BlueCross BlueShield Minnesota

MEDICARE REIMBURSEMENT POLICY

Hospital Inpatient and Observation Care Services

Active

Section: Evaluation and Management
Policy Number: 004
Effective Date: 05/01/24

Description

This policy addresses coding and reimbursement for hospital inpatient and observation care services submitted on a professional (837P) claim.

This policy does not apply to Platinum Blue.

Definitions

Initial service: An initial service occurs when the patient has not received any professional services from the physician or other qualified health care professional (QHP) or another physician or other QHP of the same specialty and same group practice during the stay.

Observation Care: As defined by the Centers for Medicare and Medicaid Services (CMS), 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 patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. For patients designated/admitted as "observation status" in a hospital, it is not necessary that the patient be located in an observation area designated by the hospital.

Subsequent service: A subsequent service occurs when the patient has received professional services from the same physician or other QHP or another physician or other QHP of the same specialty and the same group practice during the stay.

Policy Statement

The Current Procedural Terminology (CPT®) codes for hospital inpatient and observation services are defined as initial (99221, 99222, 99223), subsequent (99231, 99232, 99233), admission and discharge same day (99234, 99235, 99236) and discharge services (99238, 99239).

Initial Hospital Inpatient or Observation Care (99221,99222,99223)
Codes 99221, 99222, 99223 are used to report a patient's first hospital inpatient or observation status encounter with a physician or other QHP. As indicated in their descriptions, codes 99221, 99222 and 99223 are to be billed "per day', and include all services provided by the physician or other QHP on that day. Therefore, when a patient is admitted to observation or as a hospital inpatient via another site of service (such as hospital, ED, office, nursing facility), all services

provided by the physician or QHP in conjunction with that admission are considered to be included in the initial hospital inpatient or observation care code when performed on the same date as admission. The level of the Initial Hospital Inpatient or Observation Care CPT code reported should incorporate the preadmission services provided by the physician or QHP. Blue Cross will not separately reimburse for these preadmission services.

Observation Transition to Inpatient Status
A transition from observation to inpatient status is considered to be the same episode of care and does not constitute a new stay. Therefore, when the same physician or other QHP admits a patient from observation to inpatient status, Blue Cross will only reimburse for one initial inpatient or observation care code for the entire stay.

Observation Care Only
When billing for observation services that do not result in an inpatient admission, only the physician or QHP who orders/supervises the patient's observation care may use observation codes. The ordering/supervising physician or QHP should append modifier AI (Principal physician of record) to the observation code(s). All other practitioners must bill the appropriate non-observation, outpatient service code(s).

Subsequent Hospital Inpatient or Observation Care (99231,99232, 99233)
Subsequent hospital inpatient or observation care services should be reported with codes 99231, 99232, 99233 as appropriate. Payment is for all the care provided by the physician or QHP on the days other than the initial or discharge date.

Hospital Inpatient or Observation Care Admission and Discharge on the Same Date of Service (99234,99235,99236)
For a patient admitted and discharged from hospital inpatient or observation care services on the same date of service, codes 99234, 99235, 99236 should be submitted as appropriate. These codes should only be reported when the patient is seen by the physician or QHP at 2 separate visits on the same date – one for the admission and the other for discharge. When a patient is admitted and discharged at the same visit, an initial code (99221-99223) should be submitted.

Hospital Inpatient or Observation Discharge Services (99238,99239)
Codes 99238 and 99239 are used to report all services provided by the physician or QHP on the date of discharge, when discharge is on a date other than the initial day of hospital inpatient or observation care.

These codes represent a face-to-face service between the physician or QHP and the patient, and they are to be reported for the date of the actual visit even if the patient is discharged from the facility on a different calendar date.

Only the physician or QHP responsible for the discharge service may report codes 99238 or 99239, and Blue Cross will only reimburse one claim for codes 99238 or 99239 per patient, per hospital stay. Other physicians or QHPs who have managed concurrent health care problems and are not acting on behalf of the ordering/supervising physician or QHP, must use Subsequent Hospital Inpatient or Observation Care codes (99231 - 99233) for a final visit.

Stays Less than 24 Hours

Correct reporting of stays that are less than 24 hours depends on the actual number of hours a patient spends in inpatient and/or observation care and whether the discharge occurs on the same or a different calendar date:

Patient time in Hospital Inpatient and Observation Care	Date of discharge	Report
Less than 8 hours	Same calendar date as admission or start of observation	Initial hospital inpatient or observation care codes only*
8 or more hours	Same calendar date as admission or start of observation	Hospital Inpatient or Observation Care Admission and Discharge on the Same Date of Service codes*
Less than 8 hours	Different calendar date than admission or start of observation	Initial hospital inpatient or observation care codes only*
8 or more hours	Different calendar date than admission or start of observation	Initial Hospital Inpatient or Observation Care CPT codes* + Hospital Inpatient or Observation Discharge Day Management CPT codes

*Plus, prolonged inpatient/observation services, if applicable.
For prolonged inpatient/observation services refer *to Medicare Evaluation and Management – 006 Prolonged Services Reimbursement Policy*.

Hospital Inpatient and Observation Care Services During the Global Period
Hospital inpatient and observation care codes are not separately reimbursable during the global period of a procedure or service unless the criteria for use of CPT modifiers 24, 25 or 57 is met. Hospital inpatient and observation care services during a global period are included in the global surgical package. Refer to *Medicare Surgery/Intervention Procedure - 007 Global Surgical Package Reimbursement Policy*.

Documentation Submission

When billing observation care codes, there must be supporting medical record documentation, including timed and dated physician orders for observation services, nursing notes and physician progress notes. Documentation of observation services must be in addition to emergency department or outpatient clinic records. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

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:	24	25	57	AI			
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	99221	99222	99223	99231	99232	99233	99234
	99235	99236	99238	99239			
Revenue Codes:	N/A						

Resources

Current Procedural Terminology CPT®
Medicare Claims Processing Manual, Chapter 12
CY 2023 Physician Fee Schedule Final Rule

Policy History

05/19/2015	Initial Committee Approval Date
04/06/2020	Annual Policy Review
05/27/2021	Annual Policy Review
07/26/2022	Annual Policy Review
01/24/2023	Annual Policy Review
11/28/2023	Revised – Created separate Medicare policy
04/23/2024	Annual Policy Review