Reimbursement Policy

Observation Status

REIMBURSEMENT POLICY NUMBER: 69

Effective Date: 1/1/2024

Last Review Date: 12/2023

Next Annual Review: 12/2024

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☐ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

☐ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

☒ All health care services billed on UB04 forms (CMS 1450)

Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

☒ DRG

☒ Modified DRG

☒ Percentage of billed charges/per diem (applies only to unplanned readmissions)

POLICY STATEMENT

Note: Facility contract language and payment methodology may vary.

Outpatient Observation Services

I. Observation services may be reimbursable when both of the following (A and B) are met:

A. When determined to be medically necessary and when observation is the suitable level of care for the individual member based on **all** of the following (1-3) considerations:
   1. InterQual® criteria (InterQual® criteria are used as a baseline for determining suitability of inpatient admission or outpatient observation level of care).
   2. The independent medical judgment of a qualified health care professional.
   3. The unique clinical circumstances of the member, including both their medical history and current medical needs.

B. Observation care is directed 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).

NOTE: Hospital claims which meet or exceed two midnights are not guaranteed payment as an inpatient level of care; medical necessity requirements must still be met in order to be eligible for reimbursement at an inpatient level of care. This applies to all lines of business, including Oregon Health Plan (OHP)/Medicaid plan members.

See the Centers for Medicare and Medicaid Services (CMS) section below.

Observation Admission Converted to Inpatient Admission

II. When an observation admission is converted to an inpatient admission, the Plan's reimbursement method is to pay the entire stay as an inpatient admission (i.e., if any part of the stay is inpatient, the whole stay is paid as an inpatient admission).

Not Reimbursable as Outpatient Observation

III. The following (A.-K.) are not reimbursable as outpatient observation services:

A. Services not reasonable or medically necessary for the diagnosis or treatment of the patient.
B. No physician's order for admission to observation.
C. Services that are covered as medically appropriate during inpatient admission, or services that are part of another service, such as postoperative monitoring during a standard recovery period, (e.g., 4-6 hours), which should be billed as recovery room services or as

part of the diagnostic testing.

D. Standing orders for observation following outpatient surgery.
E. Outpatient blood administration.
F. Services provided for the convenience of the patient, the patient's family, or a physician, such as:
    - Physician is unavailable when patient is ready for discharge
    - Extended hospital stays due to lack of or delay in patient transportation, including patients awaiting transfer to another facility
    - Provision of a medical exam for patients who do not require hospital level of care
    - Time a patient may remain in the hospital after treatment is finished but waiting for transportation home
G. Observation services exceeding 48 hours, unless approved during a concurrent review or approved under an individual consideration exception provision.
H. Observation services or overnight stays that are planned prior to surgical or diagnostic procedures (i.e., pre-operative services for elective surgeries or planned outpatient surgery cases).
I. Inpatients discharged to an outpatient observation status.
J. Services provided concurrently with chemotherapy.
K. Social issues. *(See the Centers for Medicare and Medicaid Services (CMS) section below)*

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

The Plan may request medical records to confirm accurate billing and representation of observation care. Medical record documentation for observation services must include:

- A **physician order** which specifies admission to an "observation status"
- Documentation in the progress notes must include one of the following:
    - Stability for discharge or a need to continue observation status with plan for discharge within a short period of time, but prior to an inpatient admission being necessary; or
    - Medical need to convert from an outpatient observation status to an inpatient hospital admission, documenting the medical necessity for the admission.

DEFINITIONS

Outpatient Observation Services

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and at least periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate a patient's condition or determine the need for a possible admission to the hospital as an inpatient.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

GENERAL

According to the Centers for Medicare & Medicaid Services (CMS), all services must be medically reasonable **and** necessary in order to be eligible for coverage. This includes services being provided at the appropriate level of care. Decisions regarding the setting for healthcare services should be based on nationally recognized guidelines, as well as CMS requirements **and** the unique clinical circumstances of the individual receiving the services.

While CMS does allow for the use of screening tools or instruments (e.g., InterQual®), they do not *require* the use of such tools. In addition, whether screening instruments are used or not, clinical judgment **must** be applied in order to make a medical review determination, using the clinical documentation in the medical record. Thus, while the InterQual® criteria may serve as a primary source of guidance, they are not the sole information that must be considered. The independent medical judgment of a qualified health care professional, along with unique clinical circumstances of the individual member (e.g., medical history and current medical needs) **must** also be considered.

OBSERVATION CARE

According to CMS, observation care is defined as the following:

> *"Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made 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 tests. 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 only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours."*[1]

When observation is ordered by the physician this will be considered an outpatient service. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient. Observation is intended for short-term monitoring. The observation patient, if not admitted to a hospital, is expected to improve and be ready for discharge or transfer to lower level of care within 48 hours.

As stated by Medicare above, a decision to either admit as an inpatient to or discharge from the facility is generally made in 24 hours, but it may take up to 48 hours. Observation services greater than 48 hours in duration are considered to be "rare and exceptional cases." For Oregon Health Plan (OHP)/Medicaid plan members, observation stays which exceed 48 hours are generally reported as inpatient claims.[2]

However, hospital claims which meet or exceed two midnights (or 48 hours, for OHP) are not guaranteed payment as an inpatient level of care; medical necessity requirements must still be met in order to be eligible for reimbursement at an inpatient level of care. Therefore, the health plan reserves the right to allow observation care above 48 hours in lieu of an inpatient admission if discharge is not appropriate, but inpatient admission criteria are not met.

