

## OBSERVATION CARE POLICY ISSUES

### I. INTRODUCTION:

Guidelines to implement TMA Policy 99-002, Interim Policy for the Reporting and Billing of Observation Care Services.

Effective Fiscal Year 1999 (FY99), Military Treatment Facilities (MTFs) were requested to use B\*\*0 and fourth level DGE\* codes to capture workload and expenses for observation care services. The “\*\*” coding schema, which is the same one used for Ambulatory Procedure Visits (APVs), indicates the specialty of care being provided to the observation care patient. The fourth level code of Ambulatory Nursing Services (DGE\*) indicates the specifically designated area for observation care services.

The DoD Interim policy intended to minimize inconsistencies in capturing the data while also minimizing system changes and implementation costs. These guidelines outline the two methodologies to capture observation care services workload.

### II. COMMENTS:

1. Status of System Change Requests (SCRs) submitted:
  - SCR #577 to modify ADS record to document an outpatient’s placement in observation status has been approved/funded. Implementation date unknown at this time.
  - SCR #578 to enable identification (in CHCS) of patients admitted from Observation status (submitted 26 Apr 00 to MHS IM organization by UBU) – no action at this time.
2. DGE and/or DGA are proposed to allow the capture of workload and expenses for Observation Care Services when the MTF determines these areas are capable of handling a mixture of patients including those meeting the criteria of observation care. Observation patients may be physically located in dedicated observation units, the APU, or in any designated bed space.
3. All ancillary workload ordered by the physician for an observation patient will require the physician or order-entry individual to ensure the patient’s correct MEPRS FCC is entered, e.g., B\*\*0.
4. Physician personnel time will be reported under the appropriate B\*\*0 MEPRS code. Support personnel shall record their time under DGA\* if the observation patient is located on the APU, or under DGE\* if the patient is located in an observation unit or other designated observation bed.

## RECOMMENDED GUIDELINES to be effective FY01

### 1. Revised MEPRS code, DGE, Ambulatory Nursing Service

**FUNCTION:** Ambulatory Nursing Services provides a centralized program of nursing assessment and care for outpatients. Therapies include teaching; medication and fluid administration (such as intravenous (I.V.) antibiotic administration for ambulatory clinics); treatment intervention (chemotherapy); and nursing assessment. Ambulatory Nursing Services also prepares necessary records to document care provided; coordinates with various clinics, services, designated wards, third-party reimbursement coordinator, and admissions and discharge staff for pre-admission and pre-procedure processing. The Ambulatory Nursing Services work center may also designate beds for observation services that are necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. When pre-procedure processing is not performed by the APU, the DGE workcenter shall provide the services and coordinate with the clinic or APU for processing.

**COSTS:** The Ambulatory Nursing Services work center shall be a subaccount that includes all expenses incurred in operating and maintaining the function, such as expenses for personnel, supplies, travel, and any other expenses identified directly in support of Ambulatory Nursing Services activities. When performing services in support of APV patients and/or observation patients, total expenses shall ultimately be assigned through an expense allocation process to the corresponding B\*\*5 and/or B\*\*0 account associated with an Ambulatory Care (B) final operating account. Otherwise, total expenses shall ultimately be assigned through an expense allocation process to other ancillary services and to the final operating expense accounts.

**SERVICE UNIT:** Minutes of service (not multiplied by the number of staff). Raw count is the number of patients.

**ASSIGNMENT PROCEDURE:** Total expenses shall be assigned based on the ratio of minutes of service performed for each receiving account to the total minutes of service performed.

**NOTE:** Observation Care Services that will be captured as B\*\*0 are not the short term observation assessments provided incidentally and concurrently as part of outpatient procedures that may be captured for patients under Ambulatory Nursing Services (DGE) and/or Ambulatory Surgical Services (DGA). Specifically, the following services are not covered as outpatient observation services (B\*\*0) under DGE and/or DGA:

- a. Observation services which exceed 24 hours unless an exception is deemed necessary following a medical necessity review.
- b. Services which are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient, his or her family, or a physician (e.g., following an uncomplicated treatment or procedure; physician busy when patient is physically ready for discharge; patient awaiting placement in a long-term care facility.)
- c. Inpatient services.

