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Reimbursement Policy

Title: Observation Care

Policy Number: RP-085

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Medicare Advantage:	PA, WV, DE, NY	Version Effective:	September 28, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	September 28, 2026
Claim Type:	CMS 1500 and UB04	History Versions:	N/A

Description:

Observation care is a well-defined set of specific, clinically necessary and 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 to make decisions concerning their admission or discharge.

Reimbursement Guidelines:

Hospital observation services are eligible for reimbursement separate from the emergency room charges when treatment and/or evaluation requires eight (8) or more hours.

Services that are otherwise eligible for reimbursement and include observation of the patient are not eligible for separate reimbursement consideration for the observation services (this list is not all-inclusive):

- Standing orders following outpatient surgery
- No professional provider orders for observation services
- Extended observation following a procedure
- Services provided concurrently with chemotherapy
- Inpatient discharged to outpatient observation status
- Outpatient blood administration (e.g., blood transfusion)
- Routine preparation prior to, and recovery after, diagnostic testing
- Routine recovery and post-operative care after same-day surgery
- Awaiting transfer to another facility

Applicable codes: 99234 99235 99236 G0378 G0379

Documentation Requirements

All documentation must be maintained in the medical record and available upon request. All pages of the record must be legible and include appropriate identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care to the individual. Failure to produce the requested information may result in a denial for the service.

The submitted medical record should support the use of the selected diagnosis code(s). The submitted Current Procedure Terminology (CPT®) and/or Healthcare Common Procedure System (HCPCS®) code should describe the service performed. The medical record for inpatient admissions should support the diagnoses and support the selection of the principle diagnosis. The physician documentation should clearly differentiate an order for outpatient observation from an order for inpatient admission and be dated and timed. The physician must:

1. Indicate in the medical record that the individual is designated or admitted as observation status; and
2. Clearly document the reason for the individual to be admitted to observation status; and
3. Initiate the observations status, assess, establish and supervise the care plan for observation and perform periodic reassessments.

Medical records will be expected to demonstrate the consistency between the physician order (physician intent), the services provided (inpatient or outpatient) and the medical necessity of those services, including the medical appropriateness of the inpatient or observation stay. The medical record must clearly support the medical necessity for observation and should include a timed order to observe which will support the number of hours billed. Physician services are expected to be billed consistent with an individual's status as an inpatient or an outpatient and since patient status may change prior to discharge, communication among those involved in the care of the individual is essential.

Coding:

Observation services must be reported on a single line and the date of service for that line is the date that observation care begins. Observation services should not be reported with a date span or on separate claim lines even when the period of observation care spans more than one (1) calendar day. When observation services are provided by the same hospital, or hospital system, on the day of, or immediately prior to an inpatient admission, the observation services are to be reported on the inpatient claim. Reimbursement will be included in the payment for the inpatient stay.

Hospital outpatient observation services are reported with the Centers for Medicare and Medicaid Services (CMS) codes G0378 and G0379. CMS publishes guidelines for use of these codes to allow for consistent coding and billing by facilities reporting observation services.

Observation services must be reported by facilities utilizing the following guidelines:

- Observation services are submitted with type of bill 13X, 78X, or 85X.
- Report HCPCS code G0378 (hospital observation service, per hour) under the appropriate revenue code (0762) with units that represent the hours in observation care (rounded to the nearest hour).
- Observation service code G0378 will only be considered for reimbursement when the observation period meets or exceeds eight (8) hours.

Observation services code G0378 should only be reported when one of the following services was also provided on the same date of service or the day before the date reported for observation.

- Emergency department visit (99281-99285, G0380-G0384), or clinic visit (G0463), or critical care (99291), or
- Direct referral for observation reported by G0379 which must be reported on the same date of service as the date reported for observation.

Facilities should report HCPCS code G0379 when observation services are the result of a direct referral/admission for observation care without an associated emergency room visit, hospital outpatient clinic visit or critical care service on the day of initiation of observation services. Facilities should only report G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Direct admission of a patient for hospital observation care code G0379 is not reimbursable if not submitted on the same date of service as G0378. In addition, code G0379 is not separately payable when a critical care service (99291), clinic service (G0463), emergency department visit, are reported on the same date of service. G0379 cannot be billed with code 99281-99285, G0380-G0384, G0463, or 99291.

Definitions:

N/A

References:

- Center for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS)
- CMS Medicare Benefit Policy Manual, Chapter 6, Section 20.6, MassHealth Acute Outpatient Hospital Manual 130 CMR 410.4
- CMS Medicare Claims Processing Manual: Chapter 4, Section 290.5.3; Chapter 12, Section 30.6.8
- Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS®)
- National Uniform Billing Committee (NUBC)

Related Plan Policies:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines
- RP-037: Emergency Evaluation and Management Coding Guidelines
- RP-042: Global Surgery and Subsequent Services
- RP-055: Nominal Charges
- RP-057: Evaluation and Management Services

Policy Update History:

9 / 2026	Implementation