This applies to all lines of business, including OHP/Medicaid plan members.

As with all services, observation services must be reported in accordance with the CMS billing requirements (e.g., use of appropriate codes, appropriate calculation of time and units, bundling outpatient services with inpatient claims when applicable, etc.).

While concurrent review for medical necessity of observation services is not required, claims reported with an excessive number of observation hours may be audited for medical necessity review and billing appropriateness.

Social or Convenience Considerations

According to Medicare guidance:

> "Medicare contractors shall continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors shall exclude extensive delays in the provision of medically necessary care from the 2- midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors shall consider them in determining whether Part A payment is appropriate for an inpatient admission."[3]

Sources

- Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A, §10 - Covered Inpatient Hospital Services Covered Under Part A
- Medicare Program Integrity Manual, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services, §6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment
- Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B, §20.6 - Outpatient Observation Services, "A. Outpatient Observation Services Defined
- Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), §290.1 - Observation Services Overview

- Medicare Program Integrity Manual, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2 - Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions, A. Determining the Appropriateness of Part A Payment
- Noridian web page for *Inpatient to Outpatient Status Change*
- Centers for Medicare & Medicaid Services. CMS Medicare Benefit Policy 100-02; Transmittal 42.
- Oregon Health Authority (OHA). Health Systems Division: Medical Assistance Programs - Chapter 410. Division 125 HOSPITAL SERVICES. 410-125-0360. Definitions and Billing Requirements

BILLING AND CODING GUIDELINES

REPORTING OBSERVATION HOURS[4]

Services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours) are more appropriately reported as recovery room services rather than observation services. In addition, "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). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time." Therefore, some time may be carved out from the total hospital time to calculate observation hours.

Example

- A patient is placed into observation on 01/06/2023, at 2:00 pm.
- The patient is discharged from the facility on 01/07/2023, at 6:00pm.
- The patient had a surgical procedure performed, and it lasted three hours.

01/06/2022, at 2:00pm through 01/07/2022, at 6:00pm is 28 total hours. However, for observation service reporting, the facility would need to carve out the three hours of surgery time, which leaves only 25 total observation hours. Therefore, the facility would only report 25 units of observation time on their claim.

Observation time ends when all medically necessary services related to observation care are completed. Observation time could end either:

- Before discharge when the need for observation has ended, but other medically necessary services are being provided (the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit).
- Time of discharge from the hospital
- When the patient is admitted as an inpatient.

When outpatient observation services span more than one (1) calendar day, the total accumulation of observation time for the entire period of observation must be included on a single line. The date of service would be the date observation care began.

The calculation of observation time does **not** include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

INPATIENT ADMISSION CONVERTED TO OBSERVATION ADMISSION

For Medicare lines of business or for providers who contract specifically with PHP to pay using CMS's Outpatient Prospective Payment System (OPPS)*, the change from inpatient bill type to observation bill type must be made while the member is hospitalized (pre-discharge). A bill type cannot be changed post discharge as an attempt to acquire payment for observation care services. Under Medicare, if an inpatient admission is denied due to lack of medical necessity, payment may be made for certain services (as inpatient Part B services). These inpatient Part B services do **not** include observation services. Examples of inpatient Part B covered services (when medically necessary) include:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy;
- Screening mammography services;
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self-management;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision);
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO).[5]

The above covered services are billed under Type of Bill 121 (hospital Inpatient Part B) or Type of Bill 137 (if previously approved during concurrent review for observation status). [4]

For the non-covered portions of the inpatient claim that is determined to be not medically necessary, a no-pay Part A claim should be submitted for the entire stay with the following information:

- 110 Type of bill (TOB)
- All days in non-covered
- All units and charges non-covered
- M1 Occurrence Span Code with the dates of provider liability
- A remark stating that the patient did not meet inpatient criteria[5]

While not all observation care claims are subject to routine review, if payment is made inadvertently, recovery efforts may be made to recoup the erroneous payment.

**For all other lines of business or facilities who do not fall in the above categories, the facility may change the bill type to observation post-discharge.*

CROSS REFERENCES

None

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B, §20.6 - Outpatient Observation Services, A. Outpatient Observation Services Defined. Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16. . https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf. Accessed 7/7/2023.
2. Oregon Health Authority. Health Systems Division: Medical Assistance Programs - Chapter 410. Division 125 HOSPITAL SERVICES. 410-125-0360. Definitions and Billing Requirements. . https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=84940. Accessed 7/7/2023.
3. Centers for Medicare & Medicaid Services. Medicare Program Integrity Manual, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2 - Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions, A. Determining the Appropriateness of Part A Payment. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf. Accessed 7/7/2023.
4. Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), §290.1 - Observation Services Overview. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf. Accessed 7/7/2023.
5. Noridian Healthcare Solutions. Jurisdication F. Medicare Part A. Inpatient to Outpatient Status Change. Updated April 25, 2023. https://med.noridianmedicare.com/web/jfa/topics/observation/inpatient-to-outpatient-status. Accessed 7/7/2023.

POLICY REVISION HISTORY

Date	Revision Summary
11/2022	Annual review, no changes (converted to new format 2/2023)
10/2023	Interim update; updated criteria and billing guidelines
1/2024	Annual review; updated policy due to change in review processes