



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

Effective Date 10/15/2010
Next Review Date 10/15/2012
Coverage Policy Number 0411

Subject **Observation Care**

Table of Contents

Coverage Policy	1
General Background	2
Coding/Billing Information	4
References	5
Policy History	8

Hyperlink to Related Coverage Policies

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations. Proprietary information of CIGNA. Copyright ©2011 CIGNA

Coverage Policy

Observation care is defined as those services furnished by a hospital on the hospital's premises, including use of a bed and at least periodic monitoring by a hospital's nursing or other staff which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. In general, the duration of observation care services does not exceed 24 hours, although in some circumstances, individuals may require a second day. Observation care for greater than 48 hours without inpatient admission is generally considered not medically necessary and may be subject to medical review.

CIGNA covers observation care as medically necessary when an individual is not medically stable to safely permit discharge and **ANY ONE** of the following conditions is met:

- A medical condition requires careful monitoring and evaluation or treatment to confirm or refute a diagnosis in order to determine whether inpatient admission is necessary.
- The individual is undergoing treatment for a diagnosed condition (e.g., chest pain, asthma, congestive heart failure) and continued monitoring of the clinical response to therapy may prevent an inpatient admission.
- The individual has a significant adverse response to therapeutic services, invasive diagnostic testing or outpatient surgery requiring careful short-term monitoring and evaluation.

CIGNA considers observation integral to the base procedure and/or not medically necessary and does not provide separate reimbursement for observation care for the following (this list may not be all-inclusive):

- outpatient blood administration
- lack of/delay in transportation
- provision of a medical exam for individuals who do not require skilled support
- routine preparation prior to and recovery after diagnostic testing
- routine recovery and post-operative care after ambulatory surgery
- when used for the convenience of the physician, individual or person's family
- while awaiting transfer to another facility
- duration of care exceeding 48 hours
- when an overnight stay is planned prior to diagnostic testing
- standing orders following outpatient surgery
- services that would normally require inpatient stay
- no physician's order to admit to observation
- observation following an uncomplicated treatment or procedure
- services that are not reasonable and necessary for care of the individual
- services provided concurrently with chemotherapy
- inpatient discharged to outpatient observation status

General Background

Observation care is defined as the use of a hospital bed and periodic monitoring by a hospital's nursing or other ancillary staff, which are reasonable and necessary to evaluate an outpatient's condition to determine the need for possible inpatient admission. The overall goal of observation care is to provide extended evaluation and treatment, and to reduce inappropriate hospital admissions. The services provided should be specific to the individual, and not part of the facility's standard operating procedures or protocol for a given diagnosis.

Observation care services are considered for outpatient care that extends beyond the usual 2-3 hour emergency department visit time frame, unless the extended care is routinely associated with a prolonged surgical procedure or clinic visit (e.g., chemotherapy administration, blood transfusion). In these situations, the observation care is considered integral to the main procedure being performed. The length of time for most observation care services does not exceed 24 hours, although in some circumstances individuals may require a second day. Observation care for greater than 48 hours without inpatient admission is generally considered not medically necessary (Centers for Medicare and Medicaid Services [CMS] Local Coverage Determination [LCD] L1158, 2005).

Categorization of Observation Units

Observation care services have not been uniformly defined by healthcare institutions; however the American College of Emergency Physicians (ACEP) Practice Management Committee has developed Guidelines on Management of Observation Units (ACEP, 1994) which define the following three categories of observation units:

- Emergency department observation/treatment unit: A designated area within and under the direction of the emergency department for individuals who require further treatment or evaluation.
- Holding unit: A designated area in the outpatient setting that may or may not be under the control of the emergency department in which an individual is held pending prearranged actions such as admission or transfer.
- Observation status bed: a bed located in the inpatient area of the hospital in which a person may be evaluated or treated for up to 24 hours before a decision regarding disposition is needed.

Categorization of Observation Services

Outpatient observation care may be medically necessary for a variety of medical conditions including, but not limited to, patient evaluation, diagnostic testing, outpatient therapeutic services and outpatient surgery.

