Reimbursement Policy: Observation Stay (Commercial)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
R20190014	8/01/2019	RPC (Reimbursement Policy Committee)

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY:

ConnectiCare has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. ConnectiCare will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in ConnectiCare's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by ConnectiCare due to programming or other constraints; however, ConnectiCare strives to minimize these variations.

ConnectiCare follows coding edits that are based on industry sources, including, but not limited to; CPT guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. ConnectiCare uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how ConnectiCare handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, ConnectiCare may deny the claim and/or recoup claim payment.

Overview

ConnectiCare follows:

- AMA CPT coding guidelines
- CMS NCCI Manual (edits and policies)
- CMS Medicare Claims Processing Manual, Chapter 4 - Part B Hospital, 290.2.2 for Observation Services

Effective 8/01/2019, ConnectiCare no longer covers observation services that extend beyond 48 hours.

Observation services with less than 8 hours will be considered a bundled service. Observation services billed over 48 hours will be considered as exceeding limits.

Observation Services do not apply to clinics, physician offices, urgent care centers, mental health or substance abuse care and cannot be used for a planned or elective admission.

Reimbursement Policy: Observation Stay (Commercial)

Policy statement

Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours, and the need for an inpatient admission can be determined within this specific period.

The payment for Observation Services is specified in the Plan Compensation Schedule or Contract with the applicable facility. The member's medical record documentation for Observation status must indicate the need for Observation Services stating the specific problem, treatment and/or frequency of the skilled service and requires a written order by the physician clearly documented in the medical record indicating "Admit to Observation".

A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient. **The billed units of service should equal the number of hours the patient receives observation services.**

Hospitals should use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Hospitals are reminded not to report CPT codes 99217-99226 for observation services.

Additional information and discussion regarding hospital observation services can be found in the Medicare Claims Processing Manual, Chapter 4 - Part B Hospital, 290.2.2.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Observation Services may be eligible for coverage when rendered to members who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the member is stabilized.
- Member has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the usual 4-6 hours recovery period.
- The physician or nursing care that a member needs initially is at or near the inpatient level, but such intense care is expected to be necessary for less than 48 hours.
- Member requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment.
- Short term medical intervention of facility staff is required under the direction of a physician.
- Observation is needed to determine if hospitalization is required.

Reimbursement Policy: Observation Stay (Commercial)

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When all of the criteria listed above are met, charges for Observation Services are eligible for reimbursement according to the terms of the facility's contract reimbursement rate.

Unless otherwise stated in the facility's participation agreement, reimbursement for Observation Services (Revenue Code 762) includes all nursing care, ancillary services, and any Emergency Department services that preceded an observation stay. All claims submitted for Observation Status must include the number of hours.

Services that do not meet the above coverage parameters will be denied as not reasonable and necessary under Sec.1862 (a)(1)(A) of the Social Security Act. This includes denials of services that are not medically necessary, that duplicate other services, or are provided in inappropriate settings.

Services That Are Not Covered as Outpatient Observation:
The following types of services are not covered as Outpatient Observation Services:

- Observation services with less than 8 hours or that exceed 48 hours
- Any approved inpatient admission followed by an observation stay that upon review meets clinical indicators for an inpatient level of care
- Services provided for the convenience of the patient, family, or patient's physician, and not reasonable and necessary for diagnosis or treatment. Examples include observation following an uncomplicated treatment or procedure, waiting for a physician visit when the patient is physically ready for discharge, or holding in observation while awaiting placement in a long-term care facility.
- Medically appropriate inpatient admission.
- Postoperative monitoring during a standard 4-6 hour recovery period, which should be billed as recovery room services.
- Routine preparation and recovery services furnished in association with diagnostic testing, which are included in the payment for those diagnostic services.
- Observation services billed concurrently with therapeutic services such as chemotherapy or other transfusion.
- Standing orders for observation following outpatient surgery*. Note the availability of outpatient observation does not mean that procedures, for which an overnight stay is anticipated such as, cardiac catheterization for a patient with a myocardial infarction, may be performed on an outpatient basis.*
- Services that were ordered as inpatient services by the admitting physician, but were billed as outpatient by the hospital billing office.
- Claims for inpatient care such as complex surgery that meet inpatient criteria, but billed as outpatient.
- Observation care services submitted with routine pregnancy diagnoses
- Retaining a member for socioeconomic factors

Out-of-Network Facility Admissions

Admissions to out-of-network facilities in or out of the service area are monitored by telephonic review on a concurrent basis by the managing entity listed on the member's ID card. If the member is stable and needs ongoing care, a transfer may be initiated to facilitate the return of the member to care within the primary delivery system.

