

SENATE NO. 672

AN ACT DEFINING THE USE OF OBSERVATIONAL SERVICES

Whereas, The deferred operation of this act would tend to defeat its purpose, which is forthwith which is to protect the rights of patients to receive reasonable and necessary care consistent with generally accepted principles of professional medical practice, this act is hereby declared to be an emergency law, necessary for the immediate preservation of the public safety and convenience, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

*Be it enacted by the Senate and House of Representatives in General Court assembled,
And by the authority of the same, as follows:*

1 SECTION 1. Section 1 of Chapter 176O, as added by Section 27 of Chapter 141 of the Acts of
2 2000, is hereby amended by adding after the definition of “network” and before the definition for
3 “office of patient protection” the following new definition:
4 “Observation Services”-health care services furnished on a provider’s premises, including the use of
5 a bed and periodic monitoring by the provider’s nursing or other health care professional staff,
6 which are reasonable and necessary to evaluate a patient’s condition or determine the need for a
7 possible admission to the hospital as an inpatient. These services are covered only when ordered by
8 the treating health care professional authorized under applicable State licensure law and hospital
9 staff bylaws to admit an insured to the facility or to order outpatient tests. Observation services
10 may extend up to, but should not exceed, 8 hours in duration. In extraordinary circumstances an
11 observation stay may extend up to 24 hours where the treating health care professional determines

12 that additional time is needed to complete an evaluation necessary to determine the medical
13 necessity for an admission.

14 SECTION 3: Chapter 176O, as so appearing, is further amended by adding after Section 10 the
15 following new Section 10 A:

16 Section 10A: Observation Services

17 Any classification of an insured as requiring or receiving observation services shall be based solely
18 on the medical judgment and intent of the treating health care professional after due consideration
19 of the insured's presenting signs and symptoms and shall not extend beyond 8 hours duration. If
20 such health care professional' opinion, based on this evaluation, is that the insured requires less than
21 24 hours in a facility and does not require inpatient level of care during this period, such insured
22 shall be classified as outpatient observation. If the treating health care professional's opinion after
23 consideration of the insured's presenting signs and symptoms is that further evaluation and health
24 care services shall require more than 24 hours in a facility, the insured shall be classified as an
25 inpatient. The treating health care professional, in his opinion and pursuant to the provisions above,
26 may authorize that observation services be provided in excess of 8 hours in extraordinary
27 circumstances when the insured's condition remains unclear and only requires monitoring by
28 clinical staff. For observation services extending between 8 hours and 24 hours in duration, should
29 the insured require health care services in addition to monitoring by clinical staff, including
30 continued diagnostic testing and/or active treatment of the insured's condition, that insured should
31 be admitted to the facility as an inpatient. Notwithstanding the provisions of this subsection,
32 observation services shall not extend beyond 24 hours in duration under any circumstance.
33 If, after applying the principles established in subsection (a) of this section, a provider and the
34 carrier are unable to agree on the classification of a insured into an inpatient or outpatient setting,

35 the carrier must release to both the hospitalized insured and the provider a written notification that
36 (1) identifies the specific information upon which the determination was based; (2) discusses the
37 insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific
38 reasons such medical evidence fails to meet the relevant medical review criteria for an admission;
39 (3) specifies any alternative treatment option offered by the carrier, if any; and (4) references and
40 includes applicable clinical practice guidelines and review criteria.

41 If after the information directed under subsection (b) of this section is made available and a dispute
42 continues to exist, then either the insured or a representative of the insured (which may include the
43 provider) that has been notified by the carrier that it has denied coverage and payment for inpatient
44 hospital services provided to the insured, may file an appeal with the Office of Patient Protection,
45 so called, established under Section 217 of Chapter 111 of the General Laws.

46 Notwithstanding any other provision of this section, after a determination that a particular health
47 care service was appropriately classified as inpatient or an observation service, the payment rules of
48 this subsection shall apply.

49 A post surgical day patient shall be classified as requiring and receiving observation services if,
50 after a normal recovery period, additional care is required to determine the need for an admission to
51 a facility. For purposes of this paragraph, the term "normal recovery period" shall mean 8 hours
52 after the performance of the surgical procedure. If an insured is classified as requiring or receiving
53 observation services after the normal recovery period, the carrier shall reimburse the provider the
54 cost for observation services in addition to any reimbursement otherwise due said participating
55 provider for the surgical procedure.

56 The carrier shall allow participating providers to bill for observation services provided prior to the
57 date of admission and said carrier shall pay participating providers the cost for such observation

58 services. Notwithstanding the foregoing, this provision shall not prohibit participating providers and
59 carriers from entering into contractual arrangements that supersede this provision.

60 SECTION 4: Application of this Act

61 For the purposes of applying Section 3 of the Act, the Commissioner of Insurance shall promulgate
62 regulations by which a carrier shall comply with the provisions set forth in said Section 3, no later
63 than 90 days following the effective date of this Act. The regulations as set forth, shall be effective
64 in contracts between carriers and health care providers that are entered into, renewed, or amended
65 on or after the effective date of this Act.