Patient Evaluation: Individuals who arrive at the hospital with unstable medical conditions may require observation care services to determine the need for possible inpatient admission to the hospital. Unstable medical conditions may be defined as a variance from generally accepted normal laboratory values, and when clinical signs and symptoms are above or below those of the normal range, and are such that further monitoring is needed. There may be anticipated changes in the person's medical condition or status that require immediate medical intervention.

Diagnostic Testing: When routine outpatient diagnostic testing is an invasive procedure, the routine preparation prior to the test and routine recovery post-procedure are not considered observation care services. In the event a person has a significant adverse reaction that requires further monitoring, outpatient observation care may be medically necessary. For these circumstances, observation care would begin at the point in time when the reaction occurred and end when the person is stable.

Outpatient Therapeutic Services: Therapeutic services (such as chemotherapy) are often provided to individuals as a result of a diagnosed medical condition. During therapeutic services, a period time is often required to evaluate the person's response. This period of time is considered a component of the therapeutic service and is not separately reimbursable as observation care services. In the event the individual has a significant adverse reaction to the service provided (e.g., chemotherapy, blood transfusion, or other therapeutic services), observation care may be medically necessary for continued patient-monitoring and evaluation.

Outpatient Surgery: Observation care may be provided in situations where an individual exhibits an uncommon or unusual reaction to a surgical procedure (e.g., difficulty awakening from anesthesia, drug reaction, post-surgical complications) that requires monitoring or treatment beyond that customarily provided in the immediate post-operative period. Routine pre-operative preparation and recovery room services are not separately reimbursable as observation care services.

Documentation in the medical record must clearly support the medical necessity of the observation care services and include the following information:

- the attending physicians order for observation care
- the physician admission and progress notes confirming the need for observation care
- the supporting diagnostic and/or ancillary testing reports
- the admission progress notes with clock time outlining the person's condition and treatment
- the discharge notes and clock time with discharge order and nurses notes

The following outpatient observation care services are generally considered integral to the base procedure provided and/or are considered not medically necessary:

- services that are provided for the convenience of the individual, individual's family or a physician
- post-operative monitoring during standard recovery period
- chemotherapy administration
- as standing orders for outpatient surgical procedures
- outpatient blood administration
- lack of/delay in transportation
- routine preparation prior to and recovery after diagnostic testing
- routine recovery and post-operative care after ambulatory surgery
- while awaiting transfer to another facility
- duration of care exceeding 48 hours
- when an overnight stay is planned prior to diagnostic testing
- standing orders following outpatient surgery
- services that would normally require inpatient stay
- no physician's order to admit to observation
- observation following an uncomplicated treatment or procedure
- services that are not reasonable and necessary for care of the individual
- services provided concurrently with chemotherapy
- when inpatients are discharged to outpatient observation status

Literature Review

A large body of evidence exists evaluating the cost and efficiency of observation care compared to that of inpatient hospital admissions. Most publications support improved patient-satisfaction, improved quality of patient care and use of resources, and a reduction of unnecessary inpatient admissions when observation care services are provided (Agency for Healthcare Research and Quality, (AHRQ), 2000; Roberts and Graff, 2001; Martinez, et al., 2001; Koenig, et al., 2002; Ross, et al., 2003; Daly, et al., 2003, Goodacre, et al., 2004; Jaminas and Partridge, 2005; Greenberg, et al., 2006; Ross, et al., 2007; Leykum, et al., 2010; Schrock, et al., 2010). Nevertheless, the need for observation care services should be determined based on patient-specific clinical circumstances and what is considered reasonable and necessary.

Summary

The peer-reviewed, published scientific literature indicates that observation care reduces unnecessary inpatient admissions and improves quality of patient care and patient satisfaction. Outpatient observation care services may be considered medically necessary to evaluate a patient's condition in order to assess the need for patient admission. The length of time for most observation care services does not exceed 24 hours, although in some circumstances individuals may require a second day. Observation care for greater than 48 hours without inpatient admission is generally considered not medically necessary.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT [®] * Codes	Description
99217	Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity.
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or

	comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.