Observation Status – Required Patient Notification:

Federal and state laws require hospitals to notify patients of observation status as follows:

CT State Law – Public Act No. 14-180
"An Act Concerning Notice of a Patient's Observation Status":

According to the Center for Medicare Advocacy, "On June 12, 2014, Connecticut Governor Daniel Malloy signed into law a requirement that starting October 1, 2014, **Connecticut hospitals give oral and written notice to patients placed on observation status for 24 hours or more**.

Public Act No. 14-180
AN ACT CONCERNING NOTICE OF A PATIENT'S OBSERVATION STATUS.
Be it enacted by the Senate and House of Representatives in General Assembly convened:
Section 1. (NEW) (*Effective October 1, 2014*) (a) Each hospital, as defined in section 19a-490 of the general statutes, shall provide oral and written notice to each patient that the hospital places in observation status of such placement not later than twenty-four hours after such placement, unless such patient has been discharged or has left the hospital prior to the expiration of the twenty-four-hour period. Such oral and written notices shall include: (1) A statement that the patient is not admitted to the hospital but is under observation status; (2) a statement that observation status may affect the patient's Medicare, Medicaid or private insurance coverage for (A) hospital services, including medications and pharmaceutical supplies, or (B) home or community-based care or care at a skilled nursing facility upon the patient's discharge; and (3) a recommendation that the patient contact his or her health insurance provider or the Office of the Healthcare Advocate to better understand the implications of placement in observation status.
(b) The written notice described in subsection (a) of this section shall be signed and dated by the patient receiving the notice or such patient's legal guardian, conservator or other authorized representative.
Approved June 12, 2014

CMS Outpatient Observation Notice (MOON):

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours. A standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611 was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH.

In accordance with the statute, the notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

All hospitals and CAHs are required to provide this statutorily required notification no later than March 8, 2017. The notice and accompanying instructions are available at:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Observation Stay Reimbursement Guidelines:	
Emergency Services and Observation Services:	• When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed.
Ambulatory Surgery/Outpatient Procedure and Observation Services:	• Observation services related to an ambulatory surgical or other outpatient procedure are considered part of the of the routine recovery period for the procedure and *no separate observation reimbursement* will be made
Inpatient Admission Following Observation Stay:	• Case rate and DRG-based reimbursement includes all related observation services that occur within three days of the date of admission. • Per diem–based and percent-of-charge based reimbursement includes any observation stay that converts to an inpatient admission before midnight of the same day and is not separately reimbursed. • Per diem–based and percent-of-charge based reimbursement does not include an observation stay that converts to an inpatient admission after midnight of the observation day and is separately reimbursed.
Observation Status, billed hours	• *The billed units of service should equal the number of hours the patient receives observation services.*

FAQs (Commercial Plans):

Are total observation units (hours) billed on one claim line?	Yes, please submit total observation units (hours) as one claim line
What if total hours are less than 8 hours?	If a claim is submitted with an Observation Stay less than 8 hours, the Observation Stay will not be considered; instead the applicable contracted rate will be paid (i.e. Emergency Room).
What if total hours exceed 48 hours and claim is denied?	Facilities have the right to appeal an Observation Stay that is denied because it exceeds the 48-hour maximum. Medical records supporting the medical necessity will be required for review.

References

1. CMS Claims Processing Manual and other CMS publications; www.cms.gov
2. American Medical Association Current Procedural Terminology (CPT®*) Professional Edition
3. CT Public Act No. 14-180 "An Act Concerning Notice of a Patient's Observation Status" https://www.cga.ct.gov/2014/ACT/PA/2014PA-00180-R00HB-05535-PA.htm

Revision history

DATE	REVISION
12/2020	• Policy content clarified to reference applicable Observation Hours Rev Code (762)
8/2019	• Added FAQs. No changes to policy criteria or limitations/exclusions
8/2019	• New Policy guidelines; aligned with CMS and including State of CT Public Act No. 14-80 regarding member notification of "Observation Status"