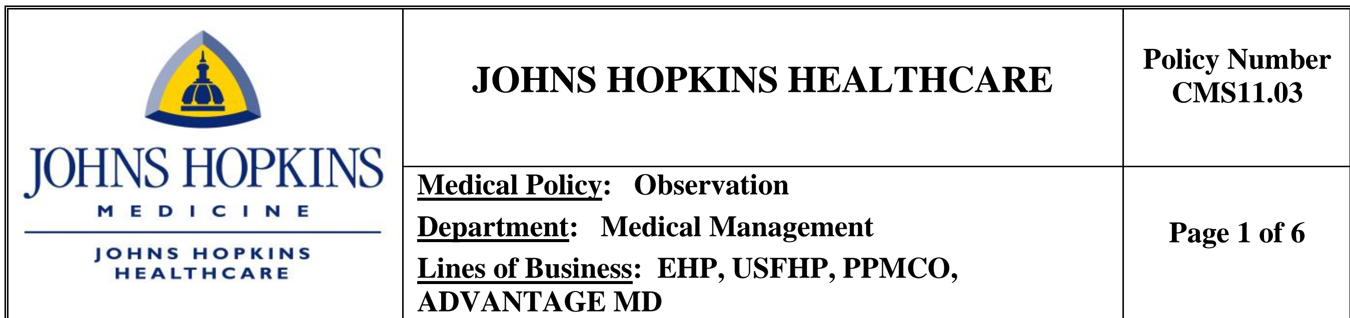

| | JOHNS HOPKINS HEALTHCARE | Policy Number CMS11.03 |
|---|---|---|
| | **Medical Policy:** Observation<br>**Department:** Medical Management<br>**Lines of Business:** EHP, USFHP, PPMCO, ADVANTAGE MD | Page 1 of 6 |

**ACTION:**

☐ New Policy Number: **Effective Date:** 5/14/2012

☒ Revising Policy Number: CMS11.03 **Review Dates:** 5/9/13, 6/6/14, 9/4/15, 12/21/16

☐ Superseding Policy Number:

☐ Archiving Policy Number:

☐ Retiring Policy Number:

Johns Hopkins HealthCare provides a full spectrum of health care products and services for Employer Health Programs, Priority Partners, Advantage MD, and US Family Health Plan. Each line of business possesses its own unique contract and guidelines which, for benefit and payment purposes, should be consulted to know what benefits are available for reimbursement. Specific contract benefits, guidelines or policies supersede the information outlined in this policy.

**POLICY:**

For Advantage MD:
Medicare does not have a National Coverage Determination (NCD) for Observation.
Local Coverage Determinations (LCDs) do not exist at this time. (Accessed October 7, 2016)

I. **Eligibility for Observation**

A. Typically patients appropriate for observation are those wherein their diagnostic and/or therapeutic services can reasonably be expected to be completed in a 24 to 48 hour time frame*. JHHC will follow InterQual® Observation criteria for the determination of level of care.

*Note ~ For Priority Partners: Per DHMH Transmittal dated December 19, 2016, Maryland “Medicaid agencies may only reimburse hospitals for up to 24 hours in an outpatient setting, which includes observations stays. 42 CFR 440.2 (a) limits outpatient services to under 24 hours. Effective January 1, 2017, managed care organizations (MCOs), our Behavioral Health Administrative Service Organization and the fee-for-service program will limit payment to under 24 hours.”

B. Medical necessity, as opposed to social factors, dictates the decision to place a patient in observation. The decision to place a patient in observation may not be based on the convenience of the patient, patient’s family or caregivers, or the physician.

C. Per Maryland Health Services Cost Review Commission (HSCRC) requirements, all hospitals have been assigned observation rates, and thus are able to bill for observation services. Inability of a provider to bill for observation services is not sufficient reason to admit a patient.

II. **Expectations for Observation Care**

A. The following are minimum expectations for observation level care:
   1. A physician order to start observation services, as well as the indication for observation; **AND**
   2. Ongoing nursing or other health care provider evaluation and monitoring related to the observation condition; **AND**
   3. Physician documentation of the plan of care, as well as ongoing care, on a minimum of a daily basis.

III. **Disposition**

A. It is expected that for the vast majority of patients, disposition will occur within 24 hours of placement in observation status. Up to 48 hours of outpatient observation care may be required in certain circumstances. Observation hours exceeding 48 hours (24 hours for Priority Partners members*), shall be denied.

B. Conversion of observation status to inpatient status should occur under one of two circumstances:
   1. Diagnostic testing indicates a severity of illness requiring inpatient care; **OR**
   2. The patient fails aggressive therapeutic care during the observation time period.

