BlueCross BlueShield of New Mexico

If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSNM may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Observation Services Policy

Number: CPCP001

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: May 22, 2023

Plan Effective Date: May 30, 2023

Description:

This policy applies to observation services provided at all facilities. This policy is not intended to address every reimbursement situation that may arise.

Observation care may be appropriate for members requiring short-term evaluation for a condition, treatment for a known condition, or monitoring for recovery. It can also be appropriate when repeat testing or re-evaluation is necessary to determine the member's diagnosis and care needs. Observation care provides a method of evaluation and treatment as an alternative to inpatient hospitalization.

Observation services may only be considered for reimbursement when provided under a physician's order or under the order of another person who is authorized by state licensure law and the provider organization's bylaws to admit members to the facility and order outpatient testing. Observation services may also be considered when the member does not meet

inpatient level of care and meets observation level of care.

Observation services must be member-specific and not part of a standard operating procedure or facility protocol for a given diagnosis or service.

Reimbursement Information:

Time

Observation time **begins** at the time documented in the member's medical record as to when the member entered observation status, that coincides with the time that observation care is initiated per the physician's order. Observation time **ends** when the services associated with observation care are completed that should coincide with the discharge orders. The observation stay hours must be documented in the "units" field on the claim form. Any care provided before the physician's order for observation, or after the physician's order for inpatient admission or discharge, is excluded from the total observation time. In most cases, the decision to discharge a member from observation care or admit to inpatient status can usually be made in less than 24 hours but not more than 48 hours. If the member's condition does not improve within 48 hours, providers should submit an authorization request for inpatient admission with clinical information that supports the inpatient level of care. Note, observation services beyond 72 hours are not eligible for reimbursement.

Additionally, if the member is discharged from observation and subsequently admitted as an inpatient, all services provided to the member while in observation are included on the inpatient claim without modifying the inpatient dates of service. E.g., The member is in observation on January 7th through January 8th, and admitted to inpatient status on January 9th. The FROM date in box 6 should be January 9th. The observation charges from January 7th through January 8th should be included on the inpatient claim.

Services Considered Not Appropriate for Observation Services include, but are not limited to:

- Chemotherapy administration;
- Lack of, or delay in, patient transportation;
- Provision of a medical exam for members who do not require skilled medical or nursing services;
- Routine preparation prior to, and recovery following, diagnostic testing;
- Routine recovery and post-operative care following ambulatory/outpatient surgery; Observation cannot be billed while the member is in routine recovery and post-operative care status.
- Services provided for the convenience of the physician, member or member's family;
- Services provided when an overnight stay is planned prior to diagnostic testing and observation criteria are not met;
- General standing orders following outpatient surgery that should be billed as recovery room

services;

- Services that would normally require inpatient stay;
- Services following an uncomplicated treatment or procedure;
- Services provided concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure (e.g., colonoscopy);
- Services provided when an inpatient is discharged to observation status;
- Services that are not reasonable and necessary for the care of the member;
- Services beyond 48 hours (Note, some contracts preclude this circumstance); Observation does not require prior authorization. However, if the member converts from observation to inpatient, the admission may require prior authorization;
- Observation status does not apply when a member is treated as an outpatient only for administration of blood and receives no other medical treatment. The use of hospital facilities is inherent in administration of blood and is included in the reimbursement for administration.

Documentation

The plan reserves the right to request supporting documentation to determine eligible reimbursement. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims are reviewed on a case-by-case basis. Documentation should include, but not limited to, the following information:

- The attending physician's order for observation care with clock time (or clock time noted in a nurse's observation admission note);
- The physician admission and progress notes confirming the need for observation care;
- The supporting diagnostic and/or ancillary testing reports;
- The admission progress notes (with the clock time) outlining the member's condition and treatment;
- The discharge notes (with clock time) with discharge order and nurse notes;
- The member must be under the care of a physician or qualified non-physician practitioner during the time of observation care and this care must be signed and documented in the medical record.

