PAYMENT REIMBURSEMENT POLICY

Title: PRP-01 Observation Care Facility Charges

Benefit Coverage Policy: BCP-04 Observation Care Services

Category: Compliance

Effective Date: 01/12/2022

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

Observation care services include initial care, subsequent care and discharge services. It is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as a hospital inpatient or if they are able to be discharged from the Hospital. Observation status is commonly assigned to patients who present to the Emergency Department and then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. During these stays, a variety of outpatient services may be rendered, such as laboratory tests, drugs, minor procedures, x-rays, and other imaging services.

Patients do not need to be located in a designated observation area as long as the medical record indicates that the patient was admitted as "observation status" and the reason for observation care is documented. Observation services are usually needed for 48 hours or less.

3.0 Policy:

Claims from the network and non-network providers billed with observation units greater than 48 may be reviewed for medical necessity prior to payment. If a claim qualifies for review, a request for clinical documentation is requested. If clinical documentation received does not medically support observation stay beyond 48 hours, the claim may be denied as not medically necessary. The claim may need to be rebilled as an inpatient stay.

4.0 Coding and Billing:

Codes that are covered may be subject to medical benefit review and benefit limits.

Observation Hours:

HCPCS G0378: Hospital observation service, per hour.

HCPCS G0379: Direct admission of patient for hospital observation care.

- The following applies to G0378 and G0379:Not expected to exceed 48 hours in duration.
- Greater than 48 hours may be reviewed for medical necessity upon submission of medical records.
- Observation services beyond 72 hours are considered medically unlikely and may be denied.

Billing Requirements:

- Observation is considered an outpatient service.
- UB-04 billing outpatient claim under a 13X or 85X type of bill (TOB).
- Report revenue code 0762 and HCPCS G0378.
- Direct admits should include revenue code 0762 and HCPCS G0379.

Verification of Compliance

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

5.0 Terms & Definitions:

Medically Necessary, Medical Necessity**.** Coverage of health care services and supplies that we determine to be medically appropriate per Health Plan medical policy and nationally recognized guidelines, and are:

- Not Experimental or Investigational Services.
- Necessary to meet the basic health needs of the Covered Person.
- Delivered in the most cost-efficient manner and type of setting that is appropriate.
- Consistent in type, amount, frequency, level, setting, and duration of treatment with scientifically based guidelines that are accepted by Health Plan.
- Consistent with the diagnosis of the condition.
- Not done for reasons of convenience.
- Demonstrated through current peer-reviewed medical literature to be safe and effective.

Even if you have already received treatment or services, or even if your health care provider has determined that a particular health care service or supply is medically appropriate, it does not mean that the procedure or treatment is a Covered Health Service under the Policy.

Observation Care. A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as Hospital inpatients or if they can be discharged from the Hospital. Observation status is commonly assigned to patients who present to the Emergency Department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Observation Status: Observation Status refers to the classification of hospital patients as "outpatients," even though, like inpatients, observation patients may stay beyond 24-hours in a hospital bed, receive medical and nursing care, diagnostic tests, treatments, supplies, medications, and food.

Observation Time: Observation time should be billed in one-hour increments, rounded to the nearest hour and reported on one line.

6.0 References, Citations & Resources:

Centers for Medicare and Medicaid Services, CMS Manual and other CMS publications.

American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and associated publications.

7.0 Revision History:

Original Effective Date: 01/01/2019

Next Revision Date: 01/01/2023

Revision Date	Reason for Revision
11/18	Reimbursement policy created.
8/19	Annual review; missing word, "hours" added after 72 in section 3.0.
10/20	Annual review; no changes, approved by CCSC 12/1/20
10/21	Annual review changed verbiage on Guidelines to be uniform, approved at the CCSC on 12-07-2021