Observation Reimbursement Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Passport by Molina Healthcare reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Policy

Passport by Molina Healthcare follows the observation guidelines outlined in the Current Procedural Terminology (CPT) Manual. 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 a patient will require further treatment as a hospital inpatient or if the patient is able to be discharged from the hospital.

Observation services are commonly ordered for a patient who presents to the Emergency Department (ED) and who then requires a significant period of treatment or monitoring to decide on admission or discharge**.**

Per CMS, Observation services generally do not exceed 24 hours. Typically, the decision to discharge a patient from the hospital following observation care or to admit the patient as an inpatient can be made in less than 48 hours, The billing of and reimbursement for observation services are limited to rendered observation services that were specifically medically necessary and typically do not exceed 48 hours.

Hospital outpatient observation services are reported with the Centers for Medicare and Medicaid Services (CMS) HCPCS codes G0378 and G0379. CMS publishes guidelines for use of these codes to allow for consistent coding and billing by facilities reporting observation services.

Professional Providers

All related Evaluation and Management (E/M) services provided on the same date of service (DOS) by the performing provider are considered integral to the observation care E/M code. Providers billing for unrelated E/M services provided on the same DOS by the same performing provider must append modifier 25 when the service is separately distinct and unrelated to the observation care.

Similarly, all related E/M services, including observation care, provided on the same DOS by the same performing provider are considered integral to an Inpatient E/M admission code. Practitioners providing observation care may report a valid observation E/M CPT code for the professional service(s) on a CMS-1500 Claim Form when the patient is not subsequently admitted as an inpatient on the DOS.

Time

Observation time starts at the time documented in the nurse's notes as to when the patient entered an observation status. Observation time ends at the time documented in the Physician or Other Qualified Healthcare Professional (QHP) discharge orders. This time should coincide with the end of the patient's treatment in observation.

Direct referrals observation time begins after the patient arrives at the facility and it is documented in the medical record that observation time has started. Hospitals should round to the nearest hour when reporting observation care; however, the total time should exclude any "carved out" time that carry an inherent time component for the service being billed (e.g., emergency room services, infusion services, services rendered billed exclusively by time, surgical, diagnostic, therapeutic services, etc.).

Reimbursement

Reimbursement will be the lesser of charges or the fee schedule rate based on the terms of your contract. The uniform payment rate will be based on the number of hours the patient is in an observation status, not to exceed 48 hours unless otherwise supported by documentation of medical necessity. When observation care is present on a surgical claim, the observation room charges will continue to be included in the surgical roll-up methodology.

Global Period

Observation Care codes are not separately reimbursable services when performed within the assigned global period of a procedure or service. Observation care services, during a global period, are included in the global package.

Authorization Requirements

Observation services do not require prior authorization; However, if a procedure is performed during an observation stay that requires an authorization the facility or Provider must seek authorization approval for that procedure.

Documentation of Observation Services

Passport reserves the right to request medical records, at any time, to confirm medically necessary services and/or accurate billing of observation services.

Coding & Billing Guidelines

The guidelines below outline the correct billing for professional and facility claims based on the individual scenario and claim forms used.

Scenario	CMS-1500 Claim Form	UB-04 Claim Form
Observation Care & Inpatient Admission on same DOS with inpatient discharge	Admission & Discharge (A&D) • Report Initial Observation/Inpatient (Including A&D) E/M (99234-99236) Place of Service • 19 or 22 Note: Performing provider may not separately report any E/M codes for evaluations related to the inpatient admission	Type of Bill • Inpatient 111 Revenue Code • 0762
Observation Care & Inpatient Admission on same DOS with inpatient admission spanning more than one DOS	Date of Admission • Report Initial Hospital E/M (99221-99223) Subsequent Hospital Care • Report Each Subsequent Day Hospital E/M (99231-99233) Discharge Date • Report Discharge Hospital E/M (99238-99239) Place of Service	Type of Bill • Inpatient 111 Revenue Code • 0762

	• 21 Note: Performing provider may not separately report any E/M codes for evaluations related to the inpatient admission	
Observation E/M not resulting in an inpatient admission	One DOS • Report Initial Observation/Inpatient E/M (99234-99236) Spanning Two DOS • Report Prolonged Inpatient/Observation E/M (99418) Spanning Multiple DOS • Report Prolonged Inpatient/Observation E/M (99418) • Report Each Subsequent Day Observation E/M (99231-99233) Place of Service • 19 or 22 Note: Performing provider may not separately report any E/M codes for evaluations related to the Observation Care	Observation Care Per Hour Type of Bill • Outpatient 131 Revenue Code • 0762 HCPCS Code • G0378 Note: Units must list total hours patient was in observation care status Direct Observation Care from Community Setting Type of Bill • Outpatient 131 Revenue Code • 0760, 0761 or 0769 HCPCS Codes • G0379 & G0378 Note: G0379 must be reported with one unit and be billed on same date as G0378

Documentation History

Type	Date	Action
Effective Date	01/01/2021	New Policy
Revised Date		

References

1. Current Procedural Terminology (CPT) Manual
2. Healthcare Common Procedure Coding System (HCPCS) Manual
3. Centers for Medicare & Medicaid Services (CMS). https://www.cms.gov/medicare-coverage-database/view/article.aspx?
4. Centers for Medicare & Medicaid Services (CMS). Reviewing Short Stay Hospital Claims for Patient Status: Admissions on or After January 1, 2016— Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf (cms.gov)
5. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B (Rev. 267, 02-04-20). — Medicare Benefit Policy Manual (cms.gov)
6. 907 Chapter 3 Regulation 010 • Kentucky Administrative Regulations • Legislative Research Commission Link: - Title 907 Chapter 3 Regulation 010 • Kentucky Administrative Regulations • Legislative Research Commission

Supplemental Information

Definitions

Term	Definition