Observation Services Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

***Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the facility or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies**.*

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities including, but not limited to, non-network authorized and percent of charge contract facilities.

Policy

Overview

Observation care is defined as a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require treatment or monitoring before a decision is made concerning their admission or discharge.

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

Reimbursement Guidelines

Observation Services (HCPCS code G0378)

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 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 (HCPCS code G0463), or
- Critical care (CPT code 99291), or
- Direct referral for observation care reported with HCPCS code G0379 which must be reported on the same date of service as the date reported for observation.

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 calendar day.

Observation care should not be reported for monitoring that is inclusive of, or included in payment for, a surgical, diagnostic, or therapeutic procedure (Example: observation associated with monitoring during surgical recovery or for routine preparation and recovery services required for a diagnostic test). HCPCS code G0378 will not be reimbursed when reported in addition to procedure codes that are assigned a status indicator of J1 or T under the CMS Integrated Outpatient Code Editor (IOCE).

The status indicator J1 and T code list can be found in the link below following this path: OCE Quarterly Release Files>OCE Quarterly Data Files>Data Table Reports>Data HCPCS.xlsx.
https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs

Direct Referral/Admission to Observation Care (HCPCS code G0379)

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 HCPCS code 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 (CPT 99291), clinic service (HCPCS G0463), emergency department visit, or a service assigned a status indicator of T or V under the CMS IOCE are reported on the same date of service.
Observation services are reported using HCPCS code G0378 Report units of hours spent in observation (rounded to the nearest hour).

State specific observation maximum hourly limits are based on state regulations and guidelines. Limits beyond the state hourly maximums will be denied.

State	Maximum Hourly Limit
Hawaii	48
Kansas	48
Maryland	24
Minnesota	48
Mississippi	23

State	Maximum Hourly Limit
Missouri	24
New Jersey	48
North Carolina	30
Texas	48
Washington DC	48

State Exceptions	
Medicaid facility claims paid under Ambulatory Patient Groups, or APG payment methodology are exempt from this policy	
Arizona	Exempt from policy
California	Exempt from policy
Florida	Exempt from policy
Indiana	• Indiana Medicaid does not require a CPT/HCPC for revenue code 0762 and does not cover HCPC G0378 • Revenue Code 0762 should be reported alone with the units of hours spent in observation (rounded to the nearest hour)
Maryland	• Per state regulations, if hospitals bill more than 24 hours under Revenue Code 0762, the entire claim will deny • Maryland is exempt from the 8 hour minimum
Massachusetts	Exempt from policy
Michigan	Exempt from policy
Mississippi	Per MSCAN: • The first 7 units are payable at zero, reimbursement is only made for units 8-23 • Services on claims billed with G0378 may span over 3 days, but all units of G0378 must be billed on one line of service
Missouri	• Per State Regulations, effective 7/1/2020, observation is covered from 24 up to 72 hours only when administering and monitoring Zulresso (HCPCs code C9055)
Nebraska	Exempt from policy
New York	Exempt from policy
North Carolina	• Per state regulations, observation is covered for the first 30 hours. Beyond 30 hours if the patient is not admitted to an inpatient status, the patient must be discharged • Per state regulation, when billing HCPC code G0378, North Carolina is exempt from the 8 hour minimum • Per state requirement NC will pay HCPCS code G0378 when reported in addition to procedure codes that are assigned a status indicator of J1 or T under the CMS integrated Outpatient Code Editor (IOCE) • Per state requirements NC will pay HCPCS code G0379 when a critical care service CPT 99291), clinic service (HCPCS G0463), emergency department visit, or a service assigned a status indicator of T or V under the CMS IOCE are reported on the same date of service
Ohio	Exempt from policy
Pennsylvania	Exempt from policy
Rhode Island	Exempt from policy
Tennessee	Exempt from policy
Texas	• Revenue Code 0762 should be reported alone with the units of hours spent in observation (rounded to the nearest hour)
Virginia	Exempt from policy

