OBSERVATION SERVICES (MEDICARE) HS-239

Applicable To:
☑ Medicare

Claims Edit Guideline: Observation Services (Medicare)

Policy Number: HS-239

Original Effective Date: 2/6/2014

Revised Date(s): 2/5/2015; 2/4/2016; 12/7/2017

BACKGROUND

The information contained within this policy will ensure that members receive care that is medically necessary and provided in the appropriate settings. 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 present 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. Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 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 (CMS, 2013, Section 290.1).

POSITION STATEMENT

Applicable To:
☑ Medicare – All Markets

An observation period begins when the member’s chart is noted with the date and time of transition to an observation bed. Initiation of services rendered shall be documented in the provider’s orders. An observation period ends when the member has completed all medically necessary services related to observatory care.

Observation services are intended for short-term monitoring, generally < 48 hours. Observation care greater than 48 hours without inpatient admission is generally considered non-medically necessary and may be subject to medical review.
Members who are not medically stable for discharge must meet one of the following:

1. Have a medical condition requiring monitoring/evaluation or treatment in order to confirm a diagnosis for determination of whether member will become an inpatient; OR,

2. Member is undergoing treatment for a diagnosed condition (e.g., chest pain, asthma, congestive heart failure) and continued monitoring of the clinical response to therapy may prevent an inpatient admission; OR,

3. Member has a significant adverse response to therapeutic services, invasive diagnostic testing or outpatient surgery requiring careful short-term monitoring and evaluation.

Services must:
- Be ordered by a provider and notated in member’s chart; AND,
- Contain orders stating the provider’s intent specific to level of care (e.g., admit to observation with date/time); AND,
- Provide documentation that includes a preprinted order or “admit stamp” with provider’s signature, date and time of order. “Standing orders” will not be reimbursed.

Dates of service not authorized for inpatient admission may be billed as observation care without prior authorization required.

NOTE: Prospective review is not required. Referrals are not required for observation services. Preregistration is required for services requiring inpatient admission (and beyond observation).

Separately Reimbursed Services

The following services are separately reimbursed when provided in addition to observation services:
- Emergency department services
- Surgical procedures
- MRI and MRA

Observation Care to Inpatient for Non-DRG Facilities

Outpatient observation provided on the day prior to an inpatient admission is reimbursed as an outpatient service. Observation time shall conclude at 12 midnight of the day of observation care. The following are examples:
- A member admitted on April 1 is considered “outpatient observation status”. On April 2, the member is admitted as an inpatient at 3 p.m. Observation care ceases at 11:59 p.m. on April 1. The time spent from midnight and 2:59 p.m. is not considered observation time due to it being inclusive of inpatient services.
- A member is admitted to inpatient care the same day as receiving outpatient observation. All services received during observation care will be reimbursed as inpatient.
- A member cannot be discharged from outpatient status following inpatient admission.

Other Information

- Hospitals must follow preregistration procedures for members admitted to inpatient status after receiving observation services.
- Mental health and substance abuse observation services must be provided or coordinated by a member’s designated mental health facility.
- WellCare may retrospectively review observation services for medical necessity to ensure compliance with Medicare guidelines.
- Hospitals are not compensated at the contracted rate for observation care and inpatient admission if a decision is made that results in an inpatient admission from the observation stay will be packaged. If observation care and admissions occur on the same calendar day, reimbursement is only given for admission.
- Emergency department services must appear on the claim, but it will not be separately payable. This does
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not affect the professional bill.
- Observation should not be billed if patient is admitted; only the appropriate inpatient code should be billed.

Non-Covered Services
Observation services are considered non-covered for the following:
- As a replacement for inpatient admission.
- Services that not medically necessary for the diagnosis and/or treatment of the member.
- Outpatient blood or chemotherapy administration.
- Delivery of medical exam for members not requiring skilled care.
- For the convenience of the provider, member or member's family (including transportation issues).
- While awaiting transfer to another facility.
- For overnight states prior to diagnostic testing.
- Standing orders following outpatient surgery.
- Services normally requiring an inpatient stay.
- Non-medically necessary services for the member.
- Services provided parallel with chemotherapy.
- When members are discharged to observation status.
- Post-operative monitoring during a normal recovery period.

Observation for members awaiting routine preoperative preparation, monitoring and postoperative recovery is covered under the allowance for surgery and shall not be billed separately. This may include (but is not limited to):
- Routine preparation prior to diagnostic testing and recovery.
- Routine recovery and post-operative care following ambulatory surgery.
- Following an uncomplicated treatment or procedure.

CODING

Covered HCPCS Codes
G0378  Hospital Observation service, Per Hour
G0379  Direct admission of patient for hospital Observation Care

REV Code
076x 0762  Specialty Services – Observation Hours; Hospital Outpatient

All observation services are reported under this code. When reported on the same date of service as 99205, 99215, 99284-99285, 99291, or G0379; and a procedure with status indicator T is NOT performed on the same date of service, or 1 day earlier, one composite payment for both services will be made. If this criteria is not met, service is packaged into the payment for other services.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES
2. EncoderPro.com for payers (for rev code 762 information).

LEGAL DISCLAIMER
The Claims Edit Guideline (CEG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CEG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s

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benefit plan may contain specific exclusions related to the topic addressed in this CEG. When a conflict exists between the two documents, the Member’s Benefit Plan always supersedes the information contained in the CEG. Additionally, CEGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CEG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

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WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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