Gateway Health
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FREQUENTLY ASKED QUESTIONS
Related to
OBSERVATION and EXTENDED ASSESSMENT and MANAGEMENT in FACILITIES
Medical Payment and Prior-Authorization Policy

This FAQ is intended as a supplemental resource to the above referenced policy located at http://www.gatewayhealthplan.com/ReimbursementPolicies.

GENERAL QUESTIONS:

Q. When did this policy go into effect?
R. Gateway Health℠ implemented the Observation and Extended Assessment Medical Payment and Prior-Authorization Policy effective for dates of service July 1, 2015 for its Pennsylvania Medicaid business.

Q. Are observation stays a covered benefit for Medicaid?
R. Observation is not a Medicaid covered benefit and as such, Medicaid does not set guidelines for the service. Absent those guidelines, Gateway has clarified our guidelines for the use of observation and they are very similar to the Center for Medicare and Medicaid Services (CMS) requirements.

Q. What is Gateway's definition of observation status?
R. Observation status applies to patients for whom an inpatient hospital admission is being considered but is not certain.

Q. When should observation status be used?
R. Observation status should be considered when the member's condition is expected to be evaluated and/or treated within 48 hours with follow-up care provided on an outpatient basis or the member is admitted to the hospital.

AUTHORIZATION QUESTIONS:

OBSERVATION STAYS DO NOT REQUIRE PRIOR-AUTHORIZATION!

Q. Under the new policy will Gateway authorize an admission that is less than 24 hours?
R. Gateway's UM department should not be contacted for any inpatient stay less than 24 hours. (See exclusions.) Please note, if a member is admitted less than 24 hours, prior authorization request is not required for observation. Inpatient stays will not be reviewed until after 24 hours have passed.

Q. When does the clock start for 24 hours?
R. The time entered into your system when the patient is registered/triaged is when the clock starts. This should coincide with the time that comes across on the UB-04 claim form.

Q. Are patients that expire before 24 hours still considered observation even if the doctor wrote the inpatient order?
R. Yes. Facilities may file an appeal for observation cases in the event the patient expires before 24 hours has passed.

Q. Will Gateway prior authorize hospital-to-hospital transfers even if the stay is less than 24 hours?
R. Yes, Gateway's UM department will prior authorize hospital to hospital transfers even when the stay is less than 24 hours.

Q. How will the new policy affect same day surgery admissions?
R. The new policy does not affect same day surgery admissions. Providers must continue to follow existing guidelines.

Q. Does this new policy affect the process for authorizing maternity admissions (moms and babies)?
R. No. The process is unchanged. Providers must continue to fax Gateway the Maternity Authorization Form.

Q. Is an authorization required if a member is admitted following observation?
R. If a member is admitted as an inpatient following observation, outpatient surgery or an emergency room event, the Facility is required to obtain an authorization. Failure to obtain an authorization could result in the inpatient claim and all other billed services being denied.

EXCLUSIONS:

Q. Are there any less than 24 hours diagnoses/situations where Gateway will pay the inpatient level of care?
R. Yes. Patients who sign out Against Medical Advise (AMA), deaths in < 24 hours, live infant deliveries and spontaneous abortions, and authorized transfers to a different facility will still be paid as inpatient level of care for stays that are less than 24 hours

CODING and BILLING QUESTIONS:

Q. What is Gateway's billing requirements for observation?

R. All of the following requirements must be met in order for a hospital to receive payment for observation:

- There must be a physician order to place the patient in observation.
- Observation time must be documented in the medical record.
- Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services. A member's time receiving observation services (and hospital billing) ends when all clinical or 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.
- The observation stay must span a minimum 8 hours and these hours must be documented in the "units" field on the claim form.
- The patient must be under the care of a physician or non-physician practitioner during the time of observation care, and this care must be documented in the medical record with an order for observation, admission notes, progress notes, and discharge instructions (notes) all of which are timed, written, and signed by the physician.

Q. Are there specific coding requirements?

R. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- A Type A or B emergency department visit (CPT codes 99284 or 99285 or Revenue Code 762 with HCPCS code G0384); or
- A clinic visit (HCPCS code G0463); or
  Critical care (CPT code 99291); or
- Direct referral for observation care reported with Revenue Code 760 with HCPCS code G0379 must be reported on the same date of service as the date reported for observation services. The number of units reported with HCPCS code G0378 or HCPCS Code G0379 must equal or exceed 8 hours.
- For payment, a HCPCS Type A ED visit code 99284, 99285, or G0384 Type B ED visit code, critical care (99291), or a G0463 HCPCS clinic visit code is required to be billed on the day before or the day that the patient is placed in observation. If the patient

is a direct referral to observation the G0379 may be reported in lieu of an ED or clinic code. In addition, the E/M code associated with these other services must be billed on the same claim form as the observation service and the E/M must be billed with a modifier -25 if it has the same date of service as the observation code G0378.

Q. What revenue code should I bill for observation services?
R. It depends. Observation services performed on an outpatient basis, as part of an Emergency Room visit, or as a result of false labor should be billed with a 762 revenue code.

If a provider contacts Gateway's UM department for authorization of an admission that is less than 24 hours, UM will advise the provider that an authorization is not required for observation services and to bill with a 760 revenue code.

Q. Can I bill for observation when the physician orders are written for an inpatient stay?
R. No. That is not in compliance with the policy nor industry standards.

Q. What will happen if I bill an inpatient admission that has not been authorized?
R. If an inpatient admission is billed and has not been authorized, the inpatient admission will be denied for no authorization. The hospital is not permitted to rebill and change the level of care after the fact. The hospital does have the right to file an Appeal.

Q. Can a facility bill for observation separate from an authorized inpatient stay?
R. No. Observation services provided prior to an authorized admission will be covered by the inpatient admission authorization and payment. The admission date will be the date the patient presented to the facility.