RB.014.C Observation Care

Original Implementation Date : 03/15/2018
Version [C] Date : 02/01/2022
Last Reviewed Date: January 2024

PRODUCT VARIATIONS

This policy applies to all lines of business unless noted below.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

POLICY STATEMENT

Outpatient hospital observation care is covered when the following Medicare coverage criteria are met:

- Outpatient hospital observation care must be reasonable and necessary.
- Decisions on the setting for delivery of health care services should be based on nationally recognized guidelines and evidence-based medical literature.

All the following requirements must be met for a hospital to receive payment for observation care:

There must be a physician order to place the patient in observation.

- The observation level of care must be medically necessary.
- Observation time must be documented in the medical record.
- Hospital billing for observation level of care begins at the time when the order to admit to Observation is placed in the record by the admitting physician. The observation level of care (and hospital billing) ends when all clinical or medical interventions have been completed, including the care provided by hospital staff and physicians that may take place after a physician has ordered the patient to be released or admitted as an inpatient.
- Observation care must span a minimum of eight hours and must be documented in the “units” field on the claim form.
- The patient must be under the care of a physician or non-physician practitioner during the time of observation care. The care must be documented in the medical record with an order for observation, admission notes, progress notes and discharge instructions (notes) — all of which are timed, written, and signed by the physician.

- For Medicare members, a signed Medicare Outpatient Observation Notice (MOON) should be documented in the medical record.

NOT COVERED:

- Outpatient observation care should not be used for routine diagnostic services and outpatient surgery/procedures.
- Outpatient observation care that is provided only for the convenience of the patient or his/her family or physician is not reimbursable.

POLICY GUIDELINES

As allowed by contract, we reserve the right to audit and adjust payments if the outcome of those audits identifies incorrect billing resulting in overpayment or underpayment. Observation care, regardless of the manner billed or reported, will be subjected to these audits and payment adjustments.

In most cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases does reasonable and necessary outpatient observation care span more than 48 hours.

Hospitals may bill patients who are directly referred to the hospital for outpatient observation care. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation care, bypassing the clinic or emergency department (ED) visit.

If the physician or healthcare professional is uncertain if an inpatient admission is appropriate, the physician or healthcare professional should consider admitting the patient for observation care.

For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Reporting Requirements

- Observation is not split by calendar days per line item. Observation is billed on one line including the total accumulation of observation time with the date that observation care began.
- All units/hours less than eight hours will pay the primary service only and will not qualify for observation care.

- When a patient is admitted to the inpatient setting directly from the emergency room (ER) and/or observation care services (OBS), services in the ER and OBS will be included in the authorized inpatient rate with no separate payment.
- We only reimburse a maximum of 48 hours of observation.
- Emergency and observation services including maternity care (e.g., false labor) are not paid separately when an authorized inpatient admission occurs within 24 hours of that care.

CODING

CPT Code	Description
N/A	
HCPCS Code	**Description**
N/A	
ICD-10 Codes	**Description**
N/A	

BENEFIT APPLICATION

Medicare members incur outpatient hospital cost sharing liability for observation care.

This reimbursement policy does not constitute a description of benefits. Rather, this assists in the administration of the members' benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as inpatients or if they are able to be discharged from the hospital. Observation care is commonly ordered for patients present in the emergency

department and who then require a significant period of treatment or monitoring for a decision to be made concerning their admission or discharge.

DEFINITIONS

Emergency Room (ER) Care: Care given for a medical emergency when it is believed that a patient's health is in serious danger.

Inpatient Care: This care includes bed and board, nursing services, diagnostic or therapeutic services and medical or surgical services.

Medicare Outpatient Observation Notice (MOON): The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH). The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which was passed on August 6, 2015. The NOTICE Act requires all hospitals and CAHs to provide written and oral notification under specified guidelines.

Outpatient observation care: This care is composed of a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as inpatients or if they are able to be discharged from the hospital. Outpatient observation care is commonly ordered for patients present in the emergency department and who then require a significant period of treatment or monitoring for a decision to be made concerning their admission or discharge.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2024 Annual Review.		

2023 Annual Review. No changes required.	C	2/1/2022
2022 annual review. Minor edits made to the policy section for clarity. The following statements were added to the guidelines section: Observation is not split by calendar days per line item. Observation is billed on one line including the total accumulation of observation time with the date that observation care began. We only reimburses a maximum of 48hrs of observation.	C	2/1/2022
The following statement was added to the guidelines section of the policy: Emergency and observation services including maternity care (e.g., false labor) are not paid separately when an authorized inpatient admission occurs within 24 hours of that care. The policy reference section was revised.	B	12/4/2019
New Policy.	A	3/15/2018

REFERENCES

1. The American Congress of Obstetricians and Gynecologists. https://www.acog.org/-/media/Departments/Coding/2016ProceduralCodinginObGyn.pdf
2. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.
3. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual Chapter 1 - General Billing Requirements. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf.
4. Centers for Medicare & Medicaid Services (CMS).Beneficiary Notices Initiative (BNI) and Medicare Outpatient Observation Notice (MOON). Available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.
5. Centers for Medicare & Medicaid Services (CMS).Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS). Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

6. Centers for Medicare & Medicaid Services (CMS).Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf.
7. Centers for Medicare & Medicaid Services (CMS). Acute Inpatient PPS. Three Day Payment Window. Implementation of New Statutory Provision Pertaining to Medicare 3-Day (1-Day) Payment Window Policy - Outpatient Services Treated As Inpatient. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Three_Day_Payment_Window.html
8. https://medicarepaymentandreimbursement.com/2015/12/billing-outpatient-observation-services.html