


Physician Observation Reimbursement


Michael Granovsky MD, CPC, FACEP
President, LogixHealth



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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



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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



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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



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Professional Observation CPT Codes

- 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



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Professional Observation CPT Codes

- **Discharge day CPT Code:**
- **99217**- Discharge Day
- **Includes** final exam, discussion of observation stay, follow-up instructions, and documentation
- Used with codes from the initial observation day codes series (99218/99219/99220)

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Coding Scenarios Observation Services

Observation Level of Care	Care All on the Same Day	Care Covers Two Calendar Days
1	99234	99218 + 99217
2	99235	99219 + 99217
3	99236	99220 + 99217

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Keys to 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 Hx**)
 - ROS: 10 systems
 - PE: 8 organ systems
- Obs services typically require a family history**
- Beware overuse of macros for ROS and PE



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Summary Documentation Requirements

Level	HPI	ROS	PFSHx	PE
99234	4	2	1	5
99235	4	10	3	8
99236	4	10	3	8

Avoid Macro Over Use 

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Macro Over Use- They Really Mean It




Re: Medical Record Review Findings & Overpayment – Dr.

As detailed in the Findings, the core issue here is not that Dr. [redacted] utilized an EMR system for documenting E/M services, but rather that “[a] significant portion of the computer generated documentation . . . appeared to be pre-populated or copied from previous dates of service for [certain] patients, or from previous dates of service from other patients, rather than being specifically updated with pertinent information for the actual dates of service for those patients.” In other words, Dr. [redacted]’s medical records did not properly or accurately document the extent and type of E/M services he may have provided to a patient at a particular visit, in

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Provider Burden- Perhaps Some Help? Seema Verma Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



We have heard repeatedly that a major source of burnout is the documentation burden associated with evaluation and management (E/M) coding, and that a change is long overdue.

Clinicians find themselves having to perform and document clinical activity that may be of only marginal relevance to the visit, but is required in order to receive the level of payment that their effort deserves.



Seema Verma
CMS Administrator

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2019 Physician Final Rule/2020 Proposed No Change Obs Codes and ED Codes

- 2019 and 2020 No changes to any E/M codes
- 2021 **office visit codes** move away from the 1995 guidelines
 - Time and Medical Decision Making (MDM)**
- Collapsed payment level for new/established patient 2-4 removed from 2020 proposed rule

NO CHANGE TO THE ED or OBS CODES

*“The proposed changes only apply to office/outpatient visit codes: CPT codes 99201 – 99215. We understand there are more **unique issues** to consider in other settings such as **emergency department care**. We may address sections of the E/M code set beyond the office/outpatient codes in future years.”*

-2019 Physician Rule

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Observation Services: CPT Typical Times and MDM Highlights

CPT Code	Typical Times	CPT Code	Typical Times
99234	40 minutes	99218	30 minutes
99235	50 minutes	99219	50 minutes
99236	55 minutes	99220	70 minutes

Medical Decision Making for Obs Patients
 Obs treatment plan, differential diagnosis, Course in the unit and responses to treatment.
 Consults, review of labs and studies, review of old records
 Co-morbidities, neuro complaints, severe exacerbations

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Physician Observation Payment

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2019 RVU Values for Observation Services

Same Day Obs	Total RVU	Over Midnight Obs	Total RVU	ED E/M Service	Total RVU
99234	3.75	99217	2.06	99284	3.32
99235	4.77	99218	2.81	99285	4.89
99236	6.13	99219	3.83		
		99220	5.23		

99217 + 99220 = 7.29 RVUs Total



2020 Proposed Rule Obs RVUs stable*

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2019/2020 RBRVS Equation

Work RVUs
 Practice Expense RVUs
 +Liability Insurance RVUs
 Total RVUs for a given code

RVU_{Total} X Conv. Factor = Medicare Payment

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2019/2020 Conversion Factor Creeping Up

2018 \$35.9996
 2019 \$36.0391
 2020 \$36.0896 (Proposed)

