Subject: Outpatient (in Facility) Observation

Medical Policy #50.0 **Original Effective Date: 11-17-2021**

Status: Reviewed **Last Review Date: 11-16-2022**

Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

For all in-network facilities, no authorization is necessary for Outpatient Services, (i.e. Observation stay) unless the stay exceeds 24 hours, the individual's status is converted to an Inpatient Admission, or the procedure specifically requires prior authorization. All out-of-state and out-of-network facilities require authorization for an Outpatient/Observation Stay greater than 8 hours.

Observation services that extend beyond a 24-hour period are not covered. Providers must contact PHP and obtain approval for inpatient status for any services beyond the initial 24-hour period.

1. Hospital Outpatient Observation Guidelines

All hospital patients are either inpatients or outpatients. Terminology of various bed types such as 'outpatient-bedded', 'same day surgery in bed' or 'outpatient in a bed' are not relevant terms.

CMS, Medicare Claims Processing Manual, Pub 100-04, Chapter 12, §30.6.8 – Physicians/Nonphysician Practitioners, Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services); and hospital billing of observation services, Medicare Claims Processing Manual, Pub 100-04, Outpatient Observation Services, Chapter 4, §290 thru 290.6),); Medicare Benefit Policy Manual, Pub 100-02, Chapter 6, §20.6 Hospital Services Covered Under Part B, Outpatient Observation Services defines Observation as:

> *"When a physician orders that a patient receive observation care, the patient's status is that of an outpatient.* ***The purpose of observation is to determine the need for further treatment or for inpatient admission.*** *Thus, a patient receiving observation services may improve and be released or be admitted as an inpatient.*
>
> *Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who presents to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.*
>
> *Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services. In the majority of 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 the majority of 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."*

Hospital outpatient observation services include the supervision of the care plan for observation, as well as, periodic reassessments. The patient is not required to be physically located in an observation area, designated by the hospital, as long as the medical record indicates that the patient was admitted to observation status and the reason for the admission to "observation status" supports the documentation in the patient's medical record.

In order to report Observation, the Admitting/Supervising Physician or Other Qualified Health Care Professional must include:

- Documentation within the member's medical record that the member is designated as or admitted to observation status. The medical record should include the Admitting/Supervising Physician or Other Qualified Health Care Professional's **written order for observation is documented in the record** including date and time and the detail the observation services the patient is to receive.
- Documentation that the Admitting/Supervising Physician or Other Qualified Health Care Professional **explicitly assessed patient risk to determine that the patient would benefit from observation care**. This documentation must be in addition to any other documentation prepared, as a result of an emergency department or outpatient clinic/other site of service encounter.
- Nursing notes and progress notes that are timed, written and signed by the Admitting/Supervising Physician or Other Qualified Health Care Professional, during the time the patient received observation care.

2. Guidelines for Reporting Hours of Hospital Observation Services

For reporting of Hospital Observation services, PHP follows, Medicare Claims Processing Manual, Pub 100-04, Outpatient Observation Services, Chapter 4, §290.2.2).

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code **G0378**.

General standing orders for observation services following all uncomplicated outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services. (See page 3 for post-surgical complications).

Observation services should not be billed concurrently with diagnostic or therapeutic services (see page 3 for post diagnostic or therapeutic services) for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. **For example,** a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

Hospital Observation Time:

1. Physician evaluation and Observation time must be documented in the medical record.
    a. A written order for observation is recorded in the medical record including date and time.
    b. There is an assessment of patient's risk to determine benefit from Observation care and is explicitly documented by the physician. The document must show the patient is in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
    c. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.
2. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
3. A patient's time receiving observation services (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.
4. Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

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.

Direct referral for observation is reported using HCPCS code **G0379** (Direct referral for hospital observation care), please see Medicare Claims Processing Manual, Pub 100-04, Outpatient Observation Services, Chapter 4, §290.5.2) for details.

