Policy

DEPARTMENT: Utilization Management	**POLICY#: UM - 022**
TITLE: Observation Coverage Guidelines	**VERSION: 1.0**
APPROVED BY: UM Committee	**DATE:** 7/26/2022
DEPENDENCIES:	

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Purpose
This policy outlines the Medicare outpatient observation services and coverage criteria.

Definitions, Abbreviations, and Acronyms

Acronym	Meaning
Obs	Observation
Inpt	Inpatient
LHP	Longevity Health Plan, the Plan
CMS	Centers for Medicare and Medicaid Services

Observation Outpatient Hospital Services
Observation care is a well-defined set of specific, clinically appropriate services which include ongoing short-term monitoring, treatment, assessment, and reassessment before a decision can be made regarding whether a patient will require further treatment as an inpatient hospitalization or if they are able to be discharged following the observation stay.

Policy
All outpatient and inpatient services must meet medical necessity criteria to be covered. All determinations must be based on nationally recognized guidelines and evidence-based literature.

Coverage of Outpatient Observation Services
Outpatient observation services are commonly ordered for patients that present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision for full inpatient admission or discharge.

Outpatient observation services are covered only when provided by the order of a physician or another individual authorized by state licensure and hospital staff bylaws to admit patients to the hospital or to order outpatient testing. In most 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 calendar hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span greater than 48 calendar hours.

Hospitals may bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department. Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly referred for observation services.

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 and for inpatient admission. Thus, a patient receiving observation services may improve and be released or be admitted as an inpatient.

All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare. Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). In most circumstances, observation services are supportive and ancillary to the other separately payable services provided to a patient. Hospitals must not bill Medicare beneficiaries directly for the packaged services.

If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determine under 42 CFR §482.30(d) or §485.641 after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, and if a waiver of liability payment is not made, the hospital may be paid for the following Part B services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B.
The services billed for Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for Part B services submitted following a reasonable and necessary Part A claim denial or hospital utilization review determination must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service.

CMS Two-Midnight Rule

When a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner must decide whether to admit the patient as an inpatient or treat as an outpatient. These decisions may have significant implications for hospital payment and patient cost sharing. Not all care provided in a hospital setting is appropriate for inpatient, Part A payment.

The Two-Midnight Rule-bases on CMS 2013 Fiscal Year Press Release:
To provide greater clarity to hospital and physician stakeholders and to address the higher frequency of patients being treated as hospital outpatients for extended periods of time, CMS adopted the Two-Midnight Rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when determining whether inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

- Inpatient admissions would be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation
- Medicare Part A payment was generally not appropriate for hospital stays expected to last less than 2 midnights. Cases involving a procedure of the CMS inpatient only list were exceptions to this rule.

The Medicare Inpatient Only list includes procedures that are typically only provided in the inpatient setting and therefore not paid under outpatient services.

Authorization Guidelines

a. Observation services beyond a 48 calendar hour period are not covered. Hospital providers must call and obtain approval for an inpatient admission beyond the initial 48 calendar hour period or submit a request for authorization in writing to the Utilization Management Department.
b. If the inpatient status is medically necessary based on clinical data and requested by the attending physician, inpatient status will be authorized regardless of the anticipated length of stay.
c. If clinical data at the time of hospital admission does not support inpatient status, regardless of the attending physician's request, the inpatient status will be denied and observation status will be recommended. If no clinical data is available from the facility, the Utilization Management Department will make an initial determination based on the Advanced Practice Provider's transition clinical documentation provided.
d. If the attending physician does not agree with the Utilization Management Department's recommendation, the clinical criteria will be reviewed by the Utilization Management Department's Medical Director for an approval or adverse determination.

e. The Utilization Management Department will facilitate a Peer to Peer with hospital provider and Utilization Management Department Medical Director before an adverse termination is made by the Utilization Management Department Medical Director.
f. The hospital will be offered appeal rights if the stay is denied for inpatient level of care.

Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
NEW		7/26/2022	Courtney Gonzales	NEW

Appendices

Medicare Claims Processing Manual (

Medicare Claims Processing Manual (