JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.016
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This document applies to the following Participating Organizations:

Advantage MD EHP Priority Partners US Family Health Plan

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I. ABOUT OUR REIMBURSEMENT POLICY

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all providers (e.g., practitioners, hospitals, suppliers, non-physician providers, etc.) eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim

- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide general billing and reimbursement guidance for observation services when it is determined to be medically necessary, and when the medical criteria and guidelines are met. This policy is applicable to both participating and non-participating providers who submit claims to JHHP, for reimbursement. In the State of Maryland, reimbursement for hospital services by all payers classified as Maryland Waiver Hospitals are based upon the rules, regulations and rates established by the Health Services Cost Review Commission (HSCRC) (COMAR 10.09.06.09(A)(1)).

III. POLICY STATEMENT

This policy applies to all CPT/HCPCS and Revenue (Rev) codes reported on CMS-1500 or UB-04 claim forms or their electronic equivalent, to a JHHP product, from network and non-network physicians, providers, and suppliers, for observation services. Claims submitted to JHHP must be billed in accordance with laws, regulatory requirements, CMS billing guidelines, provider contracts, and JHHP reimbursement policies. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible for reviewing the **"EXCEPTIONS & EXCLUSIONS" sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES and PAYMENT METHODOLOGY

A. Observation services are to be billed according to CMS observation billing guidelines.
   - In the State of Maryland, observation services shall be billed in accordance with Health Services Cost Review Commission (HSCRC) guidelines.
   - Maryland providers will be reimbursed in accordance with the HSCRC reimbursement methodology, when applicable.

B. Consistent with CMS guidance, observation services are considered outpatient services. When billing for observation services, JHHP expects the charges associated with those services to be billed as outpatient level of care services.
   - When appropriate, practitioners may bill observation care with the same CPT codes as hospital inpatient care, CPT codes 99221-99223, 99231-99239.

C. Only the practitioner who orders and is responsible for the patient's care while receiving outpatient observation services, can bill the observation care CPT codes.
   i. Services billed by non-physician practitioners are to follow the guidance found in JHHP's Advanced Practice Provider policy.

D. All hospital inpatient or observation care services, during a global period, are included in the global package and all services rendered while the patient is on observation are to be reported with the appropriate revenue codes, HCPCS/CPT codes, modifiers and diagnosis code.
   i. Hospital inpatient or observation care codes are not separately reimbursable when performed within the assigned global period of a procedure or service.

E. Observation services are not expected to exceed 48 hours in duration. Services reported over 48 hours in duration are seen as rare and exceptional cases and will be reviewed.
F. All hours of observation should be submitted on a single line and the date of service being the date the order for observation was written.
G. Hospitals are required to report observation charges with the appropriate revenue code(s) or the claim will be denied.
H. Observation ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be discharged home or admitted as an inpatient.
I. If the patient is admitted as an inpatient after observation, an order to admit is required.
J. When the patient is discharged from observation and subsequently admitted as an inpatient, all services provided to the patient while in observation are included on the inpatient claim.

V. SAME DAY ADMISSION and DISCHARGE

1. If a patient is admitted to outpatient observation care and discharged later the same calendar day, the observation admission including discharge codes may be applicable.
2. Initial observation including discharge care on the same date of service may be billed using codes 99234-99236 if the care involves 8 hours, but less than 24 hours.
3. The place of service code should identify the patient's location as outpatient for the service billed.

VI. INAPPROPRIATE BILLING of OBSERVATION SERVICES

1. Observation services should not be billed along with diagnostic or therapeutic services for which active monitoring is a part of the procedure. In situations where such a procedure interrupts observation services, hospitals are responsible for determining the most appropriate way to account for this time.
2. Observation services for future elective surgery or outpatient surgery cases are considered pre-operative and /or post-operative services, and do not meet the definition of observation care.
3. Time in the Emergency Room/Department (ER/ED) before the decision to place a patient in observation will not be covered as observation care.
4. Orders for observation services are not considered to be valid inpatient admission levels of care orders.
5. Time spent on non-clinically necessary services, or on services that could be safely performed in a lower level of care, will not be covered.
6. A transition from outpatient observation care to inpatient status does not constitute a new stay. Initial and subsequent hospital or observation care codes may not be billed for observation services provided on the same date the physician admits the patient as an inpatient.
    - Although the patient is admitted to the hospital as an inpatient on the next or subsequent calendar date, the transition from outpatient observation care to inpatient status does not constitute a new stay.
    - The new vs. established patient rules apply.
7. Prolonged services codes are not reportable in conjunction with codes for hospital inpatient or observation care, or discharge day management.
8. Observation services are not considered medically necessary when the patient’s current medical condition does not warrant observation, or when there is not an expectation of significant deterioration in the patient’s medical condition in the near future.