Coding and Billing Information

Inclusion of a code in this policy does not guarantee reimbursement. Appropriate coding is key to minimizing delays in claim(s) processing. Providers must ensure revenue codes and procedure codes accurately reflect the services rendered. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Professional Providers

If a member is admitted as inpatient, the performing provider must not separately report Evaluation and Management (E/M) codes for evaluations related to that inpatient admission. If a member is not admitted as inpatient, the performing provider must not separately report any E/M codes for evaluations related to the observation care. The following are examples of correct coding:

Observation care and inpatient admission are on the same date of service as the inpatient discharge	**Place of Service-** 19 or 22 **For the admission and discharge-** Report the initial observation and inpatient admission, including the admission and discharge E/M code(s) (99234-99236)
Observation care and inpatient admission on the same date of service with the inpatient admission being over one day of service	**Place of Service**- 21 **For the date of the admission**- Report the initial hospital inpatient or observation care E/M code(s) (99221-99223) **Subsequent observation care**- Report each subsequent day hospital inpatient or observation care E/M code(s) (99231-99233) **Discharge date**- Report discharge hospital inpatient or observation discharge service code(s) (99238,99239)
Observation E/M that does not result in an inpatient admission	**Place of Service**- 19 or 22 **For one date of service**- Report the hospital inpatient or observation care services E/M code(s) (99234-99236) **For two dates of service**- **1)** Report the initial hospital inpatient or observation care E/M code(s) (99221-99223) **2)** Report discharge hospital inpatient or observation discharge service code(s) (99238,99239)

<u>Facilities</u>

Hospitals must bill the HCPCS codes G0378 or G0379 when billing on the UB-04 Claim Form. Hospitals should not report the CPT codes for physician observation when reporting the hospital observation services on the UB-04 Claim Form.

HCPCS code G0378 must be billed with revenue code 0762 and the units equal to the number of hours the member is in an observation status. Providers will not be allowed to bill more than one line of 0762 on the UB-04 Claim Form. HCPCS code G0379 is used when the member is referred directly to observation care after being seen by a practitioner in the community and without an associated Emergency Room (ER) visit, hospital outpatient clinic visit, or critical care service on the same date of service (DOS) as the initiation of observation care. G0379 may be reported with only one unit and must be billed in conjunction with G0378.

Observation care and inpatient admission are on the same date of service as the inpatient discharge	**Revenue Code-** 0762 **Type of Bill (TOB)-** Inpatient 111
Observation care and inpatient admission on the same date of service with the inpatient admission being over one day of service	**Revenue Code**- 0762 **TOB**- Inpatient 111
Observation E/M that does not result in an inpatient admission	**Observation Care Hourly:** **Revenue Code**- 0762 **TOB**- Outpatient 131 **HCPCS Code**- G0378 **Direct admission of observation by community setting:** **Revenue Code**- 0760, 0761 or 0769 **TOB**- Outpatient 131 **HCPCS Codes**- G0378, G0379

Note: If a procedure interrupts observation services, each period of observation services is recorded with the beginning and ending times during the hospital outpatient encounter. The length of time for the periods of observation services should be added together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378.

Additional Resources

Clinical Payment and Coding Policies

CPCP002 Inpatient/Outpatient Unbundling Policy-Facility

References:

Medicare Claims Processing Manual Chapter 4, Section 290.2.2 “Reporting Hours of Observation”, Rev. 11305, Revised 03-24-22

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Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI), Medicare NCCI Medically Unlikely Edits (MUEs). Accessed 4/20/2023: https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-medically-unlikely-edits

Policy Update History:

Approval Date	Description
11/01/2016	Policy approved for BCBSTX only
03/22/2017	Policy approved by CPCP Committee; Adopted at Enterprise level
03/23/2018	Annual Review
03/26/2019	Annual Review
05/26/2020	Annual Review, Disclaimer Update
07/20/2021	Annual Review
05/22/2023	Annual Review