Coverage Determination

Prior Authorization is required. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

Coverage is for Medicare, Medicaid and Commercial.

PHP will provide coverage for Observation Room Services when it is determined to be medically necessary because the medical conditions stated below, and guidelines (1 & 2) stated above are both met.

There is no limitation on diagnosis for payment of APC 8011; however, comprehensive APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8.

For an observation stay (**a period not to exceed 48 hours**) to be considered medically necessary, the following conditions must be met:

1. The patient is clinically unstable for discharge; **And**
2. Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization; **Or**
3. **The treatment plan is not established or, based upon the patient's condition, is anticipated to be completed within a period not to exceed 48 hours**; **Or**
4. Changes in status or condition are anticipated and immediate medical intervention may be required; **Or**
5. When a patient has a significant adverse reaction (above and beyond the usual or expected response) as a result of the scheduled services, that requires further monitoring. See examples below.

Based on documentation (assessment and orders), Observation services may be considered when:

- **Patient evaluation:** When the patient arrives at the facility in an unstable medical condition, an observation stay may be appropriate while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

  When observation services that are provided only for the convenience of the patient, his/her family or the physician are not reimbursable. Physician convenience often involves consultation or outpatient testing where the patient is kept in the hospital until these services can be rendered. If the patient can safely be discharged and receive these services on an outpatient basis, then keeping the patient in observation is **not** considered covered.

- **Outpatient surgery:** Observation service coverage is restricted to situations where a patient exhibits an unwarranted or unusual reaction to the surgical procedure, such as difficulty in awakening from anesthesia, a drug reaction, or other post-surgical complications which require monitoring or treatment beyond that customarily provided in the immediate postoperative period. Monitoring or treatment beyond what is considered the normal recovery period for a particular procedure is required (e.g., post-operative bleeding, poor pain control, intractable vomiting, delayed recovery from anesthesia beyond 6 hours).

  Observation for routine pre-operative preparation services furnished prior to the surgery and recovery room services are included in the payments for the outpatient surgery and is **not** to be billed as observation services. General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of a normal recovery time, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services as part of the ambulatory surgery procedure.

- **Diagnostic services**: When a patient has a significant adverse reaction (above and beyond the usual or expected response) as a result of the test that requires further monitoring, outpatient observations services may be reasonable and necessary. Observation services would begin at that point in time when the reaction occurred and would end when it is determined that the patient is either stable for discharge or appropriate for inpatient admission.

  General standing orders for observation for routine preparation services furnished prior to the testing and recovery room services are included in the payments for those diagnostic services. Observation services should **not** be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). A scheduled outpatient diagnostic tests which are invasive in nature, the routine preparation before the test and the immediate recovery period following the test is not considered as an observation service.

- **Outpatient therapeutic services:** When the patient has been scheduled for ongoing therapeutic services as a result of a known medical condition, a period of time is often required to evaluate the response to that service. This period of evaluation is an appropriate component of the therapeutic service and is **not** considered an observation service. Observation service would begin at that point in time when a significant adverse reaction occurred, that is above and beyond the usual and expected response to the service. Observation status does not apply when a beneficiary is treated as an outpatient for the administration of blood only and receives no other medical treatment. The use of the hospital facilities is inherent in the administration of the blood and is included in the payment for administration.

Non-covered Observation services:
The following is a list of services that are not considered appropriate for observation room services (this list is not all inclusive): When the medical criteria and guidelines listed above are not met.