C. Continued stay beyond a certain time point is not sufficient justification to warrant conversion to inpatient status. Observation status cannot be retroactively converted to inpatient status; no conversions of time spent in observation care to inpatient status will be accepted.

IV. **Coverage of Observation Care Services**

A. The coverage of observation care services is dictated by the HSCRC. Observation services should be billed from the time the decision to place a patient in observation is made (as evidenced by an order to start observation services), and end when the last observation service is completed. This generally should be reflected in the order to discharge the patient. It is not dependent on the time the patient actually vacates the facility.

B. Time in the ER before the decision to place a patient in observation will not be covered as observation care. Time billed in observation should only include that time spent doing clinically necessary services. Time spent on non-clinically necessary services, or on services that could be safely performed in a lower level of care, will not be covered. Time spent awaiting diagnostic testing or treatment will not be covered if no other clinically necessary services are being provided. As an outpatient classification, diagnostic testing is reimbursed separately from observation services. Included in these testing fees is the time required to complete the test. As such, time spent in diagnostic testing should not be billed under observation services.

C. In accordance with CMS policy, when fewer than 8 hours of observation services are billed, the facility fees will be reimbursed per HSCRC regulations. [5]

D. Authorization for observation services is not required. Johns Hopkins HealthCare will conduct post-claim audits for observation services.

V. **For USFHP members, refer to the Tricare Medical Policy, Chapter 2, Section 2.3 for coverage for Observation.**
   A. A person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient to determine the need for further treatment or for inpatient admission.
   B. Up to 48 hours of outpatient observation services may be cost-shared. Observation hours exceeding 48 shall be denied.
   C. A separate authorization for outpatient observation is not required.

VI. **Documentation Requirements:**
   A. A written order for observation is documented in the record including date and time.
   B. The member's time in observation (and hospital billing) begins with the member's admission to an observation bed.
   C. The member's time in observation (and hospital billing) ends when all clinical interventions have been completed.
   D. There is an assessment of patient's risk to determine benefit from observation care and is explicitly documented by the physician.
   E. The admission into observation is based on the patient's severity of illness and the intensity of service provided.

**DEFINITIONS (if applicable or reference departmental glossary if one is available):**

VII. Observation is a status, not a location in a hospital. Location in a hospital does not determine observation versus admission status.

## BACKGROUND:

Medical observation refers to the period of time when medical professionals monitor the continuous care of specific patients. During the observation period, patients have not yet been admitted to the hospital. The process of medical observation and determining when patients should be considered for inpatient admission varies across hospitals. The average time frame for observation can be anywhere from 6 to 48 hours. The status of an individual, inpatient or outpatient, can influence insurance and hospital billing costs. If the patient is a recipient of Medicare and is never officially checked into the hospital as a patient, he/she may acquire more hospital fees and will be ineligible for insurance payments.

## CODING INFORMATION:

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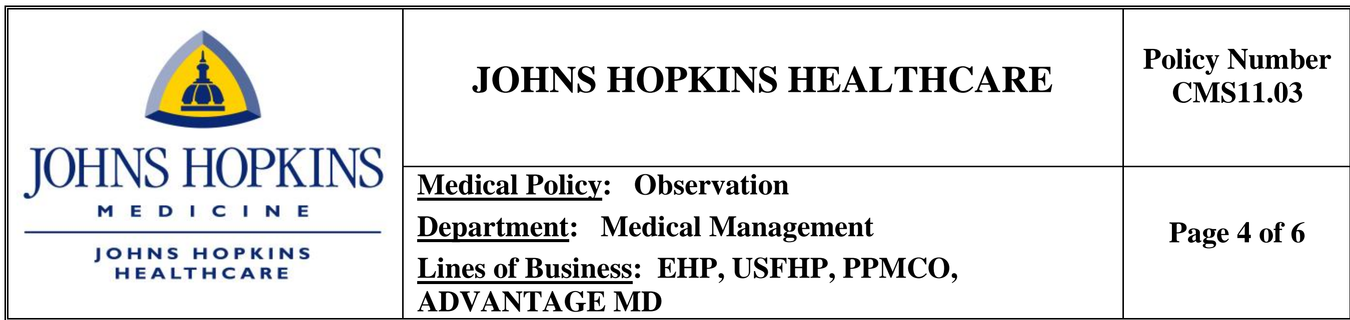


**Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage and referral requirements. All inpatient admissions require pre-authorization.**

