Product Applicability

☑ All Plan* Products

Boston Medical Center HealthNet Plan*
☒ MassHealth
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Commonwealth Care
☒ Commonwealth Choice/Employer Choice

Well Sense Health Plan*
☐ New Hampshire Medicaid

Effective Date: 01/01/2012
Policy Number: 4.36

This policy is intended to serve as a general guide for reimbursement. Please refer to the MassHealth Member Handbook, BMC HealthNet Plan Qualified Health Plans, including ConnectorCare, the Commonwealth Care or Commercial Evidence of Coverage (EOC), Schedule of Benefits (SOB) and your provider contract for specific terms of coverage and reimbursement. Unless otherwise specified in writing, reimbursement will be made at the lesser of the billed charges, or the contractual schedule of payments. Use of this policy does not guarantee payment.

Prior-authorization

Please refer to the Plan’s Prior Authorization Requirements Matrix at www.bmchp.org.

Definitions

N/A

Policy Statement

The Plan reimburses covered services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy.

Reimbursement is based on member benefits and eligibility, medical necessity review, where applicable, coordination of benefits, adherence to Plan policies, clinical coding criteria, and the BMC HealthNet Plan agreement with the rendering or dispensing provider. Plan policies may be amended at BMC HealthNet Plan’s discretion. All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including NCQA.
Service Reimbursement
The Plan covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, but shall not exceed 48 hours without authorization, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document the time when those services began and ended, the purpose of observation, and the name of the physician who ordered the Member to observation status.

Physician Services
- When a patient receives observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT code range 99218 – 99220, shall be reported by the physician. The Observation Care Discharge Service, CPT code 99217, shall not be reported for this scenario.
- When a patient is admitted for observation care and then is discharged on a different calendar date, the admitting physician shall report Initial Observation Care, from CPT code range 99218 – 99220, and CPT observation care discharge CPT code 99217.
- When a patient receives observation care for a minimum of 8 hours, but less than 24 hours, and is discharged on the same calendar date, Observation or Inpatient Care Services (Including Admission and Discharge Services) from CPT code range 99234 – 99236 shall be reported. The observation discharge, CPT code 99217, cannot also be reported for this scenario.

Facility Observation Units
- Admission to observation must be made via physician order. Neither the time the order is written nor the time a bed is reserved constitutes the start of observation time.
- Observation time begins at the clock time documented in the nursing notes/flow sheets or progress notes as the time the patient is, in fact, placed in a bed for the purpose of initiating observation care.
- Observation time ends when the patient is actually discharged from the hospital or at midnight of the day prior to being admitted as an inpatient.
- Observation time may include medically necessary services and follow-up care provided after the time the physician writes the discharge order, but before the patient is discharged.
- Reported observation time does not include the time a patient remains in the observation area after treatment is finished for reasons such as waiting for transportation home or transfer to another healthcare setting.

Emergency Department Services Preceding Observation Stay
- When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed.
Inpatient Admission Following Observation Stay

- DRG-based reimbursement includes all related observation services that occur within three days of the date of admission.
- Per diem, case rate, and percent-of-charge based reimbursement includes any observation stay that converts to an inpatient admission before midnight of the same day and is not separately reimbursed. When billing for admissions that meet this criteria, providers should omit charges associated with revenue code 0762 on the day of admission since they are not payable.
- Per diem, case rate, and percent-of-charge based reimbursement does not include an observation stay that converts to an inpatient admission after midnight of the observation day and is separately reimbursed.
- This policy term applies to all providers irrespective of the reimbursement methodologies identified in the hospital’s participation agreement.

Obstetrical Observation Stays

- When an obstetrical patient is placed in observation status the episode is considered an observation stay if delivery does not occur and the member is sent home. The entire episode is considered an inpatient admission if delivery occurs prior to discharge.

Service Limitations

Observation stay is *not* considered an appropriate designation for the following, and is therefore not reimbursed:

- Preparation for, or routine recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies, endoscopic procedures)
- The routine recovery period following an ambulatory surgery center or an outpatient procedure
- Services routinely performed in the emergency department or outpatient department
- Observation care services submitted with routine supervision of pregnancy diagnoses
- Retaining a member for socioeconomic factors
- Custodial care

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.
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Origination Date: 10/11/2011

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>0729</td>
<td>Obstetric Observation not resulting in delivery prior to discharge</td>
</tr>
<tr>
<td>0762</td>
<td>Observation Room</td>
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</tbody>
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<tr>
<th>Codes</th>
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<tbody>
<tr>
<td>99217</td>
<td>Observation care discharge day management</td>
</tr>
<tr>
<td>99218</td>
<td>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.</td>
</tr>
<tr>
<td>99219</td>
<td>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.</td>
</tr>
<tr>
<td>99220</td>
<td>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.</td>
</tr>
<tr>
<td>99234</td>
<td>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.</td>
</tr>
<tr>
<td>99235</td>
<td>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.</td>
</tr>
<tr>
<td>99236</td>
<td>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.</td>
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</tbody>
</table>

References
Legal and Regulatory References

- 130 CMR 410.414
- Medicare Claims Processing Manual Chapter 4 - Part B Hospital, 290 - Outpatient Observation Services
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Evidence of Coverage, Form No. BMCHP-CC-8
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan

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Other References
N/A

In addition to the above regulations, any bulletin issued to amend or otherwise change the above regulations are herein incorporated as references.

Related Policies
- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Inpatient Hospital, 4.112
- Obstetrical, 4.105
- Outpatient Hospital, 4.17
- Physician and Non Physician Practitioner Services, 4.608

Policy History and Approval Dates
Review Dates/Revisions
10/11/2011 – Initial approval
12/02/2013 – Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare
12/17/2014 – Annual review, template and coding updated

Approval Dates
Original Effective Date: 01/01/2012
Original Internal Approval: 10/11/2011
Original Regulatory Approval: N/A