- d. Services associated with ambulatory procedure visits.
- e. Routine preparation services furnished prior to the testing and recovery afterwards for patients who undergo diagnostic testing in a hospital outpatient department.
- f. Observation concurrent with treatments such as chemotherapy.
- g. Services for postoperative monitoring.
- h. Any substitution for an outpatient observation service for a medically appropriate inpatient admission.
- i. Services, which were ordered as inpatient services by the admitting physician, but reported as outpatient observation services by the hospital.
- j. Standing orders for observation following outpatient ambulatory procedures.
- k. An inpatient discharged to outpatient observation status following a hospital admission.

## 2. Revised MEPRS code DGA, Ambulatory Procedure Unit (APU)

**FUNCTION:** The Ambulatory Procedure Unit (APU) provides pre-procedure and post-procedure care, observation, and assistance for patients requiring short-term care of less than 24 hours. Same Day Surgeries, also known as Ambulatory Procedure Visits (APVs), are performed in a specialized area such as an APU, surgical suite, or extended care area. Refer to DoD Instruction 6025.8, reference (c), for further guidance. An APU is a location where the staff provides a centrally managed and coordinated program of nursing assessment and care planning; hospital or unit orientation; pre-procedure and discharge teaching; post-procedure monitoring; clinical and administrative interviews; initiation of procedural records and physician orders; and other functions, as appropriate. Therapies and functions include nursing assessment; case management; pre-operative teaching; providing necessary written instructions to the patient by registered nurses; parenteral fluid support; administering pre-procedure and post-procedure medications; discharge teaching; obtaining ordered pre-operative laboratory tests and radiology results; and scheduling patients for arrival time for surgery.

**NOTE:** MEPRS uses a fourth level B\*\*5 code to identify an APV; the B\*\*0 code identifies an observation care patient. These codes are linked to an APU (DGA\*) sub-account. In some cases, they could be linked to DGE\*, Ambulatory Nursing Services. The "5" in the fourth position indicates an APV performed in the APU, the "0" indicates an observation patient, and the "\*\*\*" coding indicates the clinical service performing under these services. For example, an APV performed by a Dermatology Clinic (BAP) provider will be recorded as BAP5. Refer to FCC "DGE" which provides the criteria of Observation Care Services that will be captured as B\*\*0 when the APU is utilized for Observation Care patients.

COSTS: The APU work center shall be a sub-account that includes all expenses incurred in operating and maintaining the function, such as expenses for personnel, supplies, travel, and any other expenses identified directly in support of APU and/or observation activities. Total expenses shall ultimately be assigned through an expense allocation process to a B\*\*5 and/or B\*\*0 account associated with an Ambulatory Care (B) final operating account.

SERVICE UNIT: Minutes of service. Raw count is the number of patients.

ASSIGNMENT PROCEDURE: Total expenses shall be assigned based on the ratio of minutes of service performed for each receiving account to the total minutes of service performed.

### III. COLLECTION OF WORKLOAD IN THE CLINICAL SYSTEM:

#### 1. APV Module (See below step-by-step procedures)

- Allows patient demographics to be captured
- Allows for capture of minutes of service by MEPRS specialty
- Ad hoc report is generated (APU Monthly Totals Report) and contains total case time (minutes of service) and number of cases by MEPRS codes
- Warning upon reaching 23 hours 59 minutes may be over-ridden. Does not force user to disposition patient.

#### A. APV module step-by-step procedures (provided by AF)

- Provider initiates "Observation stay when:
  - Fills-in AF Form 560 with "Observation"
  - Completes "short stay" history and physical (H&P)
- Patients are admitted to "Observation Status" for a stay up to 48 hours through A&D.
- Admissions and Dispositions (A&D):
  - completes AF Form 560 with insurance information and Advance Directives
  - Verifies full registration information
  - Schedules an Observation (OBS) Walk-in appointment in CHCS by performing the following:
    - Log into CHCS
    - Sign onto **PAS - Clerk Scheduling Menu**
    - **USV** - Unscheduled Visit (Walk-in)
    - **W** - Walk-in
    - **C** - Change Criteria
    - Select: **Patient, Clinic, Provider, Appointment Type**
    - Enter Patient Demographics (automatic DEERS check will occur)
    - Enter MEPRS code for *Observation Clinic* (i.e., BAA0, BAE0, BDA0, etc)
    - Enter **Staff Provider**
    - **WI (walk-in)** for Appointment Type
    - **File**
    - **Quit**
- **Print OBS** emboss card:

- **PAS** - Clerk Scheduling Menu
- **VAP** - Ambulatory Procedure Visit Menu
- **EAPV** - Ambulatory Care Embossed Card
- Enter Patient Data
- Select Embosser Format Name - (OBS [can also print Inpatient (I) and Ambulatory Procedure Visit (APV) cards here])
- Select correct appointment by checking date
- Stamp green patient ID band and discharge slip
- **Create OBS** record and label
  - **PAS** - Clerk Scheduling Menu
  - **TRM** - Track and Request Medical Records Menu
  - **M** - Record Tracking Application
  - **APV** - Create APV Record
  - Record Tracking File Room - **OBS**
  - **Enter Patient**
    - Press "Return" key through the records from past stays
    - **"Yes"** to create new record # or volume
  - **OBS**
    - Location - **MEPRS** Code
    - Device - **PAD1**
    - Place label and mark FMP/SSN on green folder
- **Discharge From OBS:**
  - Go to **Clerk Schedule Menu EOD processing/editing** in CHCS
  - Choose appropriate "Clinic" from which patient is being discharged, i.e., BAA0 etc...
  - Select patient to be dispositioned
  - Enter **Outpatient Disposition** i.e., *ADMT, AMA, FULL, HOME, LWBS, MDU* etc....
  - Enter **Disposition Date/Time** (This will accumulate minutes of service in CHCS)
- **MEPRS** Reporting - Workload Assignment Module (WAM)
  - WAM populates **"Minutes of Service"** on SAS 343 (DGAA) by MEPRS codes; both B\*\*5 and B\*\*0

*NOTE: Air Force uses APV software to track this category of patients. 'APU Monthly Totals Report' provides by MEPRS code, total case time (minutes of service) and total number of cases.*

*CHCS (V. 4.6) APV software: System displays a warning that patient must be dispositioned/admitted upon reaching 23 hours 59 minutes. The user can extend patient's stay for those requiring a longer stay and does not have to disposition to home or admit.*

2. ER Module (See below step-by-step procedures)
  - Allows capture of patient demographics
  - Allows for capture of minutes of service by MEPRS specialty

- Army Ad hoc report contains total case time (minutes of service) and number of cases by MEPRS codes

B. ER module step-by-step procedures (provided by Army):

- Patients classified in "observation" status will enter the facility in one of two ways:
  - After an Emergency Room Visit
  - After a normal clinic visit scheduled through the normal appointment process.
- Upon being classified as an "observation patient":
  - The initial visit will be closed in ADS with an "immediate referral".
  - Close out initial visit in CHCS
  - If patient entered through ER Module, do a referral disposition
  - If patient entered through another clinic, close as normal during EOD processing
- The patient will be inprocessed by PAD A&D or ER Personnel (after normal duty hours)
- PAD A&D or ER will make an observation patient card with:
  - MEPRS Observation Code (B\*\*0)
  - Patient demographic information
  - Ward where patient will be housed (2W, ICU, OB or L&D)
    - PAD A&D or ER will enter observation patients in CHCS ER Module
      - As a "walk in", with appointment type "OBU" and as "count" workload
      - By Observation location in CHCS (not actual ward location, but a CHCS hospital location based on the MEPRS Code)
    - Observation patients will automatically be entered into KG ADS through CHCS/ADS interface
    - E & M Codes will be recorded IAW standard ADS requirements
    - ICD9 and CPT-4 codes will be recorded IAW standard ADS requirements
- Requests for ancillary services can be processed by one of two methods:
  - CHCS outpatient "order entry" request screen
    - Physical location where patient is housed must be noted in the comment field
    - MEPRS Code must be an observation code (B\*\*0)
    - Order Entry requests can be printed in the clinic or the ancillary
  - Manual Ancillary Request Forms
    - Must be stamped with card prepared by PAD A&D, or
    - Must include the following information
      - Patient demographic information
      - MEPRS Observation Code (B\*\*0)
      - Physical location of patient (ICU, 2W, OB or L&D)
      - Requesting Physician signature
- Ad hoc reports will be written and a menu established for
  - Ancillaries so they can obtain information necessary for ward rounds
    - Physical location of patient (ICU, 2W, OB or L&D)
    - MEPRS Code for each patient (B\*\*0)

- Specific ancillary service requested
- MEPRS staff so data can be retrieved to report monthly in MEPRS
  - Number of Observation patients
  - Minutes of service provided by Nursing staff
- Utilization Management and Ward Nursing staff
  - To identify information concerning Observation patients
- Upon release from observation status, visit will be closed in ER module by one of the following:
  - PAD
  - Emergency Room
- Discharge scripts should be coded to the MEPRS Observation Code (B\*\*0)
- Physician time for care of Observation patients will be reported
  - In total patient care hours on the patient care line of the UCAPERS Clinician Utilization Worksheet
  - As a percentage of their time on the survey portion of the UCAPERS Clinician Utilization Worksheet
- When it is deemed medically necessary to admit an observation patient to an inpatient status, the observation visit will be closed in the ER module and patient will be processed as any other inpatient admission.

