

MEDICAL PAYMENT and PRIOR-AUTHORIZATION POLICY	
Policy Name:	Observation and Extended Assessment and Management in Facilities
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Approved by:	Gregory Busch, CMO
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Disclaimer

Medical Payment and prior authorization policy is intended to serve only as a general reference regarding payment and coverage for services described. This policy does not constitute medical advice and is not intended to govern and/or otherwise influence medical decisions

POLICY STATEMENT:

This policy applies to Health Options members whose clinical situation does not warrant an inpatient admission but may need to be evaluated and/or treated within 48 hours and/or the treating physician believes that allowing the patient to leave the facility would likely put the member at serious risk. The member may be admitted to the facility for an observation period or an extended assessment and management encounter. Observation Services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nurse or other staff. Observation stays do not require authorization from the health plan.

DEFINITIONS:

Observation: Observation status applies to patients for whom inpatient hospital admission is being considered but is not certain. Observation status should be used when the member's condition is expected to be evaluated and/or treated within 48 hours with follow-up care provided on an outpatient basis or the member is admitted to the hospital. Health Options follows the Centers for Medicare and Medicaid Services' (CMS) requirements regarding separate payment for Observation per your Health Options contract.

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PROCEDURES

Health Options follows the Centers for Medicare and Medicaid Services' (CMS) requirements for observation status.

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, given that the order meets guidelines for a medically necessary outpatient admission. Hospitals should round to the nearest hour. 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 another 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.

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. 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. 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.

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.

All of the following requirements must be met in order for a hospital to receive payment for Observation:

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- There must be a physician order to place the patient in observation.
- The order for observation status must be medically necessary.
- Observation time must be documented in the medical record.
- 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. A member'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.
- The observation stay must span a minimum 8 hours and these hours 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, and this 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.

The following diagnoses/situations will still be paid as inpatient level of care for stays that are less than 24 hours; patients who sign out Against Medical Advice (AMA), deaths in < 24 hours, live infant deliveries and spontaneous abortions, and authorized transfers to a different facility. Labor and delivery unit false labor stays of < 8 hours will be paid as observation when billed with the revenue code 762.

Authorization and Coding Requirements:

Authorization from Health Options is not required for Observation Services performed on an outpatient basis, as part of an Emergency Room visit, or as a result of false labor. These claims should be billed with a 762 revenue code.

If a provider contacts Health Options' UM department for authorization of an admission that is less than 24 hours, UM will advise the provider that an authorization is not required for observation services. These claims should be billed with a 760 revenue code.

Observation services provided prior to an authorized admission will be covered by the inpatient admission authorization and payment, based on rules of medical necessity. The admission date will be the date the patient presented to the facility.

The number of units reported Revenue Code 760 or 762 with HCPCS code G0378 or HCPCS Code G0379 must equal or exceed 8 hours.

The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- An emergency department visit (CPT codes 99281-285 or HCPCS code G0381 or G0384); or
- A clinic visit (HCPCS code G0463); or

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- Critical care (CPT code 99291); or
- Direct referral for observation care reported with HCPCS code G0379 must be reported on the same date of service as the date reported for observation services
- For payment, a HCPCS Type A ED visit code 99284, 99285, G0381 or G0384 Type B ED visit code, critical care (99291), or a G0463 HCPCS clinic visit code is required to be billed on the day before or the day that the patient is placed in observation. If the patient is a direct referral to observation the G0379 may be reported in lieu of an ED or clinic code. In addition, the E/M code associated with these other services must be billed on the same claim form as the observation service and the E/M must be billed with a modifier -25 if it has the same date of service as the observation code G0378.

REIMBURSEMENT:

Participating facilities will be reimbursed per their Health Options contract. If a participating facility is contractually reimbursed for observation services, the service will be paid per the contract once the minimum of 8 hours is met along with the other observation rules.

Non-participating facilities will be reimbursed for observation services as defined by the Delaware State Medicaid program.

Observation Services as part of a short procedure unit service (revenue code 761) are not compensable as a separate service and are included in the payment for the short procedure unit service.

If a member receives services from a lower level of care and is moved into observation and observation rules are met the lower level of care is considered inclusive of observation. For example if a member presents in the emergency department and is moved to observation, observation will be reimbursed and the emergency services will be inclusive of the observation reimbursement and not be separately reimbursed.

If a member is admitted as an inpatient following observation, outpatient surgery or an emergency room event, the Facility is required to notify Health Options and obtain an authorization. Failure to obtain an authorization could result in the inpatient claim and all other billed services being denied. All emergency room, outpatient surgery and observation charges related to the inpatient stay are to be included on the inpatient billing form and reimbursement will be at the authorized inpatient rate with no separate payment for the emergency room, outpatient surgery and/or observation charges.

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