Policy: Outpatient Observation Payment Policy	Policy Number: UM-19
Department: Utilization Management	**Original Issue Date: 01/01/2023**
Approver: UM Committee **Date Approved: 06/07/2023**	☐ **Date Last Reviewed / Revised _____ OR** ☐ **Date Last Reviewed / No Revisions _____OR** ☒ **New Policy / New Requirements**
Dependencies: •	**Effective Date: 01/01/2023**

I. PURPOSE

The purpose of this policy is to define Mass Advantage's policy for the coverage of outpatient observation services.

II. POLICY

Mass Advantage Health Plan covers outpatient observation services when specific conditions are met, in accordance with the member's benefits and CMS Regulations, and/or state guidelines, as applicable, and the information contained in this payment policy.

III. SCOPE

This policy applies to all lines of business and all employees and delegates of Mass Advantage.

IV. General Benefit & Payment Information

Observation services generally do not exceed 24 hours. It should be very rare that observation services should exceed 48 hours; usually they will be less than 24 hours in duration.

Mass Advantage will only cover Observation Services up to 48 hours

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours, and requires Mass Advantage prior approval. Observation claims exceeding 48 hours are subject to medical review.

V. Prior Authorization Requirements

Outpatient Observation Prior Authorization Requirements	
Outpatient Observation up to 48 hours	Prior Authorization is **NOT** required for Outpatient Observation up to 48 hours
Outpatient Observation greater than 48 hours	Prior Authorization or Medical Necessity Review **IS** required beyond 48 hours

Billing and Coding:

We will cover Outpatient Observation in accordance with Medicare guidelines on covered codes and services.

VI. References

Medicare Benefit Policy Manual Chapter 6

Definitions:

Observation care 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 hospital inpatients 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 who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Coverage: Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Hospitals may bill for patients who are "direct admissions" to observation. A "direct admission" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED). Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly admitted for observation services.

When a physician orders that a patient be placed under observation, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient (see Pub. 100-02, Medicare Benefit Policy-Manual, Chapter 1, §10 "Covered Inpatient Hospital Services Covered Under Part A" at http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf). The following types of services are not covered as outpatient observation services:

- Services that are not reasonable or necessary for the diagnosis or treatment of the patient. Services that are provided for the convenience of the patient, the patient's family, or a physician, (e.g., following an uncomplicated treatment or a procedure, physician busy when patient is physically ready for discharge, patient awaiting placement in a long term care facility).
- Services that are covered under Part A, such as a medically appropriate inpatient admission, or services that are part of another Part B service, such as postoperative monitoring during a standard recovery period, (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services.
- Observation should not be billed concurrently with therapeutic services such as chemotherapy. Standing orders for observation following outpatient surgery.

Claims for the preceding services are to be denied as not reasonable and necessary, under §1862(a)(1)(A) of the Act.

VII. Version & Review History

Version #	Action (Original Issue, Reviewed, Revised)	Date Action Taken	Brief Summary of Revision, if applicable	Individual Taking Action	Effective Date	Date Approved and By Whom
1	Original Issue	06/07/2023	Policy Origination	Latoya Johnson	01/01/2023	06/07/2023 UM Committee