If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSNM may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Observation Services Policy

Clinical Payment and Coding Policy

Number: CPCP001

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: July 20, 2021

Plan Effective Date: September 6, 2021

Description:

Observation care may be appropriate for members requiring short-term evaluation for a condition, treatment for a known condition, or monitoring for recovery. It can also be appropriate when repeat testing or re-evaluation is necessary to determine the member's diagnosis and care needs. Observation care provides a method of evaluation and treatment as an alternative to inpatient hospitalization. This policy applies to observation services provided at all facilities.

Observation services may only be considered for coverage when provided under a physician's order or under the order of another person who is authorized by state licensure law and the provider organization's bylaws to admit members to the facility and order outpatient testing. Observation services may also be considered when the member does not meet inpatient level

of care and meets observation level of care.

Observation services must be member-specific and not part of a standard operating procedure or facility protocol for a given diagnosis or service.

Observation time ends when medically necessary services associated with observation care are completed.

Reimbursement Information:

Services/Locations Defined

Recovery Room: Members that have had surgery or a diagnostic procedure that require anesthesia are transferred to a recovery room where vital signs are monitored as anesthesia wears off. Time spent in a recovery room varies depending on the procedure, surgery and type of anesthesia used. In the immediate post-operative time frame, the member is assessed in a recovery room which is almost always in close proximity to the operating room itself.

Observation Room: Clinical decision units where members typically do not meet inpatient admission but require monitoring before being admitted or discharged.

Routine Recovery: Members appear to regain control of reflexes, motor function, coordination and physiologic function before discharge.

Post-Operative Care: Begins immediately after surgery in the recovery room but can continue well after discharge.

Note, observation services are outpatient services. Therefore, placement into observation status should have been specifically ordered at a time when it was uncertain if an inpatient admission would be necessary.

When Observation Status is covered

The setting for delivery of healthcare services should be based on nationally recognized guidelines and evidence-based medical literature.

In most cases, the decision to discharge a member from observation care or admit to inpatient status can usually be made in less than 24 hours but no more than 48 hours.

Observation services beyond 48 hours may not be covered unless the provider has contacted the plan and received approval. Observation services must be medically necessary to receive payment regardless of the hours billed.

For an observation stay to be medically necessary, the following must be met:

- The member is clinically unstable for discharge; **AND**
    - Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary to assess the member's need for continued hospital stay;

OR

- A treatment plan has not been established and based on the member's condition will be completed within 48 hours; **OR**
- Changes in status or condition are anticipated that may require immediate medical intervention.

Observation Services may be categorized as follows:

- **Patient/member evaluation:** When a member arrives at a facility in an unstable medical condition, an observation stay pending determination of a definitive treatment plan may be considered appropriate, such as the "short-term evaluation for a condition (e.g. rule out Myocardial Infarction [MI]), treatment for a known condition (e.g. asthma), or monitoring for recovery (e.g. drug ingestion) may be considered appropriate." MCG OCG: OC-022 (ISC)
- **Outpatient surgery/Ambulatory Services:** Observation services coverage is restricted to situations where a member exhibits an inordinate or unusual reaction to a surgical procedure, such as difficulty in awakening from anesthesia, a drug reaction, or other post-surgical complications which require monitoring or treatment beyond that customarily provided in the immediate postoperative period. Routine pre-operative preparation and recovery room services are not to be billed as observation services. MCG OCG: OC-022(ISC).
- **Surgery associated with Observation Stays:** Observation days may be approved when associated with complex surgical procedures that have criteria outlined in MCG care guidelines and Goal Length of Stay of Ambulatory or 1 day postoperative days, such as, anterior cervical fusion. MCG ORG: S-320(ISC)
- **Diagnostic testing:** For a scheduled invasive outpatient, diagnostic test, routine preparation before the test and services provided in the immediate recovery period following the test are not considered an observation service. However, if a member has a significant adverse reaction (above and beyond the usual or expected response) to the test that requires further monitoring, outpatient observations services may be reasonable and necessary MCG OCG: OC-022(ISC). Observation services would begin when the reaction occurred and would end when the member is either stable for discharge or appropriate for inpatient admission.
- **Outpatient therapeutic services:**
  - When a member has been scheduled for ongoing therapeutic services for a known medical condition, a period of observation is often required to evaluate the response to that service. This period of evaluation is an inherent component of the therapeutic service and is not considered an observation service. Observation service would only begin when a significant adverse reaction occurs that is above and beyond the usual, expected response to the service.
  - Observation status does not apply when a member is treated as an outpatient only for administration of blood and receives no

other medical treatment. The use of hospital facilities is inherent in administration of blood and is included in the payment for administration.

