



OHIO ONLY: MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
10/06/2015	10/06/2016	10/06/2015
Policy Name	Policy Number	
Observation Care Services	PY-0003	

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

A. SUBJECT Observation Care Services

B. BACKGROUND
Patients presenting to the Emergency Department: Determinations for ongoing treatment of members presenting to an emergency department (ED) may depend on several factors. These include, but are not limited to, the specific condition in question, the member's medical history, the severity of the presenting signs and symptoms, the predictability of adverse events and/or the availability and anticipated intensity of necessary service(s) following initial evaluation and management.

Members, whether as a result of an uncertain diagnosis, unacceptable clinical risk, indeterminate course, unexpected complication(s) and/or other factors, may require a period of time for observing and monitoring, further evaluation and/or treatment. This may relate to a known condition or to establish a diagnosis in order to facilitate discharge from an ED, or conversely, to determine that further acute care in the hospital is necessary. Such situations are frequently amenable to the use of outpatient or observation care.

Patients undergoing Outpatient Procedures: Observation Level of Care should not be used for routine diagnostic services, outpatient surgeries or ambulatory procedures under normal circumstances. Further, the usual preparation and the routine or expected recovery monitoring and care following such procedures are not considered Observation Services.

Determinations for short term monitoring, evaluation and/or stabilizing care of members following invasive diagnostic testing or outpatient surgery who have sustained an unexpected delay in recovery and/or complication may be amenable to the use of observation care prior to discharge or as a means of determining that further Inpatient Care is necessary.



Observation Care: In these and other appropriate clinical settings, Observation Care has been described as “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 Care is considered to be medically necessary when “the patient's current condition requires outpatient hospital services, or when there is a significant risk of deterioration in the immediate future such that continued observation in a non-hospital environment is inadvisable.”

Any determination for Inpatient Care or Observation Care for a member is covered only when provided by the order of a physician or another healthcare professional authorized by State licensure law and hospital staff bylaws to admit patients to the hospital based on the provider's professional expectation of the care that will be needed for that member.

In general, if the treating physician or healthcare professional is uncertain if an inpatient admission is appropriate, or if the presenting complaint is symptom oriented (i.e. abdominal pain, chest pain, and shortness of breath) consideration should be given to admitting the patient for observation.

The generally accepted rule is that the physician "should order an inpatient admission for patients who are expected to need hospital care for 24 hours or longer and treat other patients on an outpatient basis. Modifications have been provided by CMS through final rule [CMS-1599-F] for the purpose of determining how inpatient admissions are reviewed for reimbursement, This rule states, “In addition to services designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (1) expects the beneficiary to require a stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation.”

The timeframe used for determining the expected stay begins when the individual begins receiving services in the hospital and includes Observation Services as well as services provided in the emergency department, outpatient and other areas.

An inpatient admission is not covered when the care can be provided in a less intensive setting without significantly and indirectly threatening the patient's safety or health.”

Decisions for the appropriate Level of Care should be made in a timely manner. In most cases, the decision whether to discharge a patient from the hospital (following resolution of the clinical situations that have led to 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 does reasonable and necessary outpatient Observation Services span more than 48 hours.”

C. DEFINITIONS

- **Inpatient Care:** Acute, medically complex management and care furnished to a patient while resident in a hospital. This includes, but is not limited to, room and board, diagnostic services; nursing, social and therapeutic services; medical and surgical services and associated ancillary care.
- **Level of Care:** The intensity and complexity of clinical (medical-surgical) services provided under the supervision of a physician, or other appropriate health care provider, within the health care facility appropriate for those services.



- Observation Services:** Patient specific services furnished by a hospital on its premises, including the use of a bed, periodic monitoring by nursing and other staff, and any other services that are reasonable and necessary to evaluate a patient's condition or to determine the need for a possible (inpatient) admission to the hospital.
- Outpatient Procedures:** Diagnostic and/or therapeutic clinical services rendered at a clinic, hospital or other medical facility which by virtue of their expected intensity do not necessitate that the patient be admitted to a hospital for an extended stay.

D. POLICY

Although the reimbursement may vary, the quality of the care and services rendered whether Inpatient or under Observation should be equivalent. For the purposes of billing codes, Observation Care is divided into "Initial" (CPT 99218-99220) and "Subsequent" phases and "Admission" and "Discharge" services.

Reimbursement for "Initial" Observation Care is covered only when billed by a physician or other qualified health care provider who ordered the hospital outpatient Observation Services and was responsible for the member during their episode of Observation Care.

"Initial" Care is also inclusive of all care rendered by the ordering physician on the date the patient's Observation Services began. "All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient Observation Services must bill the appropriate outpatient service codes."

For a physician or qualified health care provider to bill "Initial" Observation Care codes, a medical observation record, which is independent of any record developed as a result of care delivered in either an emergency department or outpatient facility, must be developed. This record should include the "dated and timed physician's orders regarding the Observation Services the patient is to receive, nursing notes, and progress notes."

In those circumstances in which a member is held in observation status for more than two calendar dates, or when physicians other than the supervising physician provide health services billing should utilize "Subsequent" observation codes T CPT 99224 - 99226).

Evaluation and management services incorporated into subsequent observation care include reviewing and updating the medical record, integrating the results of diagnostic studies and documenting changes in the patient's status in response to management since the last assessment by the physician," in addition to the interval history, exam and medical decision making.

Payment policy for medical services rendered to CareSource members is based on the principle of medical necessity. CareSource will utilize established industry guidelines when reviewing for reimbursement of medically necessary services provided as a result of inpatient admission. Observation Services are not subject to medical necessity review.

For Medicare Plan members, reference the Applicable National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Compliance with NCDs and LCDs is required where applicable.

Note: The following list of codes may not be all inclusive and codes that have been deleted or that are not effective at the time of health services are provided may not be eligible for payment.

- CPT® codes 99217-99220 are utilized for "Initial" observation care for (E/M) services provided to new or established patients admitted to "observation status" for care in a hospital.



- CPT codes 99224-99226 apply to “subsequent” observation care evaluation and management services in a hospital setting.
- CPT codes 99234-99236 are used to report E/M services provided to patients admitted and discharged on the same date of service.

HCPCS CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

1. OAC 5160-30 Alcohol and Drug Addiction Services
2. 42 CFR, Section 410.32
3. 907 KAR 3:110. Community mental health center substance abuse services
4. <http://www.healthnetworklabs.com/Pages/MedicareCoveragePolicy/GuidetoMedicaresFrequentlyUsedCoveragePolicies.pdf>

F. REVIEW/REVISION HISTORY

Date Issued: 10/06/2015
Date Reviewed: 10/06/2015
Date Revised:

G. REFERENCES

1. CMS Manual. Department of Health & Human Services (DHHS), August 26, 2011. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2282CP.pdf>
2. Centers for Medicare & Medicaid Services (CMS). Baltimore, MD, 2015. <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=27548&ContrlId=314&ver=69&ContrVer=1&Date=03%2f11%2f2013&DocID=L27548&bc=AAAAAAgAAAAAA%3d%3d&>
3. Centers for Medicare & Medicaid Services (CMS). Baltimore, MD, 2015. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf>
4. Centers for Medicare & Medicaid Services (CMS). Baltimore, MD, 2015. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2282CP.pdf>

This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

The medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.