TABLE 92: Calculation of the Final CY 2019 PFS Conversion Factor

CY 2018 Conversion Factor		35.9996
Statutory Update Factor * MACRA	0.25 percent (1.0025)	
CY 2019 RVU Budget Neutrality Adjustment	-0.14 percent (0.9986)	
CY 2019 Conversion Factor		36.0391

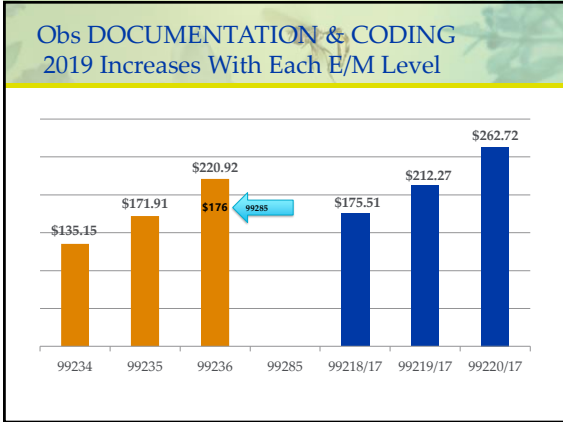
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2020 News Flash: ED RVU and Payment Increases

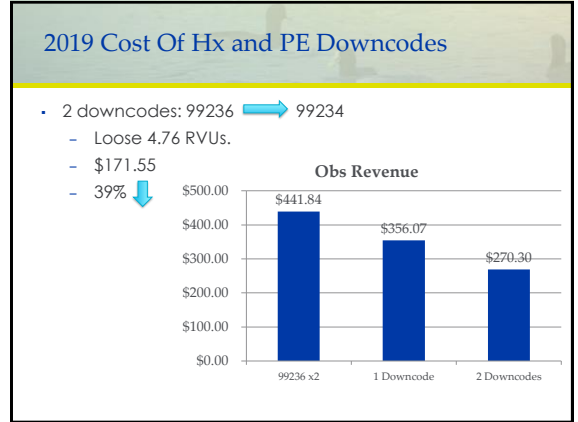
Payment Changes

Code	2020 Payment	2019 Payment	Change
99281	\$23.10	\$21.62	+1.48
99282	\$44.39	\$42.17	+2.22
99283	\$67.85	\$63.07	+4.78
99284	\$121.62	\$119.65	+1.97
99285	\$178.28	\$176.23	+2.05

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Obs Coding Methodology

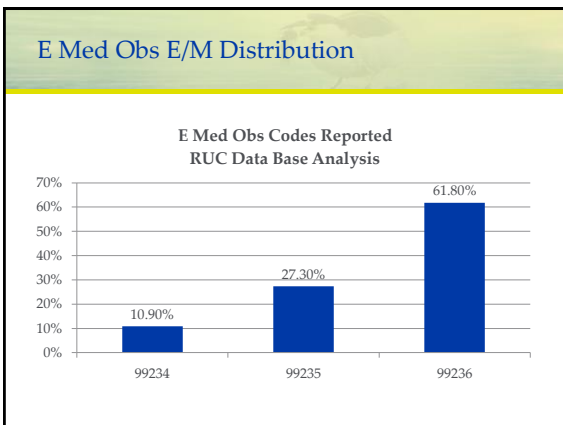
- Most ED run Observation units see higher acuity patients
- Chest pain or clinically equivalent complexity is very common
- ED Observation E/M distribution influenced by pre-selected complexity

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Clinical Benchmarks of Patient Complexity

- No AMA CPT Appendix C Obs code vignettes
- CMS RUC database 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 y.o. presents with an **asthma exacerbation** in moderate distress.
 - 99236:** 52 y.o. patient comes to the ED with **chest pain**.

