



Observation Status Payment Policy

Policy

Fallon Community Health Plan (FCHP) reimburses for observation status when acute care services are provided in a hospital setting based on the facilities contract. The hospital stay must meet severity of illness and intensity of service guidelines based on nationally recognized criteria, such as InterQual, in order to qualify for observation status. Whenever possible, the status of observation will be assigned at the time of admission, if clinical data is available from the facility. Fallon Community Health Plan will notify facilities of plan determination for observation status consistent with Utilization Management policies.

This policy applies to the facility and provider payment of observation status.

Definitions

Observation status is defined as acute services provided in a hospital which meet the intensity of service guidelines for observation status and are reasonable and necessary to evaluate an outpatient's condition to determine the need for admission.

Benefits application

Commercial

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

Senior Plan

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

Reimbursement

FCHP will reimburse acute care facilities and providers for observation status when the member meets nationally recognized criteria, such as InterQual, for observation status per their contracted rates.

If a patient is seen in the emergency department, then admitted to observation status, the emergency room co-payment will not be applicable unless otherwise stated in the member's *Evidence of Coverage*. In this situation, the emergency department technical charge is considered part of the observation charge and will not be reimbursed separately, but the professional emergency department charge will be reimbursed unless otherwise stated in the contract.

FCHP does NOT reimburse the following services in an observation setting:

- Routine therapeutic services routinely performed in outpatient settings such as blood transfusions, chemotherapy, or dialysis.

- Routine pre or post operative care following a diagnostic or surgical service.
- Separately billed diagnostic tests.
- Time for members who are awaiting nursing home placement.
- A routine “stop” between the emergency department and an inpatient admission.

If an observation patient is admitted to inpatient status, the observation services billed charges shall be denied and included in the reimbursement for inpatient services bill.

All changes in level of care will be reviewed by Inpatient Care Services to determine medical necessity using InterQual criteria.

Observation in conjunction with an ambulatory surgery procedure will **not** be routinely reimbursed. The reimbursement for normal recovery time is included in the surgical reimbursement. However, FCHP will review the following scenarios for reimbursement:

- Extended recovery due to an unusual situation such as an unexpected reaction or a complication that requires either more time than is typically required to determine the patient’s medical disposition.
- Monitoring or treatment beyond what is considered the normal recovery period for a particular procedure is required (e.g., post-operative bleeding, poor pain control, intractable vomiting, delayed recovery from anesthesia beyond 6 hrs).

Referral/notification/preauthorization requirements

Facilities are required to provide plan notification prior to claims submission on all observation stays. Reimbursement eligibility is determined by independent review by Inpatient Care Services.

Billing/coding guidelines

Facility

The following codes should be used when billing observation status:

- Revenue code: 0762 (Observation Room)
- CPT codes: 99217-99220 and 99234-99236

Note: Observation CPT code G0378 is bundled into the observation code payment for facilities unless specified otherwise by your contractual agreement.

Bill observation (room charges revenue code 0762) services on one claim line indicating the total number of hours in the service unit field.

Reimbursement will be based on the facility's contract.

Provider

The following codes should be used when billing observation status:

- CPT codes:
 - 99218, 99219, 99220 – used to report the first encounter with the patient when designated as observation status and the patient stay is 1-7 hrs and is discharged in same calendar day or the patient stays past midnight and goes into a second day.
 - 99234, 99235, 99236 – used to report when there is a minimum patient stay of 8 hours within same calendar day; patient is discharged before midnight. This one code pays for observation and discharge services.
 - 99211-99215 – used to report services in day 2 of observation; coded as outpatient E&M office visit.
 - 99221-99223 – used to report when the patient is admitted from observation status to inpatient status (POS 21).

- 99217 – used to report discharge from observation status when the discharge occurs after the first day of observation care. This should not be billed on the same day as inpatient hospital care
- Observation codes function by calendar day and are considered “outpatient” codes (POS: 22).
- Observation status is defined as services which are reasonable and necessary to evaluate an outpatient’s condition to determine the need for admission.
- Observation status implies a diagnosis and patient outcome is “not known”.
- Both observation and inpatient admissions require a written order with a date, provider signature and time of order.
- Provider documentation must clearly support the “medical necessity” of being in observation such as continual care, frequent nursing and provider visits, lab orders and diagnostic testing to support the reasonableness of continuing a stay in observation.

Observation examples:

If a patient is admitted into observation for abdominal pain, no diagnosis has been made yet and within the same day the patient is admitted/changed to an “inpatient” status, code: 99221-99223 (inpatient admission only).

If a patient is admitted to observation and stays after midnight and is discharged the next day then code:

- Day 1: 99218-99220
- Day 2: 99217 (discharge code).

If a patient is admitted and discharged within the same calendar day and has stayed a minimum of 8 hours from either observation and/or inpatient status, code: 99234-99236 (POS: 22-outpatient. This 1 code pays discharge and evaluation “all in one”.)

If patient is admitted to observation on day 1 and is still in observation on day 2 and is discharged on day 3, code:

- Day 1: 99218-99220
- Day 2: 99211-99215
- Day 3: 99217

Place of service

This policy applies to the facility and provider payment of observation status in the outpatient hospital setting.

Policy history

Origination date:	08/29/03
Previous revision date(s):	09/01/04, 08/01/07, 02/25/08, 07/01/08
Connection date & details:	05/01/09 – Updated verbiage under Reimbursement and Billing/coding guidelines to clarify FCHP reimbursement of services that move between Observation and Emergency Department, Ambulatory Surgery, and Inpatient.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.