Hospital Outpatient Observation Services

Reimbursement Policy

Policy

Community Health Options ("Health Options") reimburses observation services when Medicare billing guidelines and criteria are met.

Policy

"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 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 service must also be reasonable and necessary to be covered…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).

Hospital outpatient observation services do not require notification or authorization for dates of service March 1, 2023 and after. All other authorization requirements remain the same (for example: surgery and change to inpatient status). Health Options does not reimburse for covered observation services in excess of 48 hours.

Health Options reserves the right to request additional documentation (itemized bill and/or medical records) to review for compliance in using observation services in accordance with this policy under pre-pay or post-pay audits.

Billing Guidelines

All hospital observation services are to be billed with the appropriate codes as follows:
Revenue code:

- 0760: General Classification category
- 0762: Observation Room

HCPCS code:

- G0378: Hospital observation service, per hour.
- G0379: Direct admission of patient for hospital observation care.

Reporting Hours of Observation (as defined by CMS, Section 290.2):
"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" (CMS). The observation hours are required

to correspond with the unit/quantity field of the observation HCPCS code on the claim form and medical documentation, respectively. Report the number of observation hours in Field Locator 46 of the UB-04 claim form, via paper or electronic.

"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". Observation time should exclude the time performing diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy), (CMS).

Non-Covered Services

- Health Options does not reimburse for covered observation services in excess of 48 hours
- General standing orders for observation services directly following outpatient surgery
- Observation in replacement of recovery room
- Convenience of provider, member, family, or facility
- Wait times for facility transfer or transfer home
- Time performing diagnostic or therapeutic services for which active monitoring is a part of the procedure, time related to these services must be removed from the observation hours billed
- Observation services preceding an inpatient admission before midnight of the same day; the observation charge on the same day as the inpatient admission is not separately reimbursed

References / Resources

Centers for Medicare & Medicaid Services, Medicare Claims Processing Manual, Chapter 4, Section 290: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

Related Policies

Appeals & Reconsiderations
Facility Revenue Code Requirements
Itemized Bill Submission
Professional Services

Document Publication History

3/3/2023	Annual review: removed authorization requirement effective for dates of service on and after 3/1/2023. Updated non-covered section adding wait times and convenience.
2/22/2022	Annual review: minor administrative updates and removed non-covered ED prior to Observation
12/10/2020	Annual review; no changes
8/26/2019	Initial publication

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prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.