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News Flash! July CPT Assistant Update: Observation and Mental Health

- Historically No clear direction re coding multi day mental health "borders" or "psych holds"
- CPT Behavioral Health Vignette:
 - Agitated patient requires psychiatric admission
 - No Beds and has a 3 day ED stay
- Asked CPT how to report a 3 day "psych hold"
 - Official Answer**
 - Obs day 1 99218-99220
 - Middle days 99224-99226
 - Final day 99217
- 5 day stay 4.89 RVUs → 14.37 RVUs

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Conclusions

- Observation services continue to have a bright and growing future!
- Key areas of appropriate coding and documentation will drive the success of your units
- There is a strong trend towards emphasizing medical decision making
- Lots of good news- ED RVUs are going up, conversion factor is going up, Obs has an RVU advantage!
- After several years of advocacy mental health Observation services now recognized by CPT!

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Contact Information

Michael Granovsky, MD, CPC, FACEP
781.280.1575

mgranovsky@logixhealth.com

www.logixhealth.com

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Facility Observation Reimbursement

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President, LogixHealth



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Why Is Obs Important To Your Hospital Now?

- CMS Recovery Audit Contractors (RACs) focusing on inpatient DRG payments vs. Observation status
- Hospitals under pressure to cut costs
 - Global contracts/ACOs/directly insuring communities
- ED groups ideally suited to run efficient units with short lengths of stay
 - The masters of the throughput mindset!

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DRG Economics

- Medicare pays a fixed amount for inpatient care
- Typically a **large** amount
 - Much more than the observation payment
- Recent study calculated use of Obs instead of inpatient reduce CMS cost dramatically
- Average cost savings per patient = \$1,572
- Annual savings calculated: \$3.1 Billion

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OIG Report and Analysis: Compliance with the 2 Midnight Rule

- Hospitals were paid for a total of 1,074,267 short inpatient stays. In our review 39% were potentially inappropriate for payment because the claims did not meet CMS's criteria for an appropriate short inpatient stay.

Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

VULNERABILITIES REMAIN
UNDER MEDICARE'S
2-MIDNIGHT HOSPITAL
POLICY



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2019 RAC Contracts

* RAC Contact Info

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Your Hospital's DRG Profile: The Pepper Report

- Complex Medicare Report
- Supplies hospital data related to potentially improper DRG payments
 - Number of discharges per DRG
 - Payments per DRG
 - Length of stay per DRG
 - Highlights hospital LOS ≤ 1 calendar day
 - RAC focus for DRG take backs

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Patient Selection for Observation Services

Selecting correct patients is key to the operational success of an observation unit

- Select patients with diagnoses that have that have associated clinical protocols
- Expedite throughput
- Achieve decreased length of stay
- Reach a successful clinical endpoint

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The Spectrum of Complexity

Easier	Harder
<ul style="list-style-type: none"> • Chest pain • Abdominal pain • Headache • Cellulitis • Pyelonephritis • Asthma • Dehydration • Renal colic • Hypoglycemia • Allergic reaction • Pharyngitis 	<ul style="list-style-type: none"> • Closed head injury • Vertigo • Hematuria • Pancreatitis • SOB • CHF/COPD • Back pain <ul style="list-style-type: none"> - Non-ambulatory • Extremes of age • Mental Health <ul style="list-style-type: none"> - Substance abuse

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Picking The Right Patients: Case Study - Community Hospital

- 40K ED with a 22% admission rate
- 110 patients per day
- 24 daily admissions
 - 30% qualified for Obs over first 6 months
 - Average of 7 Obs patients per day
 - Chest pain, syncope, cellulitis, pyelo, allergic reaction, Asthma, dehydration...
 - 10 bed unitfully occupied 28 days a month
 - 2,555 patients treated
 - Average LOS decreased 16 hours
 - Prior LOS for cohort 25 hours


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Optimizing Unit Size for Profit

- Typical nurse to patient ratio 1:5
- Physician coverage 1:12
- Fixed costs: Bed space, secretary, medication administration
 - Minimum 6 bed CDU requires 36k ED feeder*
 - Profitability optimized 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

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Cost: Who Mans the Unit



OPPS Regs

- Direct supervision: during the initiation of observation (immediately available)
- General Supervision: once the patient is deemed stable (overall control)
- CMS further stated: the provider could be an **MD or NP/PA**

