MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Distribution: Outpatient Hospitals

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Subject: Observation Care Services

Effective: April 1, 2007

Programs Affected: Medicaid, Children's Special Health Care Services, Adult Benefits Waiver

The purpose of this bulletin is to expand current Medicaid Fee For Service (FFS) coverage of Outpatient Hospital (OPH) observation care services to comply with Section 1711(3) of PA 154 of 2005, the Michigan Department of Community Health's (MDCH) FY 06 budget boilerplate.

Effective for dates of service (DOS) on and after April 1, 2007, MDCH will implement Medicare's coverage policy related to observation care services. For clarification purposes, this bulletin will reiterate Medicare's current definition of observation services, coverage policy and billing guidelines. It is the intent of MDCH to remain consistent with Medicare coverage and billing policies as changes are implemented by Medicare.

Definition of Observation

Observation is a defined set of clinically appropriate specific services that include ongoing short-term treatment, assessment and reassessment before deciding whether a beneficiary requires further treatment as a hospital inpatient or discharge from the outpatient hospital.

Outpatient Observation Service Coverage

A beneficiary admitted to observation status is considered a hospital outpatient. Observation services must be reasonable and necessary, and ordered by a physician or another individual authorized by State licensure law and hospital staff bylaws to order outpatient tests or admit patients to the hospital.

Under Medicaid's Outpatient Prospective Payment System (OPPS), reimbursement for OPH observation services is packaged into the payment for other separately reimbursed services rendered on the same day. A separate Ambulatory Payment Classification (APC) payment is made for observation services only under the following conditions:

- The beneficiary must have a diagnosis of asthma, chest pain, or congestive heart failure, **and**
- The observation period must equal or exceed eight hours.

Additional guidelines and information for separately reimbursable observation services are provided in the Billing Instructions portion of this bulletin.

Medicaid Managed Care Plans may require prior authorization and additional documentation from hospitals for observation services. They may also continue, or implement use of, alternative criteria for observation services with their network hospitals.

Services Not Covered Under OPH Observation

- Services not reasonable or necessary for the diagnosis or treatment of the beneficiary.
- Services provided for the convenience of the beneficiary, beneficiary's family or the physician (e.g., after an uncomplicated procedure or treatment, physician is busy when the beneficiary is ready for discharge, or when the beneficiary is waiting for placement to a long term care facility or transportation home, etc).
- Services that are medically appropriate as an inpatient admission and covered under Part A, or services that are part of another Part B service (e.g., post-operative monitoring during a standard 4-6 hour recovery period that should be billed as recovery room services). You should not concurrently bill therapeutic services (i.e. chemotherapy) with observation.
- Services in cases when a beneficiary undergoes OPH diagnostic testing, or the routine preparation to the testing and recovery afterwards are included as part of the diagnostic services.

Beneficiary Notification for Non Coverage

If a beneficiary is placed into observation for a non-covered service, MDCH recommends providers obtain the beneficiary's written acknowledgement of their payment responsibility before providing any non-covered/non-authorized service the beneficiary elects to receive. Refer to the MDCH Medicaid Provider Manual, General Information Chapter for Providers, Billing Beneficiaries Section for additional information.

Observation Time

Observation time starts with the documented clock time in the beneficiary's medical record, coinciding with the time the beneficiary is placed in a bed for observation care and with the physician's order. Observation time ends when the beneficiary is actually discharged from the OPH or is admitted as an inpatient, and includes medically necessary services provided after the physician writes the discharge order but before the beneficiary is discharged. Do not report observation time that includes any time the beneficiary remains in observation after treatment is completed for reasons such as waiting for transportation to go home.

Billing Instructions

OPH observation claims must be submitted with type of bill (TOB) 13x. Report the total number of units (hours) for the entire observation stay on a single claim line. The DOS for the observation claim line is the date the beneficiary is admitted to observation status. The OPPS claims processing logic determines the APC assignment (i.e., whether the observation services are packaged or separately payable).

Observation services must be reported using the appropriate (combination of) Revenue and Healthcare Common Procedural Coding System (HCPCS) code(s) from the following:

- Revenue Code 0762 Observation Room
- HCPCS Code G0378 Hospital Observation Services, per hour:
    - Report G0378 when observation services are rendered to a beneficiary in observation status, regardless of the beneficiary's condition.
    - The units of service must equal the number of hours the beneficiary was in observation status.
- HCPCS Code G0379 – Direct admission of patient for hospital observation care
    - Report G0379 for observation services when a beneficiary is directly admitted to observation status/care after being seen by a physician in the community.

Report any OPH ancillary services while the beneficiary is in observation status using the appropriate revenue and HCPCS codes as applicable.

Additional Billing & Reimbursement Information for Separate APC Payment

To receive a separate APC payment for observation or direct admit to observation, the following applies:

- The qualifying ICD-9-CM diagnosis code(s) must be reported as the patient reason for visit or as the principal diagnosis, or both. (The ICD-9-CM diagnosis codes are reviewed annually and published in the OPPS Final Rule and on Medicare's OPPS web page.)

- G0378 (Hourly Observation) must be billed with an Evaluation and Management (E&M) or critical care visit reported on the same claim. The E&M or critical care visit must be one day prior to or the same day as the observation date of service.

- G0379 (Direct Admit to Observation) must be billed with G0378 (Hourly Observation) and dates of service must be the same.

- For direct admissions to observation:

    - If all separate payment criteria are met, G0378 becomes the payable APC and G0379 becomes a Status Indicator "N' and packaged.

    - If G0378 does not meet separate payment criteria, G0379 is assigned a Status Indicator of "V" and paid according to a clinic APC assignment.

No Separate Payment – Packaged Observation Service

If a Status Indicator "T" procedure occurs on the day of or the day before G0378 ("T" or "V" for G0379), no separate payment is made and the observation service is packaged.

Calculation of Reimbursement for Separately Payable Observation Services

Separately payable observation service will be reimbursed at the current Medicare APC rate with the MDCH reduction factor applied.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual and the Medicaid Provider Website.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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