REIMBURSEMENT POLICY

Observation Care Services

Active

Policy Number: Evaluation and Management - 004
Policy Title: Observation Care Services
Section: Evaluation and Management
Effective Date: 05/19/15

Product: ☒Commercial ☒FEP ☐Medicare Advantage ☐Platinum Blue

Description

This policy addresses submission and coverage for observation care services.

Definitions

Codes 99217-99220, 99224-99226, and 99234-99236 are used to report the initial or subsequent evaluation and management of a patient in observation care per day.

Revenue code 0762, Specialty Services; Observation hours are reported with the number of hours spent in observation care furnished by a hospital on the hospital's premises. Observation care includes the use of a bed and periodic monitoring by a hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

Policy Statement

Observation care is an outpatient hospital service. The hospital will bill observation care under revenue code 0762 with the appropriate HCPCS code on an institutional electronic claim format (837I).

Professional services relating to observation care are billed using the appropriate observation HCPCS code on a professional electronic claim format (837P).

The HCPCS/CPT codes for observation services are defined as initial (99218-99220), subsequent (99224-99226), admit and discharge same day (99234-99236) and discharge observation (99217). Correct reporting depends on the number of hours a patient spends in observation care.

Patient time in observation	Calendar date	Report
Less than eight (8) hours	Same calendar date	99218-99220
Minimum of eight (8) hours, but less than 24 hours and discharged	Same calendar date	99234-99236 NOTE: do not report separate code/charge for discharge (99217)
Admitted for observation care and then is discharged on the next calendar date	Two calendar dates	Initial day: 99218- 99220 Discharge day: 99217

Remains in observation for three days	Three calendar dates	Initial day: 99218-99220 Subsequent day: 99224-99226 Discharge day: 99217

Observation care time limitation

Observation Care, billed under revenue code **0762**, normally does not extend beyond 24 hours. However, claims for observation services over 24 hours will be allowed up to 48 hours. Excess observation time over 48 hours will be denied.
Blue Cross and Blue Shield of Minnesota (Blue Cross) considers hospital stays for 48 hours or more as inpatient.

Documentation Submission

Documentation must identify and describe the E/M services and procedures performed. If a denial is appealed, this documentation must be submitted with the appeal.

The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care and was admitted to the observation care.

Coverage

Services are covered only when provided by the order of a physician or other 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 clearly stated in the physician's order for observation.

The patient must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate legible progress notes that are timed, written, and signed by the physician.

Coverage criteria for hospital billing of observation room services require that services are:
Reasonable and necessary to evaluate an outpatient's condition or to determine the need for admission.
Provided as a result of a physician's order or one by another practitioner authorized by state licensure law to admit patients or order outpatient tests.

Revenue code 0762 must be billed with the services units reported as the number of hours that the outpatient is in observation status.

Hospital billing for observation services begins on the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with the physician's order for observation services. A patient's time receiving observation services (and hospital billing) ends when all clinical and 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 released or admitted as an inpatient.

Non-covered observation services include:

- Services that are not reasonable and necessary for the diagnosis or treatment of the patient, but are provided for the convenience of the patient, his or her family, or a physician.
- Services covered under other services, such as post-operative monitoring during a standard recovery period (e.g., four to six hours) should be billed as recovery services; routine preparation services furnished prior to diagnostic testing and recovery afterwards that are included in the payment for the diagnostic service.
- Standing orders for observation following outpatient surgery.
- Observation time over 48 hours will be denied.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A						
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	99217	99218	99219	99220	99224	99225	99226
	99234	99235	99236				
Revenue Codes:	0762						
Deleted Codes:	N/A						

Policy History

Initial Committee Approval Date:	May 19, 2015
Code Update:	N/A
Policy Review Date:	June 9, 2016 August 2, 2017 April 6, 2020 May 27, 2021
Cross Reference:	Evaluation and Management – 003 Hospital and Skilled Nursing Facility Care