Original Guidance 2011 OPPS
2019/2020 OPPS Rule no changes

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Inpatient and Outpatient Financial Construct

- Obs is an outpatient service covered under Medicare part B
- Concerned beneficiaries may pay more as outpatients than if they were admitted as inpatients
 - 80/20 co-insurance under part B
- Medicare Part A covers inpatient care, but with a substantial deductible
 - Recurs more than once a year
 - 2019 Inpatient expense: deductible \$1,364

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Patient Financial Detail



- 20% co pays add up for longer complex Obs stays
 - Inpatient expense: Part A inpatient deductible \$1,364
- SNF
 - Obs stay...no qualifying SNF Medicare coverage
 - 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 \$168 per day
- Self administered meds- "uncovered service" - gross hospital charges are in play

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ACEP Now Syncope Cost Comparison: Inpatient vs Observation

SERVICE	INPATIENT	OBSERVATION
Facility Fees	Patient pays Part A deductible \$1,364 Medicare Part A pays Diagnosis Related Group (DRG) 912 \$4,417 (plus deductible \$1,364)	Patient pays 50% of C-APC 0011 \$454.89 Medicare Part B pays 50% of C-APC 0011 \$1,298.31
Professional Fees	Patient pays 20% of fees: \$118.21 Medicare Part B pays 80%: \$465.23 CPT 93028 \$104.00	Patient pays 20% of fees: \$19.82 Medicare Part B pays 80%: \$115.29 CPT 93028 \$104.00
• Initial evaluation	CPT 93028 \$104.00	-
• Reassessment evaluation	CPT 93028 \$104.00	CPT 93017 \$73.45
• Discharge evaluation	CPT 93028 \$104.00	HCPCS R3040 \$64.49
• Completed history/physical examination	HCPCS T9040 \$43.35	HCPCS R3040 \$64.49
• Subsequent (ECC) interpretation	HCPCS R3040 \$64.49	HCPCS R3040 \$64.49
• ECC interpretation (if)	CPT 93010 \$85.00 (if \$20.90)	CPT 93010 \$85.00 (if \$20.90)
Medications	Patient pays \$0 Medicare Part A pays DRG payment	Patient pays with cost: \$127 Medicare Part B pays \$0
Laboratory	Patient pays \$0 Medicare Part A pays DRG payment	Patient pays \$0 Medicare Part B pays C-APC payment
Facility Diagnostic	Patient pays \$0	Patient pays \$0
• Cardiac monitoring with leads	Medicare Part A pays DRG payment	Medicare Part B pays C-APC payment
• CPT of the team		
• Cardiovascular monitoring		
• ECC (if)		
Total Payments:	Patient: \$1,288.21 Medicare Part B: \$1,298.31 Hospital: \$4,417 Professional: \$471.04 \$4,474.56	Patient: \$465.89 Medicare Part B: \$0 Medicare Part B: \$1,054.60 Hospital: \$2,261.14 Professional: \$194.11 \$3,915.74

ACEP Now: Baugh, Granovsky

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Hospital Observation Payment

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2019/2020 Facility Charge Construct

- Facility observation is a **composite** APC
- Requires a **qualifying visit and 8 hours of facility time**
- 2019 Observation **all** visits potentially qualify
 - 99281-99285 (Type A) or G0381- G0385 (Type B)
 - 99291
 - G0463 (hospital outpatient clinic visit)
 - G0379-(direct referral for observation)

2020 OPPS Proposed Rule: No Major observation changes:
Current Obs coding rules continue. **2020 OPPS page 61/819**



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2019/2020 Observation Facility Requirements

- Qualifying Visit 9928x, 99291, outpatient clinic G0463
- 8 hours reported as units of G0378 (in the units field)
- There must be a physician order for observation
- No T status procedure
- Continues for 2020 Proposed

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2019/2020 Observation: Comprehensive APC

- CMS has continued to expand the concept of outpatient packaging
 - Comprehensive APCs

A C-APC is defined as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. We established C-APCs as a category broadly for OPPS payment and implemented 25 C-APCs beginning in CY 2015

- 2016 OPPS 124/1221
- Observation C- APC 8011 active for 2019
 - 2020 OPPS Proposed construct continues

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What's Included in the Observation Comprehensive APC?

