Payment Policy CPP_07

Observation Services and Other Services Incidental to Inpatient Admission

BlueCross BlueShield of Vermont
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Next Review: September 2026 (or as needed)
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Description

This policy addresses Blue Cross and Blue Shield of Vermont (Blue Cross VT) payment for observation services as well as payment for these and other services when they are incidental (and inclusive to) an inpatient admission.

Policy & Guidelines

Services Incidental (and Inclusive to) Inpatient Admission:

For hospitals paid on a DRG basis, any services provided within the 72-hour window prior to admission should not be separately billed, as the DRG case rate covers reimbursement for those services.

For hospitals paid on a discount-off-charge or per diem basis, services rendered within the 72-hour window prior to the admission and that are related to the admission should be billed on the inpatient claim.

Observation services provided prior to admission to inpatient status are inclusive to the inpatient admission and should not be billed as a separate line item on the claim (if observation services are billed, they will be denied because they are not eligible for separate payment). Services such as emergency room care and diagnostic and/or testing services may be billed on separate lines of the inpatient claim and will be reimbursed.

When Observation Services Are Separately Payable

Blue Cross VT follows the definition for Outpatient Observation Services as articulated by the Centers for Medicare and Medicaid Services per the Medicare Benefit Policy Manual, chapter 6, section 20.6. Specifically:

> Observation care is a well-defined set of specific clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Blue Cross VT will pay separately for observation care when the service is medically necessary, and the observation care is not incidental to an inpatient stay or other outpatient service. Generally, an observation service is medically necessary if the individual is not medically stable to safely permit discharge and any one of the following conditions is met:

- A medical condition requires careful monitoring and evaluation or treatment to confirm or refute a diagnosis in order to determine whether inpatient admission is necessary; or
- The individual is undergoing treatment for a diagnosed condition (e.g., chest pain, asthma, congestive heart failure) and continued monitoring of the clinical response to therapy may prevent an inpatient admission; or
- The individual has a significant adverse response to therapeutic services, invasive diagnostic testing or outpatient surgery requiring careful short-term monitoring and evaluation; or
- Active care or further observation is needed following emergency room care to determine if the member is stabilized; or
- The physician or nursing care that a member needs initially is at or near the inpatient level, but such intense care is expected to be necessary for less than 48 hours; or
- For obstetrical patients, an episode is considered an observation stay if (1) there is a diagnosis other than routine pregnancy (in other words a complication occurred), (2) delivery does not occur, and (3) the member is sent home. Diagnostic testing performed in conjunction with an obstetrical observation stay is considered inclusive to the stay and not separately reimbursable.

When the above conditions are met, Blue Cross VT will pay for up to 48 hours of observation services. Charges should not exceed the daily semi-private medical room and board rate.

When Observation Services Are Not Separately Payable

- Observation care incidental to an inpatient admission, within the timeframes stated above.
- Observation care integral to the base procedure, such as:
    - Observation care after outpatient surgery (this is considered postoperative care and reimbursement is included in the global surgery benefit)
    - Monitoring services associated with outpatient blood administration
    - Routine preparation prior to and recovery after diagnostic testing
    - Observation following an uncomplicated treatment or procedure
    - Observation services related to a surgical day care (SDC) or other outpatient procedure are considered part of the routine recovery period for the procedure.
    - Diagnosis or therapeutic services for which active monitoring is part of the procedure (e.g., colonoscopy, chemotherapy).

- When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay (the observation stay is reimbursed in this scenario and the ED services are not).
- Services that would normally require inpatient stay (and which should be billed as inpatient)
- When the clinical need for observation does not exist, such as the following (but note, services may be provided during the "waiting" period; but those should be billed according to the correct outpatient codes and not as observation services):
    - A lack of/delay in transportation does not support the need for observation care and will not be reimbursed
    - When used for the convenience of the physician, individual or person's family
    - While awaiting transfer to another facility
    - Services that are not reasonable and necessary for care of the individual
    - When an overnight stay is planned prior to diagnostic testing
- Provision of a medical exam by someone other than an ER or critical care specialist
- Duration of care exceeding 48 hours
- There is no physician's order to admit to observation
- Inpatient discharged to outpatient observation status
- Subsequent Observation Care Codes 99231-99233 are ***not eligible*** for payment as observation services spanning more than two dates of service.
- Routine recovery exceeding 48 hours.

Provider Billing Guidelines and Documentation

See Addendum for Coding Table listing of eligible and non-eligible codes.

The following information is required (and submitted to Plan if required or upon Plan's request):

Documentation in the medical record must clearly support the medical necessity of the observation care services and include the following information:

- the attending physician's order for observation care; and
- the physician admission and progress notes confirming the need for observation care; and
- the supporting diagnostic and/or ancillary testing reports; and
- the admission progress notes with clock time outlining the patient's condition and treatment; and
- the discharge notes and clock time with discharge order and nurse's notes

Initial observation care codes 99221-99223, 99238-99239 and Subsequent observation care CPT® codes 99231-99233 are used to report evaluation and management (E/M) services provided to new or established patients designated as "observation status" in a hospital.