- Observation services that extend beyond a 24-hour period are not covered. Providers must contact PHP and obtain approval for inpatient status for any services beyond the initial 24-hour period.
- Services that are not reasonable or necessary for the diagnosis or treatment of the patient.
- Routine therapeutic services routinely performed in outpatient settings such as blood transfusions, chemotherapy, or dialysis.
- Observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.
- Provision of a medical exam for patients who do not require skilled support
- Routine preparation prior to and recovery following diagnostic testing
- Routine recovery and post-operative care following ambulatory surgery
- When used as a substitute for inpatient admission
- When observation services that are provided only for the convenience of the patient, his/her family or the physician are not reimbursable.
    - Physician convenience often involves consultation or outpatient testing where the patient is kept in the hospital until these services can be rendered. If the patient can safely be discharged and receive these services on an outpatient basis, then keeping the patient in observation is not considered covered.
- While awaiting transfer to another facility, such as the time when members are awaiting nursing home placement.
- When an overnight stay is planned prior to diagnostic testing
- Standing orders following outpatient surgery
- Services that would normally require inpatient stay
- Observation following an uncomplicated treatment or procedure
- Services that are not reasonable and necessary for care of the patient
- When inpatients discharged to observation status
- A routine “stop” between the emergency department and an inpatient admission.

For Observation to inpatient Status Change:

Observation 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 discharged home or admitted as an inpatient.

If the patient is admitted as an inpatient after observation, an order to admit is required.

Additionally, if the patient is discharged from observation and subsequently admitted as an inpatient, all services provided to the patient while in observation are included on the inpatient claim.

Since observation is considered an outpatient hospital service performed within 3 days of an inpatient admission, the services follow the 3-day/1-day payment window.

For Inpatient to Outpatient Status Change:

PHP follows CMS Publication 100-04 Medicare Claims Processing Manual, Chapter 1, 50.3.2 Policy and Billing Instruction for Condition Code 44 or Understanding and selecting inpatient vs. observation – How to decide by Novitas

In some instances, patients are admitted as hospital inpatients, but upon review it is determined that the patient does not meet inpatient criteria. If the determination occurs prior to discharge, and other criteria are met, the status may be changed to outpatient. If the criteria are not met, the status must remain inpatient.

If all criteria for changing the status from inpatient to outpatient are met, bill the entire claim as though the inpatient admission never occurred.

When a physician orders an inpatient admission, but the hospital's utilization review committee determines that the level of care does not meet admission criteria, the hospital may change the status to outpatient only when certain criteria are met.

Providers should use this code on outpatient claims only.

The change from inpatient to outpatient is met when **all** of the following conditions are met:

- The change in status from inpatient to outpatient or observation is made prior to discharge or release, while the member is still a patient of the hospital;
- The hospital has not submitted a claim to Medicare for the inpatient admission;
- A physician concurs with the utilization review committee's decision; and
- The physician's concurrence with the utilization.

The hospital may not bill observation charges retroactively to cover the time the patient was admitted as an inpatient in the hospital. Medicare does not permit retroactive orders or inference of physician orders. If observation is ordered upon the determination that the patient should no longer receive inpatient treatment, Medicare coverage begins when observation services are initiated in accordance with the physician’s order.

In **condition code 44 situations**, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter.

Regardless of what point the provider encounters the patient, whether it is the emergency room provider performing the initial

exam and treatment or the attending provider, the provider needs to be sure that an inpatient admission is the most appropriate level of care following CMS guidelines.

Utilization Review Committee Requirements

Two or more practitioners must carry out the utilization review (UR) function. At least two members must be Doctor of Medicine or osteopathy.

The determination that an admission or continued stay is not medically necessary must either be made by:

- One member of the UR committee, if the practitioner(s) responsible for the care of the patient either concurs with the determination or fails to present their views when afforded the opportunity, or
- Two members of the UR committee in all other cases.

The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views before making the determination.

If the UR committee determines that the admission is not medically necessary, the committee must give written notification, no later than 2 days after the determination, to the **hospital**, the patient, and the practitioner responsible for the care of the patient.