#### IV. AMBULATORY DATA SYSTEM (ADS)

1. When registering an observation patient, the observation encounter will be on the Service/MTF specific Authorization and Treatment Statement. Patient registration would also include the Other Health Insurance (OHI) data on a DD2569 form – Third Party Collection Program/Insurance Information.
2. Once the patient is scheduled and sent to the area designated for observation care (ward or clinic), DGE or DGA is the hospital location designated in CHCS. Minutes of service will be accumulated from the time the patient is placed in the observation area through discharge (admission or disposition to home).
3. Providers will capture Evaluation and Management (E&M) codes under B\*\*0 to document the length and acuity of observation care services on the ADS form or into KG-ADS through CHCS/ADS interface. Observation E&M codes relate to the calendar day (date) the patient spends in observation status and their acuity. Only one E&M code per observation patient will be recorded, according to the number of days (up to three) that the patient was under observation care (reference TMA Policy 99-002, Interim Policy for the Reporting and Billing of Observation Care Services).

**V. THIRD PARTY OUTPATIENT COLLECTIONS SYSTEM (TPOCS)**

A summary of the recording of Observation Care Services in ADS for billing purposes.

LENGTH OF OBSERVATION (CALENDAR DAYS OR DATES)	DAY OF SERVIC E	OBSERVATION E&M CODES FOR ACUITY			OTHER E&M CODES FOR OBSERVATION STATUS
		Low	Medium	High	
Observation care services provided within one calendar day (same date)	Day 1	99234	99235	99236	
Observation care services provided over a period of two calendar days (two dates) with release on Day 2	Day 2	99218	99219	99220	
Observation care services provided over a period of three calendar days (three dates) with release on Day 3, not exceeding 48 total hours	Day 3				99217
Admitted from observation status		99221	99222	99223	

These observation E&M codes only apply to observation care services as outlined in the definition of observation patients. These codes may not be used for post-operative recovery if the procedure is considered part of a surgical “package” such as APVs. Also, observation services after an inpatient admission are not covered. Refer to TMA Policy 99-002 that also specifies other services not classified as observation care services.

After the patient is discharged from observation care services, a copy of the completed ADS form and minutes of service (which may be collected on an ad hoc report from CHCS or manually) will be submitted manually to the Uniform Business Office (UBO) on a daily basis for billing. Until billing for observation care services is incorporated into DoD automated information systems, MTFs will bill manually. It is important that the UBO receives copies of all forms documenting workload of observation care services for billing purposes.

For billing of observation care services, the UBO staff will report the number of hours in the units’ field (Block #46 of the UB 92). Begin counting minutes of service when the patient is placed in the observation bed and round to the nearest hour. If necessary, verify the minutes of service in the nurses’ notes. For example, a patient who was placed in an observation bed at 3:03 p.m. according the nurse’s notes and discharged

to home at 9:45 p.m. will have a “7” placed in the units field. Use the following revenue code on the UB92 billing form:

<u>Revenue Code</u>	<u>Description</u>
762	Observation Care Services

## **VI. MEDICAL RECORDS**

All documentation related to an observation stay will be filed in a separate treatment record (see the note below). The medical documentation will not be integrated into the health record (HREC), outpatient treatment record (OTR), or inpatient record, except for copies of pertinent summary information, as follows:

1. Release note with a summary of pertinent diagnostic findings
2. Status of patient upon release
3. Release instructions with plans for follow-up care

NOTE: This separate treatment record will be called the Extended Ambulatory Record (EAR). The EAR will contain all APV and observation records related to the individual in one medical record jacket. A policy to establish this type of record as a formal category of records distinct from the outpatient and inpatient records is currently in development.

In cases where the patient is released from observation status to an APV, the observation medical record documentation becomes part of the Extended Ambulatory Record (EAR). In addition, a copy of pertinent summary information from the observation and APV episodes will be filed in the patient’s outpatient treatment or health record, as described above, in accordance with appropriate Service regulations.