Observation service (including admission and discharge) codes 99234-99236 are used to report evaluation and management (E/M) services provided to patients admitted and discharged on the same date of service. When a patient is admitted to observation care for a minimum of 8 hours, but less than 48 hours, and subsequently discharges on the same calendar date, the claim should be reported as an Observation or Inpatient Care Service (Including Admission and Discharge Services) codes (99234-99236).

When reporting an observation care (including admission and discharge) using codes 99234-99236, the medical record must include:

- documentation meeting the E/M requirements for history, examination and medical decision making; and
- documentation stating the stay for hospital treatment or observation care status involves at least 8 hours but less than 48 hours; and
- documentation identifying the billing physician was present and personally performed the services; and
- documentation identifying that the admission and discharge notes were written by the billing physician.

The physician supervising the care of the patient designated as being in "observation status" is the only physician who can report an initial observation care codes (99221 – 99223). It is not necessary that the patient be located in an observation area designated by the hospital, although in order to report the observation care codes the physician must:

- indicate in the patient's medical record that the patient is designated or admitted as observation status; and
- clearly document the reason for the patient to be admitted to observation status; and
- initiate the observation status, assess, establish and supervise the care plan for observation and perform periodic reassessments.

When observation status is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility), all evaluation and management (E/M) services provided by the supervising physician in conjunction with initiating observation status are considered part of the initial observation care when performed on the same date.

The observation care level of service reported by the supervising physician should include the services related to initiating 'observation status' provided in the other sites of services, as well as in the observation setting.

Observation care discharge services include all evaluation and management (E/M) services on the date of discharge from observation services and should only be reported if the discharge from observation status is on a date other than the date of initial observation care.

Observation care codes are ***not eligible*** for separate payment when performed within the assigned global period of a surgical procedure as these codes are included in the global package.

Other ancillary services (e.g., labs, therapy services, x-rays) performed while the patient receives observation stay services are to be reported using the appropriate revenue codes and CPT®/HCPCS Level II codes combinations as applicable.

Per the AMA CPT® Manual (2024) defines: "total time on the date of the encounter is by calendar date. When using medical decision making [MDM] or total time for the code selection, a continuous visit that spans the transition of two calendar dates is a single service and reported on one calendar date. If the

service is continuous before and through midnight, all the time may be applied to the reported date of service."

Report the number of observation hours in Field Locator 46.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co- insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence

payments.

Legislative and Regulatory Guidelines

Related Policies Not applicable

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

References

1. American Medical Association. (*2024). CPT®: Current Procedural Terminology (Professiona*l). Chicago IL: American Medical Association.
2. Medicare. (Benefit Policy Manual 12/21/2023). Medicare Benefit Policy Manual Hospital Services Covered Under Part B (Chapter 6. Section 20.6). Retrieved from https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c06.pdf .

Policy Implementation/Update Information

This policy was originally implemented on November 1, 2014

Date of Change	Effective Date	Overview of Change
December 2023	January 1, 2024	Amended to update the coding table with the following codes: 99217-99220 deleted and replaced with codes 99221-99223, 99238 & 99239. Codes 99234-99236 revised descriptors. Codes 99224-99226 deleted and replaced with codes 99231-99233. Added language to define total time.

September 2024	December 1, 2024	Policy moved to a new template. 48-hour window for hospitals paid on a discount-off-charge basis for services rendered prior to inpatient admission before they may be billed separately changed to 72 hours to be in alignment with hospitals paid on a DRG basis. "References" section added. Coding table edited to delete 99217, 99218, 99219, and 99220 and add 99221, 99222, 99223, 99238 and 99239 to the codes Eligible for Payment. Codes 99224, 99225, and 99226 were replaced on the list of codes Not Eligible for Payment with codes 99231, 99232, and 99233. Other language and grammatical changes were made throughout for clarification purposes only.

Approved by **Update Approved: 09/12/2024**

Tom Weigel, MD, Chief Medical Officer

Addendum A

Coding Table
for Observation and Other IP Services Incidental to IP Admission

Eligible Providers may be compensated only for the services listed below.

Please Note: *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*

Codes	Number	Description
Eligible for Payment		
Revenue Code	0762	Specialty Services, Observation Hours
HCPC Codes	G0378	Hospital Observation Service, **per hour**
	G0379	Direct admission of patient for hospital observation care
CPT® Codes	99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low-level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
	99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

Codes	Number	Description
	99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
	99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
	99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
	99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
	99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
	99239	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
	99239	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
Not Eligible for Payment		
CPT® Codes™	99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
	99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
	99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.