ACTION

☐ New Policy
☐ Repealed Policy Date:
☒ Superseded Policy Number: Medical Policy CMS11.03

The most current version of the reimbursement policies can be found on www.jhhc.com.

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Johns Hopkins HealthCare (JHHC) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

POLICY:

It is the policy of Johns Hopkins HealthCare LLC (JHHC) to reimburse hospitals for observation care services, when it is determined to be medically necessary, and when the medical criteria and guidelines are met.

SCOPE:

This policy applies to all providers participating within the JHHC provider network, as well as accredited non-participating practitioners.

DEFINITIONS:

Accredited Practitioner/Physician: for the purpose of this policy, refers to non-participating providers who are not excluded, nor opt-out physician or practitioner, and who meet the criteria for participation outlined in the credentialing policy PCR.002.

Observation Care: 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 a member will require further treatment as hospital inpatient or if the member is able to be discharged from the hospital. Observation is for a minimum of 1 hour and a maximum of 48 hours.

PROVIDER BILLING GUIDELINES AND DOCUMENTATION:

Following CMS Claims Processing Manual instructions "For a physician to bill observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter."

Documentation requirements:

1. A written order for observation is documented in the record including date and time.
2. The member's time in observation (and hospital billing) begins with the member's admission to an observation bed.
3. The member's time in observation (and hospital billing) ends when all clinical interventions have been completed.

4. There is an assessment of patient's risk to determine benefit from observation care and is explicitly documented by the physician.
5. The admission into observation is based on the patient's severity of illness and the intensity of service provided.

Time in the ER before the decision to place a patient in observation will not be covered as observation care. Time billed in observation should only include that time spent doing clinically necessary services. 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. Time spent awaiting diagnostic testing or treatment will not be covered if no other clinically necessary services are being provided. As an outpatient classification, diagnostic testing is reimbursed separately from observation services. Included in these testing fees is the time required to complete the test. As such, time spent in diagnostic testing should not be billed under observation services.

Initial Observation Care: The physician supervising the care of the patient designated as "observation status" is the only physician who can report an initial Observation Care CPT code (99218-99220). 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;
- 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.

Consistent with CMS guidelines, an Observation Care CPT code (99218-99220) should be reported for a patient admitted to Observation Care for less than 8 hours on the same calendar date.

Subsequent Observation Care: In the instance that a patient is held in observation status for more than two calendar dates, the supervising physician should utilize a subsequent Observation Care CPT code (99224 - 99226). Physicians other than the supervising physician providing care to a patient designated as "observation status" should report subsequent Observation Care.

Observation Care Discharge Services: Observation Care discharge services include all 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. Following CMS guidelines, physicians should not report an Observation Care discharge service when the Observation Care is a minimum of 8 hours and less than 24 hours and the patient is discharged on the same calendar date.

Same Day Admission and Discharge: Physicians who admit a patient to Observation Care for a minimum of 8 hours, but less than 24 hours and subsequently discharge on the same calendar date shall report an Observation or Inpatient Care Service (Including Admission and Discharge Services) CPT code (99234-99236). In accordance with CMS' Claims Processing Manual, when reporting an Observation Care admission and discharge service CPT code (99234-99236) the medical record must include:

- documentation meeting the E/M requirements for history, examination and medical decision making;
- documentation stating the stay for hospital treatment or Observation Care status involves 8 hours but less than 24 hours;
- 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.

NOTE: Hospitals should not use the CPT codes 99217-99220, 99224-99226, or 99234-99236 for observation services. The G-codes G0378 or G0379 should be used instead.

PAYMENT METHODOLOGY:

Per Maryland Health Services Cost Review Commission (HSCRC) requirements, all hospitals have been assigned observation rates. In accordance with CMS policy, when fewer than 8 hours of observation services are billed, the facility fees will be reimbursed per HSCRC regulations.

For EHP, USFHP, and AdvantageMD: JHHC will reimburse up to 48 hours of Observation Care. Beyond 48 hours, observation services will be denied.

For Priority Partners MCO: Per Maryland Department of Health (MDH) Transmittal No. 114, dated December 19, 2016, "Medicaid agencies may only reimburse hospitals for up to 24 hours in an outpatient setting, which includes observation stays. 42 CFR 440.2(a) limits outpatient services to under 24 hours. Effective January 1, 2017, managed care organizations (MCOs), our Behavioral Health Administrative Service Organization and the fee-for-service program will limit payment to under 24 hours."

CODING INFORMATION:

Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/ HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage and referral requirements. All inpatient admissions require preauthorization.

CPT ® CODES	DESCRIPTION
99217	Observation care discharge day management (This code is to be utilized 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.
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 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 physicians, other qualified health care professionals, 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. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
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 physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

CPT ® CODES	DESCRIPTION
	Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent 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 key 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 physicians, other qualified health care professionals, 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. Typically, 25 minutes are spent 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 physicians, other qualified health care professionals, 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. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
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 3 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 physicians, other qualified health care professionals, 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. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
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 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
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 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

CPT ® CODES	DESCRIPTION
	family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
HCPCS CODE	
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care
REVENUE CODES	
0760	General Classification Category
0762	Specialty services – Observation Hours/Room
0982	Professional fees – Outpatient services

EXCLUSIONS

Currently, there are no limits for OB observation when billed with revenue codes 0720-0722 alone. When billed with 0762, the above policy applies.

EXEM PTIONS

N/A

REFERENCES: This policy has been developed through consideration of the following:

CMS, Medicare Claims Processing Manual, Chapt. 4, Sect. 290 – *Outpatient Observation Services*

Code of Federal Regulations, 42 CFR 440.2(a), definition of *Outpatient*

Maryland Medical Assistance Program (MDH), MCO Transmittal No. 114 (aka Hospital Transmittal No. 246), December 19, 2016

Health Services Cost Review Commission (HSCRC). (2010). Memorandum: Establishment of an Observation Rate Center for Medical Observation Cases and Conversion of Same Day Surgery Rate Center.

TRICARE Policy Manual 6010.60-M, April 1, 2015 - Evaluation And Management, Chapter 2, Section 2.3 - *Outpatient Observation Stays*.

APPROVALS

Reimbursement Policy Committee Date: May 11, 2020

Review/Revision Dates: 4/13/2020