**NO PRE-AUTHORIZATION REQUIRED**

***Compliance with the provision in this policy may be monitored and addressed through post-payment data analysis and/or medical review audits***

| Employer Health Programs (EHP) **See Specific Summary Plan Description (SPD) | Priority Partners (PPMCO) refer to COMAR guidelines and PPMCO SPD then apply policy criteria | US Family Health Plan (USFHP), TRICARE Medical Policy supersedes JHHC Medical Policy. If there is no Policy in TRICARE, apply the Medical Policy Criteria | Advantage MD, LCD and NCD Medical Policy supersedes JHHC Medical Policy. If there is no LCD or NCD, apply the Medical Policy Criteria |
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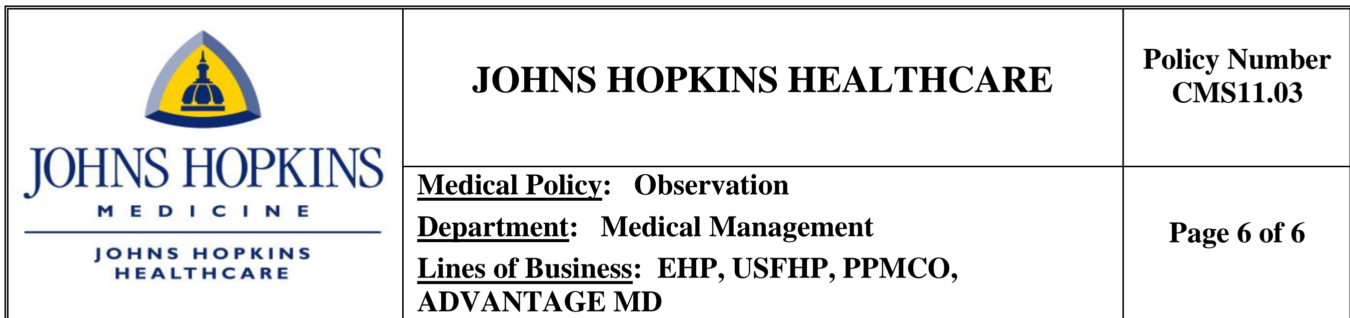
| CPT ® CODES | DESCRIPTION |
|---|---|
| **99217** | Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date |
| **99218** | Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| **99219** | Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's |

| | |
|---|---|
| | hospital floor or unit. |
| **99220** | Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit. |

| | |
|---|---|
| **99224** | Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| **99225** | Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| **99226** | Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| **HCPCS CODE** | **DESCRIPTION** |
| **G0378** | Hospital observation service, per hour |
| **REVENUE CODES** | **DESCRIPTION** |
| **0762** | Specialty services – Observation Hours |
| **0982** | Professional fees – Outpatient services |





**REFERENCE STATEMENT:**

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins HealthCare (JHHC) Medical Policy Team during the development and implementation of this medical policy. Per NCQA standards, the Medical Policy Team will continue to monitor and review any newly published clinical evidence and adjust the references below accordingly if deemed necessary.

**CLINICAL:**

1. Hale, Deborah K. "Observation Status: A Guide to Compliant Level of Care Determinations, Second Edition". 2008 HC Marketplace, edition, Chapter 1, 1-16.

**HEALTHPLAN:**

2. Cigna Medical Policy Coverage Number 0411, "Observation Care", Retrieved from: https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0411_coveragepositioncriteria_observation_care.pdf.
3. TRICARE Medical Policy 6010.57-M, February 1, 2008, Chapter 2, Section 2.3, Retrieved from: http://manuals.tricare.osd.mil/DisplayManual.aspx?SeriesId=T3TPM&TP08=87#TP08
4. Amerigroup Observation Reimbursement Policy. January 9, 2015. Retrieved from: https://providers.amerigroup.com/ProviderDocuments/MDMD_ObservationPolicy.pdf

**REGULATORY:**

5. Health Services Cost Review Commission (HSCRC) memorandum. "Establishment of an Observation Rate Center for Medical Observation Cases and Conversion of Same Day Surgery Rate Center", April 29, 2010. Retrieved from: http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/PolicyClarification/2010/CFO_ObservRate_04-29-10.pdf.
6. Health Services Cost Review Commission (HSCRC) memorandum. "Observation services", October 18, 2001. Retrieved from: http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/PolicyClarification/PriorYears/Observation%20Services%20(2001).pdf.
7. Medicare Benefit Policy Manual, Chapter 6, Section 20.6, Effective 7/6/2009. http://www4a.cms.gov/transmittals/downloads/R42BP.pdf.
8. Maryland Medical Assistance Program, MCO Transmittal No. 114, December 19, 2016