HCPSC Codes	Description
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care

Revenue Codes	Description
0762	Observation room

ICD-9-CM Diagnosis Codes	Description
	Multiple/ Varied codes

***Current Procedural Terminology (CPT®) © 2010 American Medical Association: Chicago, IL.**

References

1. Agency for Healthcare Research and Quality (AHRQ). Improving Care for People with Coronary Artery Disease. Translating Research Into Practice. Fact Sheet. AHRQ Publication No. 00-P015, January 2000. Agency for Healthcare Research and Quality, Rockville, MD. Accessed September 2, 2010. Available at URL address: <http://www.ahrq.gov/research/tripcad.htm>
2. American College of Emergency Physicians (ACEP). Emergency department observation services. Policy #400206. Approved October 1998, Revised and approved January 2008, Copyright © 2010 American College of Emergency Physicians. Accessed September 2, 2010. Available at URL address: <http://www.acep.org/practres.aspx?LinkIdentifier=id&id=32334&fid=2144&Mo=No&acepTitle=ACEP%20Policy%20Statements>
3. American College of Emergency Physicians (ACEP). Management of observation units. July 1994. Copyright © 2010 American College of Emergency Physicians. Accessed September 2, 2010. Available at URL: address:

<http://www.acep.org/practres.aspx?LinkIdentifier=id&id=29872&fid=2630&Mo=No&acepTitle=Management%20of%20Observation%20Units>

4. Burkhardt J, Peacock WF, Emerman CL. Predictors of emergency department observation unit outcomes. *Acad Emerg Med*. 2005 Sep;12(9):869-74.
5. Centers for Medicare and Medicaid Services (CMS). Local coverage determination (LCD) for observation care (L1158). Palmetto GBA. Effective 2/11/1998. Revision effective 07/15/2010. Accessed Sep 2, 2010. Available at URL address:
http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=1158&lcd_version=28&basket=lcd%3A1158%3A28%3AObservation+Bed%2FRoom+Services%3AFI%3APalmetto+GBA+%2800382%29%3A
6. Coffey RM, Barrett ML, Steiner S. Final report observation status related to hospital records. 2002. HCUP Methods Series Report #2002-4. Online September 27, 2002. Agency for Healthcare Research and Quality. Accessed September 3, 2008. Available at URL address: http://www.hcup-us.ahrq.gov/reports/FinalReportonObservationStatus_v2Final.pdf#search=%22Final%20report%20observation%20status%20related%20to%20hospital%20records.%202002%22
7. Crenshaw LA, Lindsell CJ, Storrow AB, Lyons MS. An evaluation of emergency physician selection of observation patients. *Am J Emerg Med*. 2006 May;24(3):271-9.
8. Daly S, Campbell DA, Cameron PA. Short-stay units and observation medicine: a systematic review. *Med J Aust*. 2003 Jun;178(11):559-63.
9. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS). Program memorandum intermediaries. Transmittal A-02-129. January 3, 2003. Accessed September 2, 2010. Available at URL address:
<http://www.cms.hhs.gov/Transmittals/Downloads/A02129.pdf#search=%22Program%20memorandum%20intermediaries.%20Transmittal%20A-02-129%22>
10. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS). Change request 4259. Pub 100-04 Medicare claims processing. Transmittal 787. December 16, 2005. Accessed September 2, 2010. Available at URL address:
<http://www.cms.hhs.gov/transmittals/downloads/R787CP.pdf>
11. Diercks DB, Peacock WF, Kirk JD, Weber JE. ED patients with heart failure: identification of an observational unit-appropriate cohort. *Am J Emerg Med*. 2006 May;24(3):319-24.
12. Goodacre S, Nicholl J, Dixon S, Cross E, Angelini K, Arnold J, et al. Randomised controlled trial and economic evaluation of a chest pain observation unit compared with routine care. *BMJ*. 2004 Jan;328(7434):254.
13. Greenberg RA, Dudley NC, Rittichier KK. A reduction in hospitalization, length of stay, and hospital charges for croup with the institution of a pediatric observation unit. *Am J Emerg Med*. 2006 Nov; 24(7):818-21.
14. Hoot NR, Aronsky D. Systematic review of emergency department crowding: causes, effects, and solutions. *Ann Emerg med*. 2008 Aug;52(2):126-36.
15. Koenig BO, Ross MA, Jackson RF. An emergency department observation unit protocol for acute-onset atrial fibrillation is feasible. *Ann Emerg Med*. 2002 Apr;39(4):374-81.
16. Jagminas L, Partridge R. A comparison of emergency department versus in-hospital chest pain observation units. *Am J Emerg Med*. 2005 Mar;23(2):111-3.
17. Leykum LK, Huerta V, Mortenson E. Implementation of a hospitalist-run observation unit and impact on length of stay (LOS): A brief report. *J Hosp Med*. 2010 Aug 17.

