Observation Status Payment Policy

Policy

The Plan reimburses observation status provided in an acute hospital setting based on the facility's contract. The hospital stay must meet as acute hospital level of care by CMS or InterQual, or observation level of care by 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

Facility reimbursement

Observation is an acute outpatient hospital service. Reimbursement for observation/outpatient hospital services is based on the terms of the facility's contract.

For MassHealth ACO members, the Plan reimburses observation based on the Executive Office of Health and Human Services (EOHHS) Adjudicated Payment per Episode of Care (APEC) payment methodology (3M EAPG).

For commercial and Medicare members, the Plan reimburses observation based on the Medicare Outpatient Prospective Payment System (OPPS) payment methodology.

The claims processing logic will determine whether observation is separately payable or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter.

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.

Observation billed in conjunction with an ambulatory or outpatient surgical procedure will not be routinely reimbursed. The reimbursement for normal recovery time is included in the surgical reimbursement.

Professional reimbursement

The Plan reimburses evaluation and management services provided to plan members admitted to observation status in an acute care hospital. Physicians and other qualified healthcare providers

should follow CMS billing guidelines as described in the Medicare Claims Processing Manual, Chapter 12, Section 30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services) and the codes specified under Billing/coding guidelines below.

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 coding
G-codes to be used by hospitals reporting observation services under revenue code 0762 (Observation Room):

- G0378- Hospital observation services, per hour
- G0379- Direct admission of patient for hospital observation care.

Facilities reimbursed under either the EAPG (Enhanced Ambulatory Patient Grouping) or Medicare OPPS payment methodology are expected to bill using the appropriate MassHealth/Medicare billing standards and will be reimbursed as such.

Professional coding
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).

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

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. July 2022 - Clarified reimbursement for observation services under the Executive Office of Health and Human Services (EOHHS) Adjudicated Payment per Episode of Care (APEC) payment methodology; clarified reimbursement for observation services under the Medicare Outpatient Prospective Payment System (OPPS) payment methodology.

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.