readmission reduction penalties
    - 2% of Medicare revenue increasing to 3%

**Observation Increased $$$ ... What's The Catch?**
- 2014 ObservationAPCs 8002 /8003 → APC 8009
  - G0378 would continue to be reported
    - 8 hours required
  - APC 8009 payment is $1199
    - $500 increase from 2013
  - What's the catch?
  - Increased packaging → significant financial impact
  - Many status indicator X ancillary services, (i.e. lab) would be packaged into the primary (Obs) service
  - 2015 proposed rule- further packaging including all ancillaries < $100

**Observation Direct Hospital Revenue**

<table>
<thead>
<tr>
<th>Year</th>
<th>CMS Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$705.27</td>
</tr>
<tr>
<td>2011</td>
<td>$714.33</td>
</tr>
<tr>
<td>2012</td>
<td>$720.64</td>
</tr>
<tr>
<td>2013</td>
<td>$798.47</td>
</tr>
<tr>
<td>2014</td>
<td>$1,199.00</td>
</tr>
</tbody>
</table>

**Conclusions**
- Observation services will be an expanding determinant of our financial success
- Documentation and correct coding methodology drive the revenue per patient
- Focused patient selection, throughput and protocols optimize RVUs/day
- Packaging of services will lead to resource use pressure and efficiency pressure!
- The ED throughput culture is ideally suited to maximize Observation financial success
CMS Obs Supervision Requirements

Direct Supervision

- Initiation of observation: direct supervision
- Direct supervision: the Physician/NPP must be immediately available to furnish assistance and direction. The Physician/NPP is not required to be present in the room.

General Supervision Requirements

- General supervision:
  - Once the patient is stable
- General supervision: procedure is furnished under the Physician/NPP's overall direction and control
  The Physician's/NPP's presence is not required.

CMS and members of Congress concerns

- Beneficiaries spending long periods of time in Obs without being admitted as inpatients
- Obs is an outpatient status
- Concerned beneficiaries may pay more as outpatients than if they were admitted as inpatients
  - 80/20 co-insurance under part B
  - Self administered (P.O.) medications not covered
  - If not inpatient then responsible for SNF charges
    - In 2012, 11% of Obs was > 3 days

Patient Financial Considerations

- 20% co pays add up for longer complex Obs stays
  - Inpatient expense: Part A inpatient deductible $1,216
- SNF
  - Obs stay…no qualifying SNF Medicare coverage
    - Patient may be entirely responsible - $5,000
    - Typical stay starts at roughly $250 per day
  - Qualifying inpatient stay spanning 3 nights
    - No patient SNF cost sharing for first 20 days
    - After 20 days co-payment is $145 per day
- Self administered meds- “uncovered service” - gross hospital charges are in play (average bill $528)
Contact Information

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