- Everything! (Most: Labs, CT, US, procedures, IVF, Meds)
- Except (S, I, F, G, H, L and U)
 - The following services are excluded from comprehensive APC packaging
 - Some Brachytherapy services (status indicator U)
 - Pass-through drugs, biologicals and devices (status indicators G or H)
 - Corneal tissue, CRNA services, and hepatitis B vaccinations (status indicator F)
 - Influenza and pneumococcal pneumonia vaccine services (status indicator L)
 - Ambulance services
 - Mammography

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Observation Increased Payments in 2019 What's the Catch?

- Observation is a Comprehensive APC
 - mini DRG
- Bundling: Most Labs, ancillaries, radiology, procedures, hydration/injection/infusion

"A C-APC is defined as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service."

- 2019 OPPS page 73/1182

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The Obs Pendulum: Facility Financial Risk/Reward

- Risks: overuse of observation
 - Financial-lower payment to hospital vs. inpatient
 - Loss of 3 day qualifying stay for SNF coverage
 - Potential higher out-of-pocket expense for patients
- Risks: underuse of observation
 - Inappropriate inpatient admissions - RAC target
 - Short inpatient stays:
 - Decrease CMI
 - Hospital payment denials

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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 the economics
- Packaging of services will lead to resource use pressure and efficiency pressure!
- The **ED throughput culture** is ideally suited to maximize observation financial success

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Contact Information

Michael Granovsky, MD, CPC, FACEP

mgranovsky@logixhealth.com

www.logixhealth.com

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Educational Appendix

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RAC Contact Information

Recovery Audit Contractors					
Region	States	Websites	Email	Phone Number	
Region 1 Performantrac Recovery, Inc.	CT, IN, KY, MA, ME, MI, NH, NY, OH, RI, and VT	https://performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580	
Region 2 Colvill, LLC	AR, CO, IA, IL, KS, LA, MO, MN, MS, NE, NM, OK, TX, and WI	https://Colvill.com/RAC	RACInfo@Colvill.com	1-866-360-2507	
Region 3 Colvill LLC	AL, FL, GA, NC, SC, TN, VA, WV, Puerto Rico and U.S. Virgin Islands	https://www.Colvill.com/RAC	RACInfo@Colvill.com	1-866-360-2507	
Region 4 HMS Federal Solutions	AK, AZ, CA, DC, DE, HI, ID, MD, MT, ND, NJ, NV, OR, PA, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas	https://racinfo.hms.com/home.aspx	racinfo@emallhms.com	Part A: 1-877-350-7992 Part B: 1-877-350-7993	
Region 5 DME/HIE/Performantrac Recovery, Inc.	Nationwide for DMEPOS/HEA/Hospice	https://performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580	

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2020 Physician Proposed Rule Obs RVUs

Observation Services CPT Codes (Proposed CY 2020 Values)					
CPT	2019 wRVU	2019 Total RVUs	w2020 wRVU (Proposed)	2020 Total RVUs (Proposed)	Total RVU % of
99217 (Observation Care Discharge)	1.28	2.06	1.28	2.03	-1.5%
99218 (Initial Observation Care)	1.92	2.81	1.92	2.84	+1.1%
99219 (Initial Observation Care)	2.60	3.83	2.60	3.86	+0.8%
99220 (Initial Observation Care)	3.46	5.23	3.56	5.19	-0.8%
99234 (Subsequent Observation Care)	0.76	1.12	0.76	1.12	No change
99235 (Subsequent Observation Care)	1.39	2.06	1.39	2.05	-0.5%
99236 (Subsequent Observation Care)	2.00	2.95	2.00	2.97	+0.7%
99234 (Obsers/hosp same day)	2.56	3.75	2.56	3.77	+0.6%
99235 (Obsers/hosp same day)	3.24	4.77	3.24	4.77	No change
99236 (Obsers/hosp same day)	4.20	6.13	4.20	6.14	+0.2%

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CMS PFSHx Observation Requirement

- CMS requires that comprehensive observation histories have 3 of 3 PFSH elements rather than the 2 of 3 requirement for ED/E/M codes
 - Medicare 1995 DGs page 6**
 - May utilize the nurse's notes but beware
 - Rarely document a Family Hx

"A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient."

