Policy: Outpatient Observation Payment Policy	Policy Number: CL-02
Department: Claims, Utilization Management Policy Owner: Melissa Heath, RN/Director, Utilization Management	Original Issue Date: 01/01/2023
Approving Committee: None, Melissa Heath, RN Dependencies: Mass Advantage Mass Advantage Definitions, Abbreviations and Acronyms Date Approved: 03/10/2025	☒ Date Last Reviewed / Revised [03/10/2025] OR ☐ Date Last Reviewed / No Revisions [mm/dd/yyyy] OR ☐ New Policy / N/A Effective Date: 01/01/2025

PURPOSE

This policy defines outpatient observation services and the methods in which such claims are reimbursed for clinically appropriate services.

POLICY

Mass Advantage covers outpatient observation services when specific conditions are met, in accordance with the member's benefits, CMS Regulations, and/or state guidelines, as applicable, and in accordance with the payment methodology defined by the providers' contract. In lieu of a contract, providers will be reimbursed according to the applicable payment methodology defined by CMS.

SCOPE

This policy impacts the following departments and workflows:

Departments: Claim, Utilization Management

Workflows: Claims, Utilization Management

PROCEDURES

Observation care is a set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision is made regarding whether patients will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital.

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., patient awaiting placement to 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 or as standing orders for observation following an outpatient surgery. Claims preceding services are to be denied as not reasonable and necessary, under §1862(a)(1)(A) of the Act.

The determination of whether to discharge or admit a patient should be made within 48 hours. Reimbursement for additional hours beyond 48 hours will only be allowed in extremely rare situations subject to post clinical review. If the extended stay is not approved beyond the 48 hours the facility will be required to split the claim into allowed and disallowed components.

REGULATORY CITATIONS AND POLICY REFERENCES

- Medicare Claims Processing Manuals and related transmittals

  Medicare Benefit Policy Manual, Chapter 6

VERSION AND REVIEW HISTORY

Version #	Action (Original Issue, Reviewed, Revised)	Description of Changes	Policy Owner/ Business Lead Name/Title	Approving Committee Or Business Lead Approver	Committee or Business Lead Approval Date
v1	Original Issue	Policy origination	Latoya Johnson	UM Committee	06/07/2023
v2	Revised	Aligned policy with current CMS guidelines.	Melissa Heath, RN	Melissa Heath	5/22/2024
v3	Revised	Policy formatted to new template, added additional guidance on CMS guidelines.	Melissa Heath, RN	Melissa Heath	3/10/2025