When Observation Services are not covered

In general, observation services are not covered when the medical criteria and guidelines listed above are not met.

Services not considered appropriate for observation room services include, but are not limited to:

- Those considered not reasonable and/or medically necessary for the diagnosis or treatment of the member;
- Outpatient blood or chemotherapy administration;
- Lack of, or delay in, patient transportation;
- Provision of a medical exam for members who do not require skilled medical or nursing services;
- Routine preparation prior to, and recovery following, diagnostic testing;
- Routine recovery and post-operative care following ambulatory surgery; Observation cannot be billed while the member is in routine recovery and post-operative care status.
- Services provided for the convenience of the physician, member or member's family;
- Services provided while awaiting member transfer to another facility and observation or inpatient criteria are no longer met;
- Services provided when an overnight stay is planned prior to diagnostic testing and observation criteria are not met;
- General standing orders following outpatient surgery that should be billed as recovery room services;
- Services that would normally require inpatient stay;
- Services following an uncomplicated treatment or procedure;
- Services provided concurrently with chemotherapy;
- Services provided when an inpatient is discharged to observation status;
- Services that are not reasonable and necessary for the care of the member.

Clinical Guidelines

1. When in receipt of clinical data requesting hospital authorization **and inpatient status is requested by the attending physician**, inpatient status is considered medically necessary if:

a. The member meets clinical indications as outlined in MCG care guidelines AND

b. The Goal Length of Stay or Benchmark Length of Stay is 1 or more days per MCG care guidelines.

Note, a member's care in observation should be reassessed, and failure to improve sufficiently after appropriate treatment indicates appropriateness for inpatient admission. Inpatient admission or transition to inpatient admission from observation care is generally indicated when a condition (e.g., acute MI) is diagnosed requiring a longer-term stay or when longer-term treatment or monitoring is needed for a condition (e.g., persistent severe asthma).

2. If clinical data at the time of hospital presentation does **not** support inpatient status, **regardless of the attending physician's request**, observation status will be offered and if not accepted by the facility, the request will be transferred to the Medical Director to review and make a determination.

Physician & Facility Documentation Information

Medical records may be requested for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Documentation should include the following information:

- The attending physician's order for observation care with clock time (or clock time noted in a nurse's observation admission note);
- The physician admission and progress notes confirming the need for observation care;
- The supporting diagnostic and/or ancillary testing reports;
- The admission progress notes (with the clock time) outlining the member's condition and treatment;
- The discharge notes (with clock time) with discharge order and nurse notes.

Coding and Billing Information

Inclusion of a code in this section does not guarantee reimbursement.

Applicable service codes: Revenue code 0762 and/or one of the following procedure codes 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, G0378, G0379, and G0463

Providers must report the ED (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.

Specific criteria includes:

- A physician order to place the patient in observation;
- A CPT Type A ED visit code 99281, 99282, 99283, 99284, 99285; or a Type B ED visit HCPCS code G0380-G0384; or critical care CPT code 99291; or a HCPCS clinic visit code G0463, is required to be billed on the day before or the day that the member is placed in observation;
    - If the member is a direct referral to observation, the G0379 may be reported in lieu of an ED or clinic code.
    - The E/M (Evaluation and Management) code associated with these services must be billed on the same claim as the observation service and include modifier -25 if provided on the date of service for observation code G0378.
- The 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 member into observation status;
- The member must be under the care of a physician or non-physician practitioner during the time of observation care, and this care must be documented in the medical record with an order for observation, admission notes, progress notes, and discharge instructions (notes) all of which are timed, written, and signed by the physician;
    - A non-physician practitioner licensed by the state and approved by internal credentialing and bylaws to supervise patients in observation may do so.

All related services rendered to the member should be accurately coded in addition to the observation HCPCS code G0378.

References:

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Medicare Claims Processing Manual Chapter 4, Section 290.2.2 “Reporting Hours of Observation”, Rev. 10541, Effective 12-31-20

Clinical Payment and Coding Policy, CPCP002 Inpatient and Outpatient Unbundling

Policy Update History:

Approval Date	Description
11/01/2016	Policy approved for BCBSTX only
03/22/2017	Policy approved by CPCP Committee; Adopted at Enterprise level
03/23/2018	Annual Review
03/26/2019	Annual Review
05/26/2020	Annual Review, Disclaimer Update
07/20/2021	Annual Review