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Potential Profitability Staffing Metrics

- Example 8 bed unit- mature program moderate protocols
- Physician Time
 - 10 minute of doc time per patient for morning rounds
 - 5-7 minutes for evening rounds
 - ED doc responds prn as required over night
- APP Time
 - 1 hour per patient
 - APP responds from the ED prn for minor issues

More intensive protocols require increased staffing!
DKA and PE patients don't take care of them selves

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How to Calculate the 2 days

"The final rule clarifies that the benchmark used in determining the expectation of a stay of at least two midnights begins when the beneficiary starts receiving services in the hospital. This would include outpatient care received while the beneficiary is in **observation** or is receiving services in the **emergency department**, operating room, or other treatment area."



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2-Midnight Rule: Key Definitions

2-Midnight Rule

The Benchmark: "We are specifying that for those hospital stays in which the physician expects the beneficiary to require care that crosses 2 midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate"

-2014 IPPS Final Rule 60/2225

The Presumption: "Inpatient hospital claims with lengths of stay greater than 2 midnights after the formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts."

-2014 IPPS Final Rule 1726/2225

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The Notice Act

- The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals to provide written and oral notice, within 36 hours, to patients who are in observation or other outpatient status for more than 24 hours
 - Passed August 2nd, 2015 but they forgot to go through the paper work reduction process step so initially delayed
 - Requires use of the Medicare Outpatient Observation Notice (MOON)

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MOON Basics

- The MOON is a standardized notice to inform beneficiaries (including Medicare health plan enrollees) that they are an outpatient receiving observation services and are not an inpatient of the hospital or (CAH)
- All hospitals and critical access hospitals (CAHs) are required to provide the MOON beginning no later than March 8, 2017

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MOON Process

- When delivering the MOON, hospitals and CAHs are required to explain the notice and its content, document that an oral explanation was provided and answer all beneficiary questions to the best of their ability
- Signature of Patient or Representative: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents. If a representative's signature is not legible, print the representative's name by the signature
- Date/Time: Have the patient or representative place the date and time that he or she signed the notice

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CMS Sample MOON

Medicare Outpatient Observation Notice

Patient name: _____ **Patient number:** _____

You're a hospital outpatient receiving observation services. This is not an inpatient admission.

Your costs for medications:
 Usually, observation and leave the master drug, including "self-administered drugs," you get in hospital admission settings like an emergency department aren't covered by Part D. "Self-administered drugs" are drugs that a patient takes at home. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. Part D plans tend to pay out-of-pocket for brand drugs and generic drugs for the same drug. Contact your drug plan for more information.

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
 - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
 - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicare, a Medicare Advantage plan or other health plan. Medicaid or the state may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary hospital services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

Signature of Patient or Representative _____ **Date** ____/____/____

OMB No. 0938-0047 | OIG No. 01-05-0001 | HHS.gov | Medicare.gov | www.cms.gov | www.medicare.gov | www.medicareadvantage.com | www.medicare.gov | www.medicare.gov

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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

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Patient 20% Co Pay

- Being an outpatient may affect what you pay in a hospital:
- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay: A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
- 20% of the Medicare-approved amount for most doctor services, after the Part B deductible

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SNF Not Covered

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury.
- An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged

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Inpatient Part A Coverage and SNF

- Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

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Contact Information

Michael Granovsky, MD, CPC, FACEP
781.280.1575

mgranovsky@logixhealth.com

www.logixhealth.com

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