

Observation care may be rendered in an emergency department, an observation unit, or an inpatient floor. Regardless of location, these patients are technically considered outpatients. Observation may be maintained for up to 48 hours. After that, the patient must either be discharged or admitted. There are two sets of codes for reporting observation care:

Same calendar day observation/discharge: 99234 - 99236. These codes include admission, observation, and discharge and are not reported in conjunction with any other E/M codes on the same date, even if observation is initiated at another site. Medicare requires that patients be in observation for 8 hours or more to report these codes.

Different calendar day observation/discharge: 99218 - 99220. These codes are used for day one of observation when the observation spans more than one calendar date. These codes include admission, supervision of the care plan, and periodic reassessment. Use these codes for Medicare patients who are in observation status for less than 8 hours.

Observation discharge: 99217. When observation lasts more than one calendar day, report services on day two by using the observation discharge code.

Observation codes have been assigned higher RVUs than outpatient/office E/M codes because of the extra work involved. Make sure that your documentation of observation care is thorough and complete. Omission of just one element can translate to lower reimbursement.

- Documentation guidelines require that all three key components (History, Exam, MDM) meet or exceed the level of service selected.
- Documentation should include date and time of admission to observation status, admitting orders and observation plan, nurses' notes, and physician progress notes from periodic assessments. When the patient is discharged, the physician should note final exam results, the discharge plan and instructions, and the actual time of discharge.

Special Situations

- For inpatient admission from observation status, use 99221 – 99223 to report all services rendered that day.
- Use modifier 25 if observation is initiated during the same encounter as a procedure performed for a condition unrelated to the reason for observation.
- Use outpatient/office visit codes 99212-99215 for patients in observation status if documentation does not support the use of observation codes.

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