EmblemHealth | ConnectiCare

Reimbursement Policy:

Observation Stay

(Medicare and Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20240055	EH:11/14/2024 CCI: 8/01/2019	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have 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. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our 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, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow 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. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

EmblemHealth/ConnectiCare follow:

- 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

EmblemHealth/ConnectiCare will consider reimbursement for observation services that extend beyond 48 hours when CMS guidelines are met.

Observation services with less than 8 hours will be considered a bundled service. Observation services billed over 48 hours will be considered, upon medical record review; *in rare and carefully documented circumstances, the limit may reach 72 hours.*

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.

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 in rare circumstances, up to 72 hours*; and the need for an inpatient admission can be determined within this specific period.

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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 99221-99223 and 99231-99239 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

Reimbursement Guidelines:

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.

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, but no longer than 72 hours without a discharge or admission. **There will be no reimbursement for observation services in excess of 72 hours.** Change in patient status must be indicated by physician order. The hospital will not be reimbursed for both observation room charges and room & board fees on the same day.

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When all 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.

Exclusions: 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; except in rare and carefully documented circumstances, when the limit may reach 72 hours.
- An observation claim within 30 days of an inpatient discharge, that upon review, is deemed to be medically related (see our Hospital Readmission Reimbursement Policy)
- 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.
- 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

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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 and is not separately reimbursed.
Observation Status, billed hours	• *The billed units of service should equal the number of hours the patient receives observation services.*

Observation Status – Required Patient Notification:

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

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

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NY State Regulations:

Changes to the Public Health Law (PHL) regarding observation status, became law on Oct. 21, 2013, and became **effective Jan. 19, 2014**. The new PHL Section 2805-w requires hospitals to inform patients who are assigned to observation status that they are not admitted to the hospital but are under observation status. Oral and written notice is required within 24 hours of assignment to observation status. The written notice must be signed by the patient or the patient's legal representative to acknowledge receipt. If the patient refuses to sign the notice, documentation of the attempt to provide it and of the refusal must be recorded in the patient's medical record. At a minimum, the written notice must include that observation status may affect the patient's Medicare, Medicaid and/or private insurance coverage for the current hospital stay, including medications and other pharmaceutical supplies, as well as coverage for any subsequent discharge to a skilled nursing facility, home, or community-based care. It must encourage the patient to contact his or her insurance plan for more specific information on coverage.

FAQs	
Are total observation units (hours) billed on one claim line?	You may continue to submit as you normally would for CMS; If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins
What if total observation hours exceed 48 hours?	EmblemHealth/ConnectiCare follow CMS guidelines for Observation Stay exceeding 48 hours. As per the CMS IOMPublication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 290.1, "CMS maintains a clear expectation that observation services should not exceed a 48-hour timeframe (*except in rare and carefully documented circumstances, when the limit may reach 72 hours*). Hours of observation care are to be counted from the time documented in the medical record that coincides with the physician's order for observation services. Observation time cannot be counted retroactively, regardless of the time that other hospital care was originally initiated, often in the ED. "

References:

1. CMS Claims Processing Manual and other CMS publications; www.cms.gov
2. American Medical Association Current Procedural Terminology (CPT®*) Professional Edition
3. CMS Claims Processing Manual https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf.
4. pdf290.2.2 - Reporting Hours of Observation (Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)

5. NY Senate.Gov- Section 2805-W — Patient notice of observation services, https://www.nysenate.gov/legislation/laws/PBH/2805-W (updated Sep. 22, 2014)

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	11/14/2024	• Updated with NYS Regulations regarding patient notification on “Observation Status”
EmblemHealth ConnectiCare	7/25/2024	• Policy expanded to include EmblemHealth Medicare and Medicaid **effective 11/14/2024** • Updated with reference/link to our Hospital Readmission Reimbursement Policy for additional clarity.
ConnectiCare	7/25/2024	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
ConnectiCare	2/2023	• Revised Hospital Inpatient and Observation Care Services E/M codes
ConnectiCare	3/2022	• Claim line FAQ updated to align with CMS
ConnectiCare	12/2020	• Policy content clarified to reference applicable Observation Hours Rev Code (762)
ConnectiCare	8/2019	• Added FAQs. No changes to policy criteria or limitations/exclusions
ConnectiCare	8/2019	• New Policy guidelines; aligned with CMS and including State of CT Public Act No. 14-80 regarding member notification of “Observation Status”