CLINICAL MEDICAL POLICY	
Policy Name:	Observation Care (Hospital Outpatient)
Policy Number:	MP-081-MC-PA
Responsible Department(s):	Medical Management
Provider Notice/Issue Date:	09/01/2023; 10/01/2022; 09/17/2021; 09/21/2020; 10/01/2019
Effective Date:	10/01/2023; 11/01/2022; 10/18/2021; 10/19/2020; 10/01/2019
Next Annual Review:	08/2024
Revision Date:	08/16/2023; 08/17/2022; 08/18/2021; 08/19/2020
Products:	Pennsylvania Medicare Assured
Application:	All participating hospitals and providers
Page Number(s):	1 of 6

Policy History

Date	Activity
10/01/2023	Provider Effective date
07/19/2023	QI/UM Committee review
07/19/2023	Annual Review: Revised 'Procedures' section and certain Medical Necessity Guidelines. Removed retired CMS LCA (retirement effective date January 1, 2023). Removed the following deleted CPT codes: 99217, 99218, 99219, 99220, 99224, 99225, and 99226; replaced with the following CPT codes: 99221, 99222, 99223, 99231, 99232, 99233, 99238, and 99239, all per AMA guidance. Updated 'Reference Sources' section.
11/01/2022	Provider Effective date
08/17/2022	QI/UM Committee review
08/17/2022	Annual Review: No changes to clinical criteria. Updated CPT code 99217 code description. Replaced CMS Inpatient Only list with 2022 version. Updated Reference Sources section.
10/18/2021	Provider effective date
08/18/2021	QI/UM Committee review
08/18/2021	Annual Review: No changes to criteria. Updated the following CPT code descriptions according to the AMA: 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235 & 99236. Replaced 2020 CMS 'Inpatient Only' PPS list with 2021 PPS list. Minor formatting changes, and updated the Reference section.
10/19/2020	Provider effective date
08/19/2020	QI/UM Committee review

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08/19/2020	Annual Review: removed all hyperlinks; replaced 2019 Medicare Inpatient Only list with 2020 list; updated Reference section
10/04/2019	Removed the reference to the prior medical policy CL-200-MD-PA as this policy address Medicaid products only.
10/01/2019	Provider effective date
09/23/2019	Clarification Update: Removed information related to Condition Code 44 as unnecessary for this policy and clarified admission date requirement.
08/21/2019	QI/UM Committee review
08/12/2019	Initial policy developed

Disclaimer

Highmark Wholecare℠ medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Highmark Wholecare℠ may provide coverage under the medical-surgical benefits of the Company's Medicare products for medically necessary hospital outpatient observation care.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

Definitions

Observation - 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.

Medicare Outpatient Observation Notice (MOON, Form CMSD-10611) - A standardized notice to inform Medicare patients (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or Critical Access Hospital.

Procedures

Outpatient observation is an alternative to inpatient admission. A physician order documented as admit to observation will follow this policy. Conversely, a physician order documented as admit will be treated as an inpatient admission, and this policy will not apply.

1. Medical Necessity Guidelines Observation Care
    - Observation care is a well-defined set of specific and clinically appropriate services. These include ongoing short term treatment, assessment, and reassessment, which occur 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 require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.
    - Medical care provided under 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.
    - Providers must follow Medicare Guidelines for Observation services and reporting hours of observation including that:
        - Hospitals and Critical Access Hospitals are required to provide a Medicare Outpatient Observation Notice (MOON) to patients informing them that they are outpatients receiving observation services and are not inpatients of a hospital or Critical Access Hospital. The MOON is to be delivered to patients who received observation services as an outpatient for more than 24 hours and must be delivered no later than 36 hours after observation services begin. The MOON may be delivered before a patient receives 24 hours of observation services as an outpatient.
    - Providers must report all services rendered in observation with the appropriate revenue codes, HCPCS codes, CPT codes, and ICD-10 diagnosis codes.

2. Observation Services do not require prior authorization.

3. The Medical Record must document the need for clinically appropriate services, treatments, assessments, and testing. The documentation should include the following information but is not limited to:
    - Physician admission and progress notes:
    - Diagnostic and/or ancillary testing reports;
    - The discharge notes (with clock time) with discharge order and nurses notes

4. Observation services should not be billed in some situations:
    - Observation services should not be billed along with diagnostic or therapeutic services for which active monitoring is a part of the procedure. Note that when active monitoring is part of the procedure the hospital may determine the most appropriate way to account for this time. Examples include:
        - Standing orders following an outpatient surgery
        - Extended observation following a procedure
        - Services provided concurrently with chemotherapy
        - Routine recovery and post-operative care after same-day surgery
        - Awaiting transfer to another facility

    - Outpatient blood administration
  - Observation services provided for the convenience of the patient, the patient's family, or a physician.

5. Post-payment Audit Statement
   The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Wholecare℠ at any time pursuant to the terms of your provider agreement.

6. Place of Service
   The proper place of service for observation is hospital outpatient.

Operational Guidelines *Do not include on external version*

- This medical policy will be applied on a postservice, postpayment basis for both professional and facility claims.

Coverage Determination and Links

Highmark Wholecare℠ follows the coverage determinations made by CMS as outlined in the NCD, and the state specific LCD/LCA.

CMS Link

- CMS Website

NCD/LCD Link

- There are no current NCD/LCDs related to this topic.

Coding Requirements

Providers must report the Emergency Department or clinic visit code or if applicable, G0379 (direct referral to observation) and G0378 (hospital observation services, per hour) and the number of units representing the hours spent in observation (rounded to the nearest hour) for all observation services. Submitted claims must adhere to Medicare Billing Guidance including but not limited to:

- A HCPCS Type A ED visit code (99281, 99282, 99283, 99284, 99285) or G0384 Type B ED visit code, critical care (99291), or G0463 HCPCS clinic visit code is required to be billed on the day before or the day that the patient is placed into observation status.
  - If the patient is a direct referral to observation, the G0379 may be reported in lieu of an ED or clinic code.
  - The Evaluation and Management code associated with these services must be billed on the same claim as the observation and include modifier -25 if provided on the same date of service for observation code G0378.
- Observation stay hours must be documented in the 'UNITS' field on the claim form. For facilities, the clock starts at the time that observation services are initiated in accordance with a practitioner's order for placement of the patient into observation status.
- The patient must be under the care of a physician or nonphysician practitioner during the time of observation care. This care must be documented in the medical record with admission

notes, progress notes, treatments and discharge instructions which are timed, written, and signed by the physician.

- A nonphysician practitioner licensed by the state and approved by internal credentialing and bylaws to supervise patients in observation may do so.

Procedure Codes

CPT Code	Description
Professional Provider Billing Codes	
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
99239	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
Facility Billing Code	
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care

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Reference Sources

Novitas Solutions, Inc. Part B Fact Sheet: Observation Services. Last modified March 3, 2023. Accessed on July 10, 2023.

Centers for Medicare and Medicaid Services (CMS). Medicare Claims Process Manual: Chapter 30- Financial Liability Protections. Published date January 21, 2022. Accessed on July 10, 2023.

Centers for Medicare and Medicaid Services (CMS). Newsroom Fact Sheet: Two-Midnight Rule. October 30, 2015. Accessed on August 2, 2022.

Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 4 – Part B Hospital. Revision date April 5, 2023. Accessed on July 10, 2023.

Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 6 – Hospital Services Covered Under Part B. Revision date December 31, 2020. Accessed on July 10, 2023.

Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing – Transmittal 11842. February 9, 2023. Accessed on July 10, 2023.

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