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## Documenting Observation Services

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In the recent past there has been a shift in the Evaluation & Management services being reported in the ED setting. As a whole, documenting and reporting of observation services is on the rise. While RVU's are certainly a major component of this influx, it is also coupled with a clearer understanding of what "Observation" entails & the documentation requirements that must be met.

Observation services are appropriately utilized when admission or discharge is not a foregone conclusion. This can be further broken down into two subcategories: (1) Lack of diagnostic certainty, and (2) The need for therapeutic intensity. In both scenarios a formal "Observation" would help determine whether the patient needs to be admitted or can safely be discharged.

There is no question that many ED patients fit into these categories. With that in mind, a few key details regarding the documentation requirements should serve as a basis or a reminder, thereby increasing your observations.

Documentation should include five aspects:

1. Formal Admission to "observation status", including date and time.
2. Reason for placement into observation.
3. Progress notes addressing key points during observation period.
4. Summary of patient's condition, exact date and time of discharge from "observation status".
5. For upper level observation services, documentation should include" four HPI elements, 10 or more ROS, all three histories (Past Medical, Family and Social History), and an eight-or-more organ system examination.

Three additional reminders:

1. Observation is a "status", not a distinct "location".
2. The outcome of the observation (i.e. admission or discharge) is not a contributing factor in the reporting of these services.
3. Observation services are not time-based codes. (Medicare does, however, place a time requirement on some of the observation codes, but observation services can still be reported in these instances.)

There is a significant variance in the documentation requirements of observation services as compared to the typical emergency department visit (99285) in that all three histories (Past Medical, Family and Social History) must be documented. Deficiencies in this area are the most common reason that observation services are down-coded. With all these thoughts in mind, emergency physicians can better document observation services.

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