TO: General Acute Care Hospitals, Chronic Disease Hospitals, Children's Hospitals, Psychiatric Hospitals

RE: Guidelines for Observation for Medical and Behavioral Health Services

Effective for dates of services on and after July 1, 2016, the Connecticut Medical Assistance Program (CMAP) will model Medicare's coverage policy related to observation services as outlined in Medicare's Claim Processing Manual Chapter 4 – *Part B Hospital (Including Inpatient Hospital Part B and OPPS* posted at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf. This change coincides with the implementation of the Outpatient Prospective Payment System (OPPS) and includes behavioral health observation services. As of July 1, 2016, this bulletin supersedes Provider Bulletin **2011-46** *Clarification of Observation Guidelines.*

A patient admitted to observation status is considered a hospital outpatient. Observation services are those services furnished by a hospital and provided in a licensed hospital space, including a bed and periodic monitoring by a hospital's clinical staff. Hospitals may provide observation services for patients for whom a diagnosis and a determination concerning admission, discharge, or transfer can be reasonably expected within 8-48 hours. Documentation in the patient's medical record must provide the medical necessity justification for the observation service. Observation services for reasons other than medical necessity (e.g., waiting for transportation, waiting for housing placement or waiting for an available inpatient bed) are not reimbursable by the Department.

Observation begins at the time appearing on the order for placement of the patient into observation written by a physician, advanced practitioner registered Nurse (APRN), certified nurse midwife (CNM), or physician assistants (PA) (hereafter, "practitioners"). The medical record should contain the order for observation, observation admission notes – including medical necessity for the observation, progress notes, and discharge notes which are timed, written and signed by the practitioner.

Reimbursement for Observation Services

Under OPPS, hospitals are reimbursed for observation using a comprehensive APC (C-APC) when the service is provided in conjunction with an appropriate type A or B ED visit, critical care, outpatient hospital clinic visit or a direct referral from a community practitioner to observation.

In order to be reimbursed for observation services, a patient must be in observation status for a minimum of eight (8) hours. The 8 hours is not inclusive of the time that the patient spent in the ED or any other licensed hospital space prior to receiving the order observation services. In the rare circumstance that an observation stay exceeds 48 hours; the patient may remain in observation status with no further reimbursement from the Department for the observation stay. A medically necessary ancillary service (e.g., diagnostic laboratory, radiology services) provided by the outpatient hospital, regardless of the length of time a patient is in observation status is eligible for reimbursement.

For observation services with less than eight hours, the outpatient hospital should bill with the following and reimbursement for observation will be dependent upon the status indicator (SI) for the other services billed. In some cases, depending on the SI, only the outpatient hospital clinic or emergency department visit will pay.

- HCPC for observation (G0378) with the corresponding units (units = hours in observation)
- The appropriate procedure code for the Type A or Type B ED visit, Outpatient Hospital Clinic visit or Critical Care.

As part of observation services, Medicare created "J2" status indicator (SI) to identify specific combinations of services or Comprehensive Observation Services APC (C-APC). When C-

APC services are performed together and reported on a single claim, all other OPPS services are considered adjunctive. This creates a single payment for all comprehensive services billed on the same claim. Comprehensive observation services will be reimbursed if the following criteria are met:

- Claim does not contain a Healthcare Common Procedure Coding System (HCPC) code with SI "T" (procedure or service, multiple procedure reduction applies) reported on the same day or one day prior to the date associated with HCPCS code G0378 (observation services per hour);
- The claim does not include a HCPCS code with the SI of "J1" (Hospital outpatient services paid through C-APC); and
- The claim contains eight or more units of services described by G0378; and has one of the following codes:

HCPC Code	Description
99281	Emergency Department Visit – level 1
99282	Emergency Department Visit - level 2
99283	Emergency Department Visit – level 3
99284	Emergency Department Visit – level 4
99285	Emergency Department Visit – level 5
99291	Critical Care first hour
G0379	Direct Admission of patient for hospital observation care
G0380	Level 1- hospital ED provided in type B emergency department
G0381	Level 2- hospital ED provided in type B emergency department
G0382	Level 3- hospital ED provided in type B emergency department
G0383	Level 4- hospital ED provided in type B emergency department
G0384	Level 5- hospital ED provided in type B emergency department
G0463	Hospital outpatient clinic visit

General standing orders for observation services following all outpatient surgery are not recognized as a separate observation service and hospitals should not report/bill as observation care. Services such as postoperative monitoring during a standard recovery period (e.g. 4-6 hours) should be billed as recovery room services. Routine recovery should not be expected to exceed 24 hours.

For patients undergoing diagnostic testing and routine preparation services for outpatient surgery and procedures, observation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic testing and preparation services.

Observation is reimbursed by the Department for observation stays ranging between 8 and 48 hours, if deemed medically necessary. For observation stays that extend beyond 48 hours, the hospital must do one of the following:

- Request an inpatient admission if medically necessary;
- Discharge the client according to the practitioner's orders; or
- Keep client in observation status with no further observation reimbursement from the Department.

Obstetric Observation Stay

To be considered for obstetric (OB) observation, the medical record should indicate an order from a practitioner for OB observation. If the ordered observation stay does not result in a delivery, the service should be billed as non-OB observation as long as all of the observation requirements contained within in this PB are met. If a delivery occurs prior to discharge, the entire encounter should be billed as an inpatient admission.

BILLING INSTRUCTIONS

Observation services must be reported using the appropriate combination of Revenue Center Code and HCPCS code (s) from the following:

- RCC 762-Observation Room
- HCPC code G0378-Hospital Observation Services, per hour:
  - Report G0378 when observation services are rendered to a patient in observation status.
  - The unit of services must equal the number of hours the patient is in observation status.

- HCPCS Code G0379-Direct admission of patient for hospital observation care
    - Report G0379 for observation services when a patient is directly admitted to observation status after being seen by a practitioner in the community.
    - G0379 must be reported on the same date of service as G0378.
    - Report units of hours spent in observation. The unit of services must equal the number of hours the patient is in observation status.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single detail line for the date that observation care begins. All services related to the observation stay should be billed on the same claim. Any other ancillary service performed while the patient is in observation status should be reported separately using the appropriate CPT/HCPCS codes.

Inpatient Stay Following Observation

When an observation stay results in an inpatient admission, prior authorization from the appropriate entity is required. The date of the inpatient admission will be the date of the inpatient order. Observation services that result in an inpatient admission to the same hospital shall not be reimbursed separately. Observation services will be rolled into the inpatient admission. Please refer to PB 2015-82 "Three Day Rule: Outpatient Stay Prior to Inpatient Admission" for more information on services that will not pay if billed within three (3) days of an inpatient admission.