Outpatient Hospital Observation Policy (CES)

Policy Number: ADMINISTRATIVE 282.1 T0
Effective Date: December 1, 2020

Instructions for Use

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Related Policies
None

Applicable Lines of Business/Products

This policy applies to Oxford Commercial plan membership.

Application

This reimbursement policy applies to services reported using the UB04 claim form or its electronic equivalent or 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.

Overview

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.

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 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 must only be considered for reimbursement when the observation period meets or exceed 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.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

HCPCS Code	Description
G0378	Observation Services
G0379	Observation Services

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 observation services that can be reported.
4	Q:	Can I report G0378 when the patient is to be observed/monitored for 2 hours?
	A:	No. The CMS billing and payment guidelines indicate the 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*.

References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. *[2020R6013A]*

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

Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS)

Centers for Medicare and Medicaid Services (CMS) Integrated Outpatient Code Edit (IOCE)

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

Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update • Reformatted and reorganized policy; transferred content to new template
12/01/2020	• New Reimbursement Policy

Instructions for Use

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific

benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.