



Medicare Part C Medical Coverage Policy

Observation Services

Original Date: February 18, 2004

Review Date: September 21, 2023

Next Review: September 2024

******This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE OR SERVICE

Observation services are defined as the use of a bed and periodic monitoring by a hospital's nursing or other ancillary staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

The services may be considered eligible for coverage only when provided under a physician's order (or under the order of another person who is authorized by state statute and the hospital's bylaws to admit members and order outpatient testing).

Observation should not be used as a substitute for medically necessary inpatient admissions. Outpatient observation services should not be used for the convenience of the hospital, the physicians, members, or member's families or while awaiting placement to another health facility.

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

POLICY STATEMENT

Coverage will be provided for observation services when it is determined to be medically necessary, as outlined in the below guidelines and medical criteria.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and

- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

INDICATIONS FOR COVERAGE

Observation will be considered medically necessary if the following conditions are met:

- The member arrives at the facility with an unstable medical condition (generally via the Emergency Department); **and**
- Laboratory, radiologic, or other testing is necessary to assess the member's need for hospitalization; **or**
- The treatment plan is not established; however, based upon the member's condition, completion of a treatment plan is anticipated within a period not to exceed 48 hours.

An **unstable medical condition** can be defined as the following:

1. Variance from generally accepted, normal laboratory values, **and**
2. Clinical signs and symptoms are present that are above or below those of normal range (for the member) and are such that further monitoring, and evaluation is needed, **or**
3. Changes in the member's status or condition are anticipated, and immediate medical intervention may be required.

Observation Services may be categorized as follows:

Patient evaluation: When the member arrives at the facility in an unstable medical condition (generally via the Emergency Department), an observation stay pending determination of a definitive treatment plan and the need for possible admission to the hospital as an inpatient may be considered reasonable and necessary.

Outpatient surgery: Observation service coverage is restricted to situations where a member exhibits an uncommon or unusual reaction to the 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. Observation services would begin at that point in time when the reaction occurred and would end when it is determined that the member is stable for discharge or it is determined the member requires inpatient admission.

Diagnostic testing: For scheduled outpatient diagnostic tests which are invasive in nature, the routine preparation before the test and the immediate recovery period following the test is not considered as an observation service. However, when a member has a significant adverse reaction (above and beyond the usual or expected

response) as a result of the test that requires further monitoring, outpatient observations services may be reasonable and necessary. Observation services would begin at that point in time when the reaction occurred and would end when it is determined whether or not the member required inpatient admission. Medical review decisions will be based on the documentation in the member's medical record.

Outpatient therapeutic services: Observation status does not apply when a beneficiary is treated as an outpatient for the administration of blood only and receives no other medical treatment. The use of the hospital facilities is inherent in the administration of the blood and is included in the payment for administration.

When the patient has been scheduled for ongoing therapeutic services as a result of a known medical condition, a period of time is often required to evaluate the response to that service. This period of evaluation is an appropriate component of the therapeutic service and is not considered an observation service.

The observation service begins at that point in time when a significant adverse reaction occurred that is above and beyond the usual and expected response to the service.

WHEN COVERAGE WILL NOT BE APPROVED

When the above medical criteria and guidelines are not met.

POLICY GUIDELINES

1. When in receipt of clinical data requesting hospital authorization, MCG shall be applied to the case. If guidelines are met for inpatient status, inpatient status shall be authorized regardless of anticipated length of stay (LOS).
2. Upon application of MCG, if the clinical data at the time of hospital presentation does not support inpatient status, the request will be reviewed by a Plan medical director. The member shall be authorized for the appropriate level of care based on presenting symptoms.
3. If MCG cannot be applied to the clinical data at the time of hospital presentation, severity of illness/intensity of service guidelines shall be used to determine the appropriate setting for the member's medical management. A Plan medical director will be consulted to determine the appropriate setting for the member's medical management.

The nurse reviewer will consult with a Plan medical director before any denial of services.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable codes: 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, G0378, G0379

The Plan may request medical records 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.

SPECIAL NOTES

An admission to observation by the attending physician does not require prior plan approval.

If after the initial observation period the member's clinical status deteriorates or remains unstable and/or additional clinical information is provided that meets MCG criteria for admission, the nurse may authorize an inpatient stay retroactive to the date of the member's admission to the facility as an observation member.

References:

1. Medicare Local Coverage Determination for Outpatient Observation Bed/Room Services – Palmetto GBA Part A/B (L34552); Effective date: 10/01/2015; Accessed via <http://www.cms.gov/> 08/16/2023.
2. Medicare Benefit Manual, Chapter 6, Section 20.6 (Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16); accessed via <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> reviewed on 08/16/2023.

Policy Implementation/Update Information:

Revision Date: February 22, 2006

Revision Date: November 28, 2007: No criteria changes made

September 2009: No changes proposed to the review criteria. Formatting and minor wording changes only.

March 2012; criteria added to be consistent with Medicare LCD.

Revision Date: August 20, 2014; Annual Review; no changes. October 29, 2015 updated LCD due to ICD-10 update only.

Revision Date: July 20, 2016; Annual Review; no CMS updates, minor revisions to policy for consistency. References updated.

Revision Date: September 20, 2017; Review requested by leadership; No CMS updates. Minor Revisions Only.

Revision Date: September 18, 2019; Annual Review; No CMS Updates. Minor Revisions Only.

Revision Date: September 15, 2021; Annual Review. No CMS Updates. Minor Revisions Only.

Revision Date: September 21, 2023: Annual Review; No CMS Updates. Verbiage added to reflect LCD. Codes added.

Approval Dates:

Medical Coverage Policy Committee: September 21, 2023

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