Effective for dates of service on or after December 1, 2010, the benefit criteria for outpatient observation services will change for Texas Medicaid.

Observation care is defined by the Centers for Medicare & Medicaid Services (CMS) as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital's nursing or other ancillary staff to evaluate the client's condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services (revenue code 762) are a benefit only when medically necessary and when provided under a practitioner's order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client's need for an inpatient admission.
  - The treatment plan is not established or, based on the client's condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
  - The medical necessity for inpatient treatment is unclear, that is:
    - The client's medical condition requires careful monitoring, evaluation, or treatment to identify a diagnosis and determine whether an inpatient admission is necessary
    - There is a delayed or slow progression of the client's signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.

- The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.

Medically necessary services that do not meet the definition of observation care should be billed separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner’s expectation of the care that the client will require.

**Categories of Outpatient Observation Services**

**Direct Outpatient Observation Admission**

A client may be directly admitted to outpatient observation from the evaluating practitioner’s office without being seen in the emergency room by a hospital-based practitioner. The practitioner’s order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for "direct admission" will be considered an inpatient admission unless otherwise specified by the practitioner’s orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

**Observation Following Emergency Room**

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client’s medical condition are anticipated, and further evaluation is necessary.
If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be billed on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit.

**Observation Following Outpatient Day Surgery**

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be billed as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

**Observation Following Outpatient Diagnostic Testing or Therapeutic Services**

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.

**Documentation Requirements**

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client’s medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner’s admission and progress notes, which must confirm the need for observation care, outline the client’s condition, treatment, and response to treatment, and be dated and timed.
- Nurse’s notes that reflect the time at which the client was admitted to the observation bed, the reason for the observation stay, and must be dated and timed.
- All supporting diagnostic and/or ancillary testing reports, including orders for the testing or any preadmission testing.
- Procedure notes and operative notes that are dated and timed and address any complication that would support admission to observation status.
• Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must detail orders and any complications that require admission to observation status and must be dated and timed.

• Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.

• All of the client education that was provided during the observation stay.

• The order for discharge from observation care, which must be signed, dated, and timed.

• The discharge notes, including nurse’s notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 24-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner’s order (practitioner intent) and the services that were actually provided were consistent. The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were billed.

**Reporting Hours of Observation**

Providers must bill the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client’s medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner’s order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of billing observation services, one unit equals one hour. Partial units/hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner’s order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client.
If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. However, reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be billed concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. In situations where a diagnostic or therapeutic procedure interrupts the observation stay, hospitals should record for each period of observation services the beginning and ending times of the observation period and add the lengths of time for the periods of observation services together to reach the total number of units reported on the claim.

Recovery room hours that are associated with an outpatient procedure must not be billed simultaneously with hours of observation time.

Revenue code 761 will be denied if it is billed for the same date of service by the same provider as revenue code 760, 762, or 769.

**Client Status Changes**

When a client’s status changes from outpatient observation to inpatient admission, both the outpatient observation service and the inpatient admission must be billed as separate details on the same inpatient claim. The date of the inpatient admission is the date on which the client was admitted to inpatient status. The practitioner’s order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the client’s discharge.

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client’s status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This billing practice is acceptable under Texas Medicaid if all of the following conditions are met:

- The change in client status is made before discharge or release while the client is still a patient of the hospital.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR committee’s determination.
- The practitioner’s concurrence with the UR committee’s decision is documented in the client’s medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care.

**Services that are Not a Benefit**
Outpatient observation services that are not medically necessary or appropriate are not benefits of Texas Medicaid, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner’s order, including services ordered as inpatient services by the ordering practitioner, but billed as outpatient by the billing office.
- For clients awaiting transfer to another facility, such as for nursing home placement.
- For clients with lack of or delay in transportation.
- As a convenience to the client, client’s family, the practitioner, hospital, or hospital staff.
- For routine preparation before or recovery after outpatient diagnostic or surgical services.
- When an overnight stay is planned before diagnostic testing.
- To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
- Following an uncomplicated treatment or procedure.
- As standing orders for observation following outpatient surgery.
- For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
- For outpatient blood or chemotherapy administration and concurrent services.
- For services that would normally require an inpatient admission.
- Beyond 48 hours from the time of the observation admission.
- For a medical examination for clients who do not require skilled support.