

n05594

## Outpatient Observation Services

---

### *Values*

Accountability • Integrity • Service Excellence • Innovation • Collaboration

---

#### **Abstract Purpose:**

This guideline is to provide Network Health's reimbursement process related to services that are covered when Medicare coverage criteria are met. All outpatient hospital observation services must be reasonable and necessary to be covered.

#### **Policy Detail:**

- I. In the majority of cases, the decision whether to discharge a patient from the hospital following the resolution of the reason for the observation care or to admit the patient as an inpatient can usually be made in less than 24 hours.
  - A. The criteria is based on:
    1. The time when observation care is initiated and ended in accordance with a physician's order and documented in the patient's medical record.
    2. All the hours for the entire time period of observation, even if the period spans more than 1 day, and the date of service reported is the date observation care begins.
    3. The number of units reported must equal or exceed 8 hours.
    4. The patient must be in the care of a physician during observation, documented in the medical record by outpatient registration, discharge and progress notes that are timed, written and signed by the physician.
  - B. Outpatient observation services should not be billed for routine or concurrently with diagnostic or therapeutic services and outpatient surgery/procedures. If a procedure interrupts observation services, the hospital determines the most appropriate way to account for the time.
  - C. Observation is provided hourly for a minimum of 8 hours. Observation services with less than 8 hours of observation are not eligible for Medicare reimbursement and would be billed with the appropriate E/M level.
  - D. No procedure with a "T" status indicator can be reported on the same day or day before observation care is provided.

- II. In only rare and exceptional cases do reasonable and necessary outpatient observation stay exceed 48 hours. 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, but not more than 72 hours. Claims billed with observation over 72 hours will be denied.

**Regulatory Citations:**

None

**Related Policies:**

None

**Related Documents:**

None

<b>Origination Date:</b> 01/01/2017	<b>Approval Date:</b> 09/10/2025	<b>Next Review Date:</b> 09/10/2026
<b>Regulatory Body:</b> None	<b>Approving Committee:</b> Policy Committee	
<b>Policy Owner:</b> Craig Clifford	<b>Department of Ownership:</b> Operations	<b>Revision Number:</b> 3
<b>Revision Reason:</b> 7/3/2019 - The last paragraph changed to indicate the decision to admit should not be greater than 72 hours, and if a claim is submitted greater than 72, the claim will be denied. 06/02/2020 – CONSENT No revisions, but I don't see this is posted on the Provider Resources page, and I believe it should be. 3/3/2022 Added correct owner and updater 8/2/2022 Changed last sentence from “Claims billed with observation over 72 hours will be denied.” to "Observation hours exceeding 72 will be denied." and added "Observation billed on a single claim line in excess of 72 hours will be denied with Claim Adjustment Reason Code (CARC) 152 "Payer deems the information submitted does not support this length of service". The provider must submit any overage on a separate claim line when observation hours are greater than 72. Network Health may require submission of clinical records before or after payment of claims for the purpose of identifying improper billings and/or detecting suspicious claims." 7/26/23 – Annual review – consent. 7/25/24 - CONSENT 7/18/25 – Annual review. No changes.		