



<u>Payment Policy:</u> Observation Services		
<u>Original Date Approved:</u> 03/02/2018	<u>Effective Date</u> 05/01/2018	<u>Date Revised:</u> 2/25/2020
<u>Scope:</u> Commonwealth Care Alliance (CCA) Product Lines: <input checked="" type="checkbox"/> <u>Senior Care Options</u> <input checked="" type="checkbox"/> <u>One Care</u>		

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance® (CCA) reimburses for observation status when acute care services are provided in a hospital setting based on the facility's contract.

Observation services ordered in instances for patients that present to the emergency department and then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Observation services are defined as services provided in a hospital to treat and/or evaluate a condition and should result in either a discharge within 48 hours or a verified diagnosis that will be followed by an inpatient admission. Observation status should be assigned at the time of admission if clinical data is available. CCA will determine observation status consistent with Utilization Management policies.

The following providers may bill for observation services:

- A physician who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care
- A physician who does not have inpatient admitting privileges but who is authorized to furnish hospital outpatient observation services may bill these codes.
- There must be a medical observation record for the patient that contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.
- Reimbursement for observation care is for all the care rendered by the ordering physician on the date(s) that the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving observation services must bill the appropriate outpatient service codes.



REFERRAL/NOTIFICATION/PRIOR AUTHORIZATION REQUIREMENTS:

Prior Authorization is not required for Observation Services

PROVIDER REIMBURSEMENT:

CCA reimburses covered, medically necessary observation services according to CCA's contracted terms with a facility. **CCA will reimburse up to 48 hours of observation services.** Services are covered only when provided by the order of a physician or other individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be clearly stated in the physician's order for observation, as documented in the medical record by admission, discharge, and other appropriate legible progress notes that are timed, written, signed, by the physician. Coverage criteria for hospital billing of observation services are:

- Reasonable and necessary (i.e. safe effective, non-investigational, and appropriate based on available medical information) to evaluate an outpatient's condition or to determine the need for admission.
- Provided as a result of a physician's order or one by another practitioner authorized by state licensure law to admit patients or order outpatient tests.
- Revenue code 0762 must be billed with the service units reported as the number of hours that the outpatient is in observation status. Hospital billing for observation begins on the clocked time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with the physician's order. A patient's time receiving observation services (and hospital billing) ends when all clinical and 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.

Status Change to Inpatient Admission:

- If the CCA member is being transferred from Observation to Inpatient status, the Transition of Care (TOC) unit and designated hospital will work collaboratively to have the member discharged to the next level of care.
- The provider will submit clinical documentation to the TOC unit who will run through Interqual to determine the appropriate level of care. The TOC unit will work directly with the hospital utilization management staff to help in determining the appropriate level of care for the member.
- When requesting authorization for inpatient services for a member admitted through observation, the date of the inpatient admission should be the date the patient was seen in observation.
- Observation charges should be billed as part of the inpatient claim and will be reimbursed according to the provider's inpatient reimbursement rate.



Non-covered observation services include:

- Services that are not reasonable and necessary for the diagnosis and treatment of the patient but are provided for the convenience of the patient, his or her family, or a physician.
- Services covered under other services, such as post-operative monitoring during a standard recovery period (e.g. four to six hours) should be billed as recovery services; routine preparation services furnished prior to diagnostic testing and recovery afterwards that are included in the payment for the diagnostic service.
- Standing orders for observation following outpatient surgery
- Observation care services/time between 49 and 72 hours will be reviewed prior to denial to ensure observation criteria is met. Observation services over 72 hours could be denied depending on criteria limitations and physician review.
- CCA will typically pay per Medicare Outpatient Prospective Payment System (OPPS) guidelines and consider observation services 48 hours or less.

BILLING AND CODING GUIDELINES:

Report all outpatient facility services related to the observation stay on the same claim form. Observation services begin with a physician's order. Observation services end when all clinical and 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.

Facility

Hospitals are required to report observation charges under the following revenue codes:

0760 General Classification

0762 Observation Room

Facilities that are reimbursed according to Ambulatory Payment Classification (APC) should bill for observation care for the Direct Referral of a patient with code G0378. The number of units reported for G0378 must equal or exceed 8 hours.

Observation code G0378 is bundled into the payment for other observation codes unless specified otherwise in the contractual agreement. Bill observation (room charges revenue code 0762) services indicating the total number of hours in the service unit field. Reimbursement will be based on the facility's contract.

Facilities should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or hospital outpatient surgical procedure (status indicator T procedure) on the day observation care begins.



Professional (Provider)

The following codes should be utilized when billing for observation care:

- 99218, 99219, 99220: Initial Observation care per day (not reported if admission and discharge of observation status is on the same date of service)
- 99217: Used to report discharge from observation status if the discharge occurs on a date other than the initial observation status.
- 99224-99226: Subsequent Observation Care, per day
- 99234-99236: Observation or Inpatient Hospital care (not reported if observation or inpatient status spans more than one date of service. Only reported when admission/discharge for the same date of service)
- 99221- 99223: Initial Inpatient Hospital care

RELATED SERVICE POLICIES:

[Evaluation & Management](#)

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

Medicare IOM Claims Processing Manual 100-04 290 Observation

CCA Website <http://www.commonwealthcarealliance.org>

POLICY TIMELINE DETAILS

1. Drafted March 2018
2. Review and Revision of Formatting February 2020