When an inpatient admission is changed to outpatient status, the change must be documented in the medical record along with:

- Orders and notes that indicate why the change was made
- The care that was furnished
- The participants in making the decision to change the status

Outpatient observation notice:

- All patients receiving services in hospitals and clinical access hospitals (CAHs) must receive a Medicare outpatient observation notice (MOON) no later than 36 hours after observation services as an outpatient begin.
- The MOON informs patients, who receive observation services for more than 24 hours, of the following:
- They are outpatients receiving observation services and not inpatients.
- Reasons for such status.
- Hospitals and CAHs may deliver the MOON to a patient receiving observation services as an outpatient before the patient has received more than 24 hours of observation services but no later than 36 hours after observation services begin.

Coding

The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

HCPCS Code	Code Description
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care

Reviewed by / Approval Signatures

Clinical Quality & Utilization Mgmt. Committee: Gray Clarke MD
Senior Medical Director: David Yu MD
Date Approved: 11/16/2022

References

1. CMS, Medicare Claims Processing Manual, Pub 100-04, Chapter 12, §30.6.8 – Physicians/Nonphysician Practitioners), Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services); and hospital billing of observation services, (Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11), (Rev. 10742, 05-03-21). [Cited 10/18/2022]
2. CMS, Medicare Claims Processing Manual, Pub 100-04, Outpatient Observation Services, Chapter 4, §290 thru 290.6), 290.5.3 - Billing and Payment for Observation Services Furnished, Beginning January 1, 2016, (Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16) [Cited 10/18/2022]
3. CMS, Medicare Benefit Policy Manual, Pub 100-02, Chapter 6, §20.6 Hospital Services Covered Under Part B, Outpatient Observation Services, (Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16) (Rev. 10541, 12-31-20). [Cited 10/18/2022]
4. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual Chapter 1 - General Billing Requirements. 50.3.2 - Policy and Billing Instructions for Condition Code 44, (Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD10; ASC X12: November 4, 2014). [Cited 10/18/2022]
5. Centers for Medicare & Medicaid Services (CMS). Beneficiary Notices Initiative (BNI) and Medicare Outpatient Observation Notice (MOON). Section 400, of Chapter 30 of the CMS Claims Processing Manual, (Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17). [Cited 10/18/2022]

6. Understanding and Selecting Inpatient vs Observation – How to decide. https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00003168, Last modified: 08/08/2022. [Cited 10/18/2022]:
7. Novitas, Changing Inpatient to Outpatient, Last modified: 10/21/2021. [Cited 10/20/2022]
8. The Centers for Medicare & Medicaid Services (CMS) Internet Only Manual Publication 100-04, Chapter 1, Section 50.3.2, (Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014). [Cited 10/18/2022]
9. Medicare Program Integrity Manual, Chapter 3, 3.3.2.4 Signature Requirements. (Rev. 11032; Issued: 09-30-21; Effective: 10-12-21; Implementation: 08-27-21). [Cited 10/18/2022]
10. CMS IOM Publication 100-04, Claims Processing Manual, Chapter 3, Section 40.3 Outpatient Services Treated as Inpatient services. (Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of
11. ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September 23 2014) [Cited 10/18/2022]
12. Medicare Learning Network (MLN) Matters, MM9935 Revised-Medicare Outpatient Observation Notice (MOON) Instructions, Related CR Transmittal #: R3698CP, Related Change Request (CR) #: CR 9935, Related CR Release Date: January 27, 2017, Effective Date: February 21, 2017. [Cited 10/18/2022]
13. Novitas, Observation Services FAQs, Last modified: 07/07/2022. [Cited 10/18/2022]

Publication History

11-17-21	Original effective date. Reviewed by PHP Medical Policy Committee on 11/03/2021. This policy is for hospital outpatient observation services. The policy will follow CMS regulations for all product line. The outpatient hospital observation services are not for inpatient setting. The policy includes status change from outpatient observation to inpatient and for status change from inpatient to outpatient observation. PA will continue to be required for G0378 and G0379.
11-16-22	Annual review. Reviewed by PHP Medical Policy Committee on 10/21/2022. The CMS manuals pertaining to Observation guideline remains unchanged. Codes G0378 and G0379 will continue to require PA.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: ***Click here for Medical Policies***

Web links:

At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.