Parkland Community Health Plan

Provider Network News

Parkland Community Health Plan Policy Update: Hospital Outpatient Observation Service Requirements

PCHP wants to notify providers about an upcoming system update to the Hospital Outpatient Observation Service requirements to ensure alignment with the Texas Medicaid Provider Procedural Manual (TMPPM) requirements. These updates will be applied prospectively, with an implementation date of June 24, 2025. Providers are encouraged to update their billing system to prevent claim denials.

Observation Care Definition

Observation care is defined by the Centers for Medicare & Medicaid Services (CMS) as a set of clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment. These services are provided while determining whether a member requires inpatient admission or can be discharged from the hospital.

According to the TMPPM, outpatient observation services are typically ordered for members who present to the emergency department and require a significant period of treatment or monitoring to make an admission or discharge decision. These decisions are generally made within 24 hours but no longer than 48 hours.

Providers must submit the number of observation hours for which a member was under observation care.

Observation time begins at the clock time documented in the member's medical record and ends when all medically necessary services related to the observation care are completed. The observation care is reported per unit equal to 1 hour on the hospital outpatient revenue code. Claims submitted with observation room units exceeding 48 hours will be denied.

Medical Necessity for Observation Services

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

- The member is clinically unstable for discharge and one of the following additional conditions applies:
  - Laboratory, radiology, or other testing is necessary to assess the member's need for an inpatient admission.
  - The treatment plan is not established or, based on the member's condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The member 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 member's medical condition requires careful monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary.
  - There is a delayed or slow progression of the member'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 member 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 member will require observation care for a minimum of eight hours.

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

The following new requirements will apply:

1. **Single-Line Reporting**

   Observation services that span more than one day (i.e., extends past midnight) must be reported on a single line, and the date of service for that line is the date that observation care began. Observation services should not be reported with a date span on separate claim lines even when the period of observation care spans more than one calendar day. Observation services reported on revenue code 0762 should reflect the hours of observation for the entire length of stay.

   A Claim for observation services exceeding 48 hours will be denied in its entirety.

2. **Brief Observation Periods**

   Brief observation services following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., breathing treatment) are more appropriately coded as treatment room with revenue code 761 and the appropriate HCPC or CPT code. Brief hospital outpatient observation billed with less than 6 hours of observation will not be reimbursed.

3. **Observation Services Following a Scheduled Day Surgery**

   If the member requires additional care beyond the normal recovery period and the member is placed in outpatient observation, the day surgery must be submitted under the HASC NPI and taxonomy code, and the observation period must be billed on an outpatient claim with TOB 0131 and the hospital NPI and taxonomy code.

For all requirements and for changes,
refer to the TMPPM located at

https://www.tmhp.com/resources/provider-manuals/tmppm