PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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I. RELATED POLICIES:

A. MCUP3014 - Emergency Services
B. MCUG3024 - Inpatient Utilization Management
C. MCUG3118 - Prenatal and Perinatal Care

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Observation Stay: A period of up to a maximum of 48 hours when a Member's medical condition requires continuous monitoring on an out-patient basis to evaluate patient's medical condition or to determine need for in-patient admission. Such services are covered only when provided by the order of a physician. An observation day should be billed as 1 unit per each 24 hour period to a maximum of 2 units for a 48 hour period.
B. Labor Check: An in-hospital evaluation of a pregnant Member beyond 20 weeks from the last menstrual period (LMP) who presents with a complaint of uterine contractions or suspected rupture of membranes. Claims for labor checks are considered only if the woman is evaluated and discharged. If a woman is admitted to the hospital based upon the findings at the labor check, the labor check visit is considered to be a component of the inpatient stay and is not paid as a separate claim.
C. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual-Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. N/A

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V. PURPOSE:

This policy describes the conditions under which observation codes should be used for the care of Partnership HealthPlan of California Members.

VI. POLICY / PROCEDURE:

A. Providers can bill the observation code when a Member's medical condition requires continuous monitoring for an additional period of time beyond what is usual and customary for the service provided up to a maximum of 48 hours.

B. Emergency Services: The observation code is to be used if the Member requires more than two hours of continuous monitoring starting from the time that the initial clinical assessment has been completed. Reassessments of the Member's condition must occur at least every 20-30 minutes.

C. Post-Operative Recovery Services: Member must require monitoring for more than two hours after leaving the surgical area in order to use observation codes. Monitoring must be performed in order to evaluate the Member for postoperative complications and nursing reassessment must be done every 20-30 minutes. The observation code can be billed at one unit for each 24-hour period up to a maximum of 48 hours or 2 units. The first two hours are covered by the recovery room fee.

D. Outpatient Services: Member must require monitoring for more than two hours following an outpatient procedure or treatment. Monitoring must be necessary in order to stabilize the Member before discharge and nursing reassessment must be done at least every 20-30 minutes. The observation code can be billed beyond the second hour.

E. Labor and Delivery (L&D): Obstetrical patients seen in the context of a labor check may require observation for a time period beyond one hour to determine whether labor is present or in order to evaluate a potential medical or obstetrical problem. In this case, the claim should be submitted with the observation code (with the number of observation units indicated), and not as a labor check. Individual interventions may be ordered and billed to Partnership as described below:

1. Obstetrical Observation Claims using code Z7514:
    a. When a pregnant Member beyond 20 weeks from the LMP is evaluated in labor and delivery for an urgent obstetrical condition other than active contractions or suspected rupture of membranes, only the observation code should be used and not the labor check code.
    b. Monitoring must include nursing reassessment at least every 20-30 minutes with detailed notes regarding the Member's obstetrical status. The observation code Z7514 can be billed by the facility if the Member is monitored in the labor and delivery area and no other room charges are billed.
    c. During the observation period, individual interventions such as stress and non-stress tests, diagnostic ultrasound evaluations, and non-routine laboratory tests may be ordered and then billed to Partnership.
    d. Partnership reviews for medical necessity all claims submitted for "observation" of obstetrical patients. The medical record pertaining to the observation period must be submitted with the claim.
2. Labor checks are to be billed with code 99221 and are an all-inclusive code, payable to the clinician.
    a. Labor checks include, but are not limited to:
        1) Check-in and interval history
        2) Fetal monitor strip [not full non-stress test (NST)]
        3) Cervix check; sterile speculum exam if necessary
        4)
        5) Sonogram for fetal position and fetal heart rate (FHR), as needed
        6) Blood pressure checks.
    b. Partnership pays for up to three labor checks per Member per 24-hour period. A single labor check can be billed per confinement in L&D; multiple claims for labor checks are not paid if

provided during the same confinement.

c. Non-stress tests, contraction stress tests, and routine prenatal labs are not paid if provided during a labor check. Lab services are paid if medically necessary.

d. If a labor check requires observation for over one hour, or if evaluation of a potential medical or obstetrical problem is necessary, the claim must be submitted as an observation claim "Z7514" rather than a labor check.

3. In some hospitals, pregnant patients over a specified gestational age (usually 20 weeks LMP) are referred to L&D, rather than the emergency department, for evaluation of non-obstetrical problems, as well as those related to pregnancy.

a. Claims for urgent problems not requiring either a labor check or observation are paid at the emergency department or urgent care visit rate.

b. Claims for emergent problems are paid on a fee for service basis. If an observation period is necessary beyond the time needed for initial patient evaluation, the observation billing code Z7514 may be used.

c. The same diagnosis and procedure codes used to differentiate between emergent and urgent care visits in the emergency department are used for non-obstetrical evaluations.

d. If a pregnant Member is evaluated and treated for a non-obstetrical problem in the L&D area, the provider must bill according to Partnership policy MCUP3014 Emergency Services policy for payment of emergent or urgent problems. Claims for emergent problems are paid on a fee-for-service basis.

F. If a Member requires more than 48 hours of monitoring, the claim must be made for an inpatient day and the fees will be covered by the hospital capitation rate or per diem rate if there is a physician's order to admit the Member as an inpatient and the Member meets medical criteria (InterQual® and/or Partnership policy). The observation rate will not be reimbursed when the Member is allowed to sleep at the site at a time when the Member does not require continuous monitoring.

VII. REFERENCES:

A. InterQual® Criteria
B. Medi-Cal Guidelines
C. Medicare Guidelines (for Partnership Advantage Members)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
04/09/2025

Medi-Cal
10/10/97 (name change only); 06/01/00; 04/18/01; 02/20/02; 10/20/04; 10/19/05; 11/16/05; 06/21/06, 08/20/08, 06/17/09; 07/21/10; 10/01/10; 11/28/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 03/13/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 03/13/24; 04/09/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

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PREVIOUSLY APPLIED TO:
MCUP3017 Health Services Review of Non-admission In-hospital Obstetrical Evaluations (Solano County Only) was Archived 04/12/2023

Healthy Kids KK UM113 11/16/2005; MPUP3018 (Healthy Kids program ended 12/01/2016)
06/21/06, 08/20/08, 06/17/09; 07/21/10; 10/01/10; 11/28/12; 02/18/15; 02/17/16 to 12/01/16

Healthy Families:
MPUP3018 - 10/01/2010 to 03/01/2013