BlueCross BlueShield of Vermont
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Corporate Payment Policy 07
OBSERVATION SERVICES PAYMENT POLICY
Updated effective 01.01.2021

Document Precedence

The Blue Cross and Blue Shield of Vermont (BCBSVT or Plan) Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT 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 BCBSVT 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 BCBSVT 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 BCBSVT 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 BCBSVT Payment Policy Manual and Plan's claim editing solution, Plan's claim editing solution takes precedence.

Payment Policy

Description

An observation stay is an alternative to an inpatient admission and is defined as those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

Such 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. The reason for observation must be stated in the orders for observation.

Observation care for greater than 48 hours ***without*** inpatient admission is considered ***not eligible*** for payment and will be considered provider liability.

Policy

Eligible Observation Care

BCBSVT covers observation care as medically necessary when an 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, BCBSVT will allow charges for up to 48 hours of observation services. Charges cannot exceed the daily semi-private medical room and board rate.

In the event that an observation stay converts to an inpatient admission/stay, the observation stay becomes *inclusive* to the inpatient admission/stay and is ***not eligible*** for separate payment.

Not Eligible for Payment

Charges for observation care are not appropriate, and will not be reimbursed, in the following scenarios:

- In cases where a hospital is reimbursed for inpatient services using either a case rate or DRG-based methodology, that inpatient reimbursement includes all related observation services that occur within three days of the date of admission.
- In cases where a hospital is reimbursed for inpatient services using either a per-diem or percent-of-charge methodology, that inpatient reimbursement includes an observation stay that converts to an admission before midnight of the same day (if the stay converts to an admission after midnight, the observation stay is reimbursed separately from the inpatient stay).
- Observation care services submitted with routine pregnancy diagnoses.
    - The entire episode is considered an inpatient admission if delivery occurs prior to discharge.
    - If delivery does not occur and the patient is sent home,
- 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.

- 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)
- A lack of/delay in transportation does not support the need for observation care and will not be reimbursed
- Provision of a medical exam by someone other than an ER or critical care specialist
- When used for the convenience of the physician, individual or person's family
- While awaiting transfer to another facility
- Duration of care exceeding 48 hours
- When an overnight stay is planned prior to diagnostic testing
- There is no physician's order to admit to observation
- Services that are not reasonable and necessary for care of the individual
- Services provided concurrently with chemotherapy
- Inpatient discharged to outpatient observation status
- Subsequent Observation Care Codes 99224 – 99226 are ***not eligible*** for payment as observation services spanning more than two dates of service.
- Routine recovery exceeding 48 hours.

Benefit Determination Guidance

Payment for Observation 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 Observation 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 (BCBSVT 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.

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 CPT-4® codes 99217-99220 and subsequent observation care CPT-4® codes 99224-99226 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) CPT-4® 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.

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 CPT-4® code (99218-99222). 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.

Initial Observation Care CPT-4® code (99218-99220) would be reported for a patient admitted to observation care for less than 8 hours on the same calendar date.

Per CPT-4®, Observation discharge day management CPT-4® code 99217 "includes final examination of the patient, discussion of the hospital stay, instructions for continuing care and preparation of discharge records."

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.

Physicians, who admit a patient to observation care for a minimum of 8 hours, but less than 48 hours, and subsequently discharges on the same calendar date, shall report an Observation or Inpatient Care Service (Including Admission and Discharge Services) CPT-4® code (99234-99236).

When reporting an observation care admission and discharge service CPT-4® code (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 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.

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-4®/HCPCS Level II® codes combinations as applicable.

If the period of observation stay spans more than one calendar day, all of the hours for the entire observation stay period must be included on a single claim line and the date of service for that line is the date that the observation stay begins.

Report the number of observation hours in Field Locator 46.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug

Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Eligible Providers

Policy applies to all facilities/outpatient surgical centers contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network facilities/outpatient surgical centers.

Audit Information:

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Policy Implementation/Update Information

Original effective date: November 1, 2014
Updated effective November 1, 2014
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Approved by **Date Approved: 10/13/2020**

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Addendum

Coding Table[12]

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(a)	Specialty Services, Observation Hours
HCPC Codes®	G0378	Hospital Observation Service, **per hour**
	G0379	Direct admission of patient for hospital observation care
CPT-4 Codes™	99217	Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from observation status if the discharge is on other than the initial date of observation status. To report services to a patient designated as observation status or inpatient status and discharged on the same date, use the codes for Observation or Inpatient Care Services {including Admission and Discharge Services, 99234-99236 as appropriate}.)
	99218	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to observation status are of low severity.
	99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination, and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to observation status are of moderate severity.
	99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to observation status are of high severity.
	99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.
	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key

Codes	Number	Description
		components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.
	99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.
Not Eligible for Payment		
CPT-4 Codes™	99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.
	99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
	99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

[1]*Current Procedural Terminology CPT™ codes and descriptions are the property of the American Medical Association.*
[2]*Healthcare Common Procedure Coding System (HCPCS) code set and descriptions are the property of CMS.*