18. Madsen T, Mallin M, Bledsoe J, Bossart P, Davis V, Gee C, Barton E. Utility of the emergency department observation unit in ensuring stress testing in low-risk chest pain patients. *Crit Pathw Cardiol*. 2009 Sep;8(3):122-4.
19. Martinez E, Reilly BM, Evans AT, Roberts RR. The observation unit: A new interface between inpatient and outpatient care. *Am J Med*. 2001 Mar;110(4):274-7.
20. Medicare Benefit Policy Manual. Chapter 6- Hospital Services Covered Under Part B. Rev. 128, 05-28-10. Outpatient Observation Services. Accessed September 2, 2010. Available at URL address: http://search.cms.hhs.gov/search?q=hospital+services&site=cms_collection&output=xml_no_dtd&client=cms_frontend&proxystylesheet=cms_frontend&oe=UTF-8
21. Miescier MJ, Nelson DS, Firth SD, Kadish HA. Children with asthma admitted to a pediatric observation unit. *Pediatr Emerg Care*. 2005 Oct;21(10):645-9.
22. Roberts R, Graff IV LG. Economic issues in observation unit medicine. *Emerg Med Clin North Am*. 2001 Feb;19(1):19-33. Review.
23. Ross MA. Chest pain observation units reduce hospital admission in people with acute chest pain. *Evidence-based Healthcare*. 2004 Aug;8(4):180.
24. Ross MA, Compton S, Medado P, Fitzgerald M, Kilanowski P, O'Neil BJ. An emergency department diagnostic protocol for patients with transient ischemic attack: a randomized controlled trial. *Ann Emerg Med*. 2007 Aug; 50(2):109-19.
25. Ross MA, Compton S, Richardson D, Jones R, Nittis T, Wilson A. The use and effectiveness of an emergency department observation unit for elderly patients. *Ann Emerg Med*. 2003 May;41(5):668-77.
26. Rydman RJ, Zalenski RJ, Roberts RR, Albrecht GA, McCarren M, Misiewicz VM, Kampe LM. Patient satisfaction with an emergency department chest pain observation unit. *Ann Emerg Med*. 1997 Jan;29(1):109-115.
27. Schrock JW, Reznikova S, Weller S. The effect of an observation unit on the rate of ED admission and discharge for pyelonephritis. *Am J Emerg Med*. 2010 Jul;28(6):682-8.
28. Sikka V, Ornato JP, Gonzalez MS. The financial and operational impact of an observation unit and holding area on an emergency department and its inpatient hospital. *Acad Emerg Med*. 2006 May;13(5):S129.
29. Whitcomb WF, Nelson JR. Hospital Physician – Observation Unit Interface. In: *Hospital Medicine. Section I: General Issues in Hospital Medicine. Chapter 4: Hospital Interfaces*. Copyright 2005 by Lippincott Williams & Wilkins.

Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	10/15/2008	0411	Observation Care

"CIGNA", "CIGNA HealthCare" and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, CIGNA Health and Life Insurance Company, CIGNA Behavioral Health, Inc., CIGNA Health Management, Inc., and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company or CIGNA Health and Life Insurance Company.