Observation Status Payment Policy

Policy

The Plan reimburses for observation status when acute care services are provided in a hospital setting based on the facility's 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. The maximum amount of time that the Plan will authorize for observation level of care is 48 hours. Whenever possible, the status of observation will be assigned at the time of admission, if clinical data is available from the facility. The Plan will notify facilities of Plan determination for observation status consistent with Utilization Management policies.

Physician orders are to clearly identify inpatient or observation/outpatient status. 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.

Reimbursement

The Plan 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.

The Plan 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 billed.

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, the Plan will review the following scenarios for reimbursement:

- Extended recovery due to an unusual situation such as an unexpected reaction or a complication that requires 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 hours).

- InterQual criteria will be applied to these post-surgical requests as well as to requests arising out of emergency department visits.

Referral/notification/prior authorization requirements

For services pre-dating the below dates 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.

Effective January 1, 2018 prior authorization is no longer required for in-network facilities.
Effective August 1, 2018 prior authorization is no longer required for out-of network facilities.

Billing/coding guidelines

Facility: Facilities reimbursed according to Ambulatory Payment Classification (APC) should bill with code G0378.
Otherwise, the following codes should be used when billing observation status:

- Revenue code: 0762 (Observation Room).
- CPT codes: 99217-99220, 99224-99226, and 99234-99236.

Observation code G0378 is bundled into the payment for other observation codes unless specified otherwise in the contractual agreement.

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

Reimbursement will be based on the facility's contract.

Professional:
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 hours 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 the same calendar day; patient is discharged before midnight. This one code pays for observation and discharge services.
  - 99224-99226 – Used to report services in day 2 of observation.
  - 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 19 or 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. Physician orders are to clearly identify inpatient or observation/outpatient status.

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 19 or 22-outpatient. This one 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: 99224-99226
- Day 3: 99217

EAPG (Enhanced Ambulatory Patient Grouping) providers are required to bill within the appropriate Medicaid standards and will be reimbursed as such.

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 07/01/2009 - 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. 09/01/2011 - Updated policy section to indicate the maximum amount of time FCHP will authorize for observation level of care; updated billing guidelines section to reflect CPT code updates. 01/01/2014 - Added discussion about billing G0738 when reimbursed according to APC. 11/01/2015 - Annual review and moved to new Plan template.
Connection date & details:	July 2016 – Added POS 19; added requirement that physician orders clearly identify patient status. November 2017 – Annual Review, no updates. April 2018 – Updated authorization section July 2018 – Added EAPG billing language. October 2018 – Updated the authorization section. October 2019 – Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. 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. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and

are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.