Washington	Exempt from policy
Washington DC	• Washington DC has a maximum of 48 hours for observation
Wisconsin	Exempt from policy

Codes

G0378	G0739

Attachments

Status Indicator J1 List	Status Indicator J1 List
Status Indicator T List	Status Indicator T List
Status Indicator V List	Status Indicator V List

Questions and Answers

1	**Q:** How do I report HCPCS code G0378 for observation care that began at 10:00 PM on one date (Friday), but was not discharged until 4:00 PM on the following day (Saturday)? **A:** Observation care is reported on a single claim line using the date of service on which the patient was admitted for observation. For this example, HCPCS code G0378 would be reported on a single claim line with 18 units and the Friday date of service. No other claim would be submitted for that observation period.
2	**Q:** Is it appropriate to report HCPCS code G0379 (direct admission for observation care) when the patient was admitted through the emergency department? **A:** No. HCPCS code G0379 is intended for use when the patient is seen by a physician in the community and then sends the patient to the outpatient facility specifically for observation services. The placement of a patient in observation care after receiving outpatient services such as an emergency department visit, outpatient clinic visit or critical care is not considered a direct admission to observation.
3	**Q:** How would I report the appropriate hours/units when an observation service started at 10:15 AM and ended at 6:52 PM on the same day? **A:** It would be appropriate to round to the nearest hour, so in this example you would round the start time to 10:00 AM and the end time to 7:00 PM. That would equate to 9 hours/units of reportable observation services.
4	**Q:** Can I report G0378 when the patient is to be observed/monitored for less than 8 hours? **A:** Yes. You should accurately report the number of observation units/hours provided, but in order to be considered for reimbursement under the CMS billing and payment guidelines and this policy, the indicated number of units reported with HCPCS code G0378 must equal or exceed 8 hours.
5	**Q:** Why are the CPT observation codes 99217-99220, 99224-99226, and 99234-99236 not addressed in this policy? **A:** These CPT codes are for reporting physician or other healthcare practitioner professional services. These services are addressed in the UnitedHealthcare commercial reimbursement policy titled, “Observation and Discharge Policy, Professional”.

6	**Q:** Can I report HCPCS code G0379 with revenue code 0760? **A:** No. When reporting services for the direct admission for observation G0379, report with Revenue code 0762.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and8 other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History

11/17/2023	Policy Version Change State Exception: North Carolina updated
9/24/2023	Policy Version Change State Exception: Mississippi and Texas updated Attachments Section: Updated Status Indicator T list
9/10/2023	Policy Version Change State Exception: Maryland and North Carolina updated History Section: Entries prior to 9/10/2021 archived
6/25/2023	Policy Version Change Attachments Section: Updated Status Indicator J1 and Status Indicator T lists History Section: Entries prior to 6/25/2021 archived
5/1/2023	Policy Version Change Header: Updated Branding Attachments Section: Corrected T Status list
1/1/2023	Policy Version Change Attachments Section: Updated Status Indicator J1, Status Indicator T and Status Indicator V lists History Section: Entries prior to 1/1/2020 archived
6/26/2022	Policy Version Change Attachments Section: Updated Status Indicator J1 and Status Indicator T Lists
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2/28/2022	Policy Version Change State Exception: Washington DC added
2/6/2022	Policy Version Change State Exception: Minnesota added History Section: Entries prior to 2/6/2020 archived
1/1/2022	Policy Version Change Attachments Section: Updated Status Indicator J1, Status Indicator T and Status Indicator V lists
12/1/2021	Policy Version Change

	Overview Section: Added reference to observation codes Reimbursement Guidelines: Removed state guidelines and pricing methodology, added reimbursement criteria and coding requirements Questions & Answers: Removed Q&A # 1 and 2, added new Q&As 1 – 5 Attachments Section: Added code lists for codes with CMS IOCE status indicators J1, T and V History Section: Entries prior to 12/1/2020 archived
5/1/2018	Policy implemented by UnitedHealthcare Community Plan