VII. DOCUMENTATION REQUIREMENTS

1. Observation services must be ordered by a physician or other qualified healthcare provider. The clock time begins at the time that observation services are initiated in accordance with a physician's order. JHHP does not permit retroactive orders or the inference of physician orders.
2. The order for outpatient observation services must be in writing and clearly specify outpatient observation. The order must include the reason for observation, services ordered and be signed, dated and timed by the physician responsible for the patient during his/her outpatient observation care.
    - Verbal orders are permitted but must be documented by the individual receiving the order. The ordering practitioner must review and confirm the verbal order when they see the patient.
3. The medical record is expected to demonstrate the consistency between the practitioner order, the services provided, and the medical necessity and intensity of those services provided, including the medical appropriateness of the observation stay.
4. JHHP will use medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the visit.
5. An assessment of a patient's risk must be documented in the medical record to determine benefit from observation care and is explicitly documented by the physician.
6. When billing for observation admission and discharge on the same day, the medical record must include documentation stating the stay for observation care involves at least 8 hours and less than 24 hours on the same calendar date.
    - The documentation must also include dated and timed physician orders regarding the care the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services.
    - The physician must also document the care provided, which includes the admission and discharge were both personally performed by the physician in person.

VIII. EXCEPTIONS and EXCLUSIONS

EXCLUSION:

The 3-day (or 1-day) payment window policy does not apply to the following:

A. Ambulance services
B. Maintenance renal dialysis services
C. When the admitting hospital is a critical access hospital (CAH), unless the CAH is wholly owned or operated by a non-CAH hospital
D. Outpatient diagnostic services included in a rural health clinic (RHC) or federally qualified health center (FQHC) all-inclusive rate
E. Outpatient diagnostic services furnished more than 3-days (or 1-day) prior to inpatient admission
F. Skilled nursing facilities (SNF)
G. Home health agencies (HHS)
H. Hospices

EXCEPTION:

AdvantageMD: JHHP aligns with CMS guidance for Observation Care Services. Please consult the authoritative guidance found in the applicable Medicare Manuals.

- G0378: Hospital observation service, per hour. Report units of hours spent in observation (rounded to the nearest hour).
- G0379: Direct admission of patient for hospital observation care.
- All JHHP Medicare Advantage members receiving services in hospitals and clinical access hospitals (CAHs) must receive a Medicare outpatient observation notice (MOON) no later than 36 hours after observation services as an outpatient begin. The MOON informs patients, who receive observation services for more than 24 hours, of the following:
  - They are outpatients receiving observation services and not inpatients.
  - Reasons for such status.

Hospitals and CAHs may deliver the MOON to a patient receiving observation services as an outpatient before the patient has received more than 24 hours of observation services but no later than 36 hours after observation services begin.

Priority Partners: JHHP aligns with Maryland Medicaid billing and reimbursement methodologies. Please consult the authoritative guidance found in the Maryland Department of Health's: Provider Manuals, Provider Transmittals, and their Billing Instructions for CMS-1500 and UB-04 claim forms, to obtain specific information on policy, benefits, and coverage for Observation Care services.

- JHHP aligns with the Maryland Medicaid Provider Manual for billing and reimbursement/payment methodologies for observation services. As such, per state regulations, if hospitals bill more than 24 hours under Revenue Code 0762, the entire claim will deny. Maryland is exempt from the 8-hour minimum.

USFHP: JHHP aligns with the TRCIARE Manuals for observation care services, for billing and reimbursement/payment methodologies.

IX. CODES, TERMS and DEFINITION

Definition of Terms

Term	Definition

3-day/1-day payment window	For the purpose of this policy, the following is in accordance with CMS guidance: 3-day/1-day payment window also known as outpatient services treated as inpatient and is applicable for diagnostic services and non-diagnostic services (related to the admission) rendered during the 3 days (hospitals subject to IPPS, inpatient prospective payment system) or 1 day (hospitals excluded from IPPS) prior to an inpatient hospital admission (even if the days cross the calendar year) are considered inpatient services and must be included on the inpatient hospital claim: **Hospitals subject to IPPS** Acute care hospitals **Hospitals and units excluded from IPPS** Psychiatric hospitals and units Inpatient rehabilitation facilities and units (IFRs) Long-term care hospitals (LTCH) Children’s hospitals Cancer hospitals **Note:** Hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC) are subject to the 3-day payment window.
Diagnostic services	Diagnostic services, including non-patient laboratory tests, provided to a member by the admitting hospital, 3-days (or 1-day) prior to inpatient hospital admission, including the date of admission, are considered inpatient services and must be included on the inpatient hospital claim. *For example, patient admitted on Wednesday, the outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included on the inpatient claim.*

Observation Care Services	Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being 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 Time	In accordance with CMS, outpatient observation services generally do not exceed 24 hours. The decision to either discharge a patient from the outpatient observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. Although some patients may require a second day of outpatient observation, only in rare and exceptional cases do outpatient observation services span more than 48 hours.
Per Day	Applicable to this policy, the time counted toward the hospital inpatient and observation care codes is “per day” also referred to as "date of encounter" which means "calendar date". Practitioners will select a code that reflect all services provided in all sites on the date of service.
Place of Service	Observation care is an outpatient service. Although the code range includes inpatient and outpatient services, the place of service code should identify the patient's location for the service billed. Claims for observation care are typically billed with place of service code (POS) -22 (outpatient hospital).

CPT/HCPCS Codes

CPT Code	Definition
99202 - 99499	Evaluation and Management Service Codes - General
99231 - 99239	Subsequent Hospital Inpatient or Observation Care Visit and Hospital Inpatient or Observation Discharge Day Management Codes

X. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical AssociatioN
- Maryland Health Services Cost Review Commission (HSCRC)
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners
- TRICARE Manuals

XI. REVISION HISTORY

Date	Review/Revision	Reason for Modification	Approved By
10/25/2023	Revision	Updated policy language, format and references	Reimbursement Policy Committee (RPC)