The treatment record will be filed in the inpatient record room or in a limited access area in conjunction with any inpatient records. The retirement process for inpatient records will apply to the EAR. Records will be retired to the National Personnel Records Center in accordance with applicable regulations.

## **VII. PERSONNEL SYSTEM/LABOR UTILIZATION**

Physician time for care of Observation patients will be reported under B\*\*0. Supporting staff (nurses, technicians) will report their time under the appropriate FCC: DGE or DGA. When personnel are shared among different patient care areas, including Observation Care Services, the time reported by these personnel must reflect an appropriate representation of their time.

## **VIII. SERVICE FINANCIAL SYSTEMS**

Service-specific financial guidance will address the reporting structure (coding for supplies, equipment, labor, and other commodities) necessary to accurately capture the expenses associated with Observation Care Services.

## **IX. MEPRS/EAS ALLOCATION**

MTFs will update their Account Subset Definition (ASD) to ensure that the B\*\*0 observation code is included. DGE and DGA FCCs may be applicable for Observation Care Services. The square footage should be determined for the designated area, as appropriate. Minutes of service and number of patients under DGE and/or DGA will be the dual performance factors reported in MEPRS.

## NUTRITION CARE GUIDANCE

1. Contact the Regional Medical Command Cost Accountants; they have gone to a MEDCOM Training Course to standardize practices and reinforce policies on NCD accounting.
2. Enter all APV and Observation meals into the NMIS accounting report. On the Monthly Facility Summary Report, there is a column on page 2 labeled "APV/OP." All APV/OP weighted meals should be entered here. The next update/revision of NMIS will separate this column into two distinct columns - one for APVs and one for Observation Pt. This is so that MEPRS can accurately track the costs for each category.

If you don't enter the number of weighted meal days (used to be called Rations) to NMIS, you are not capturing the workload nor generating the income to buy the food used to feed the APVs and Observation patients. How you document/track these meals served is a local decision but it must provide an auditable trail.

a. You can use a roster (provided by CHCS, PAD or Nursing, etc) of APVs/OP in the same way the A&D sheet does for tracking inpatients and you use for calculating inpatient weighted meals served income. We agreed to use a value of .4 for APVs and .8 for Observation patients. This would generate an average of meals in the same way the A&D sheet does for inpatient meals.

b. You can keep track of actual meals served at each meal and generate exact income for the day by using the number of actual breakfast, lunch, and dinner meals served to each category (using the values .2, .4 and .4 for the specific meals; multiplying these values times the number of meals served and then adding the numbers will result in a total of actual weighted meal days for APVs/OP.

3. In addition to a variety of accounting methods for the APV/OP, each hospital has chosen a different approach to providing food for these categories. You are serving anything from crackers and juice, to a sack lunch, to a full meal to these patients. Some MTFs are even collecting money from the patients for the food/beverages provided. However, the original intent of this system when the status and name of "Same Day Surgery" patients changed to "APVs" was not to charge the patients since we considered the food/beverage provided an "Oral Challenge (In the past, "Same Day Surgery" patients were considered inpatients and were charged an inpatient hospitalization charge which includes subsistence)." The Health Affairs policies on these categories state or will state that patients are NOT to be charged for the "oral challenge" when on a ward/in a bed for this category. If an APV patient ambulates to the D. Hall and consumes a meal he should be charged the appropriate amount regardless of his status and an Observation Patient should not be ambulating to the dining room by definition that he's under "observation."

4. One issue that has been raised is if APVs have wrist bands and enter the dining hall there is no easy way to tell them from an inpatient. This should be looked into and appropriate action taken to resolve even though patients with wrist bands are entered into the cash register, no income is generated from that figure since all inpatient

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income is generated through the A&D sheet irregardless of whether they eat on the wards or in the D. Hall. If this is happening at your MTF, you will be losing the income generated from APVs, not keeping track of the workload involved in providing "oral challenge" and essentially violating the policy.

5. The BOTTOM LINE is: If you're not tracking APVs/OP patients and accounting for them in the NMIS, you are not getting reimbursed for the subsistence provided nor are you accounting for your workload. Failure to do so is contrary to the current policies and improperly requires you to absorb the costs at the expense of the patients and staff feeding.

POC for Nutrition Care policies is COL Forman, Nutrition consultant, MCHO-CL-R, 210-221-6344.