Observation

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Molina Healthcare follows the observation guidelines outlined in the Current Procedural Terminology (CPT) Manual. 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 a patient will require further treatment as a hospital inpatient or if the patient is able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the Emergency Department (ED) and who then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge.

Reimbursement Guidelines

Professional Providers

All related Evaluation and Management (E/M) services provided on the same date of service (DOS) by the performing provider are considered integral to the observation care E/M code. Providers billing for unrelated E/M services provided on the same DOS by the same performing provider must append modifier 25 when the service is separately distinct and unrelated to the observation care.

Similarly, all related E/M services, including observation care, provided on the same DOS by the same performing provider are considered integral to an Inpatient E/M admission code. Practitioners providing observation care may report a valid observation E/M CPT code for the professional service(s) on a CMS-1500 Claim Form when the patient is not subsequently admitted as an inpatient on the DOS.

Institutional Providers

Hospital observation codes should be reported whether the observation service is separately payable or packaged. The Healthcare Common Procedure Coding System (HCPCS) observation codes must be used when billing on the UB-04 Claim Form. Hospital observation must be reported with the HCPCS codes G0378 (Hospital Observation Services, Per Hour) and G0379 (Direct Admission of Patient for Hospital Observation Services). Hospitals should not report the CPT codes for physician observation when reporting hospital observation services on the UB-04 Claim Form.

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.

Please note, 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 may not be billed on the same claim as pre-labor monitoring services on revenue code 072x (excluding 0723). When both the 0762 and 072x revenue codes (excluding 0723) are billed on the same claims will be rejected to the provider.

HCPCS code G0378 must be billed with revenue code 0762 and the units equal the number of hours the individual is in an observation status. Providers will not be allowed to bill more than one line of 0762 on the UB-04 Claim Form.

Direct Admission of Patient for Hospital Observation Services (HCPCS code G0379)

HCPCS code G0379 is used when an individual is referred directly to observation care after being seen by a practitioner in the community and without an associated Emergency Room (ER) visit, hospital outpatient clinic visit, or critical care service on the same DOS as the initiation of observation care. G0379 may be reported with only one unit and must be billed in conjunction with G0378.

If a patient has two distinct observation stays on the same or overlapping days, separate claims may be submitted for each stay. However, if documentation supports that an early discharge resulted in the second stay, the charges for the Observation Care may be combined onto one claim.

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 before a decision is made to proceed to surgery, 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 lists can be found in the Integrated Outpatient Code Editor (IOCE) Release Files, available through the link provided in the references section below.

Time

Observation time starts at the time documented in the nurse's notes as to when the patient entered an observation status. Observation time ends at the time documented in the Physician or Other Qualified Healthcare Professional (QHP) discharge orders. This time should coincide with the end of the patient's treatment in observation.

Direct referrals observation time begins after the patient arrives at the facility and it is documented in the medical record that observation time has started. Hospitals should round to the nearest hour when reporting observation care; however, the total time should exclude any "carved out" time that carry an inherent time component for the service being billed (e.g., emergency room services, infusion services, services rendered billed exclusively by time, surgical, diagnostic, therapeutic services, etc.).

Observation Greater than 48 Hours

Per CMS, "Observation services generally do not exceed 24 hours. It should be very rare that observation services should exceed 48 hours; usually they will be less than 24 hours in duration." Molina Healthcare will reimburse for observation up to 72 hours, however, any claim that is submitted with observation hours greater than 48 hours will require medical records to be submitted with the claim.

Reimbursement

Reimbursement will be the lesser of charges or the fee schedule rate. The uniform payment rate will be based on the number of hours the patient is in an observation status. Separate rates have been established for 0-5 hours,

6-36 hours, 37-72 hours and > 72 hours. When observation care is present on a surgical claim, the observation room charges will continue to be included in the surgical roll-up methodology. Other services rendered in conjunction to Observation Care need to be billed separately.

For reimbursement of observation services, services must be reported on a single line with the date of service beginning on the day observation care is initiated. 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.

Enhanced Ambulatory Patient Groups (EAPG)

Claims priced under EAPG, when observation care is present on a surgical claim, reimbursement will be packaged with a significant procedure EAPG. Separate payment will be allowed for observation care with a medical visit EAPG.

Outpatient Observation vs Inpatient DRG Payment Methodology

Any outpatient claims billing observation greater than 24 hours, may be audited by Molina Healthcare to determine if it is more cost effective to pay the inpatient DRG rate for those claims. Molina Healthcare will reimburse the facility the lesser of the outpatient payment or the inpatient DRG rate.

Global Period

Observation Care codes are not separately reimbursable services when performed within the assigned global period of a procedure or service. Observation care services, during a global period, are included in the global package.

Coding & Billing Guidelines

The below guidelines outline the correct billing for professional and facility claims based on the individual scenario and claim forms used.

Scenario	CMS-1500 Claim Form	UB-04 Claim Form
Observation Care & Inpatient Admission on same DOS with inpatient discharge	• Report Initial Observation/Inpatient (Including A&D) E/M (99234-99236) • Place of Service: 19 or 22 • Note: Performing provider may not separately report any E/M codes for evaluations related to inpatients admission	• Type of Bill: Inpatient, 111 • Revenue Code: 0762
Observation Care & Inpatient Admission on same DOS with inpatient admission spanning more than one DOS	Date of Admission: Report initial hospital E/M (99221-99223) • Subsequent Hospital Care: Report Each Subsequent Day Hospital E/M (99231-99239) • Discharge Date: Report Discharge Hospital E/M (99238-99239) • Place of Service: 21 • Note: Performing provider may not	• Type of Bill: Inpatient, 111 • Revenue Code: 0762

	separately report any E/M codes for evaluations related to the inpatient admission	
Observation E/M not resulting in an inpatient admission	• If on DOS: Report Initial Observation/Inpatient E/M (99234-99236) • If spanning two DOS: Report Prolonged Inpatient/Observation E/M (99418) • Spanning Multiple DOS: Report Prolonged Inpatient/Observation E/M (99418). Report Each Subsequent Day Observation E/M (99231-99233) Place of Service: 19 or 22 • Note: Performing provider may not separately report any E/M codes for evaluations related to the Observation Care	• Observation Care Per Hour: • Type of Bill: Outpatient 131 • Revenue Code: 0762 • HCPCS Code: G0378 • Note: Units must list total hours patient was in observation care status. • Direct Observation Care from Community Setting: • Type of Bill: Outpatient 131 • Revenue Code: 0760, 0761, or 0769 • HCPCS Code: G0378 • Note: G0379 must be reported with one unit and be billed on same date as G0378

Limitations & Exclusions

While reimbursement is considered, payment determination is subject to, but not limited to:

- Group or Individual benefit
- Provider Participation Agreement
- Routine claim editing logic, including but not limited to incidental or mutually exclusive logic, and medical necessity
- Mandated or legislative required criteria will always supersede.

In instances where the provider is participating, based on member benefits, co-payment, coinsurance, and/or deductible shall apply.

Supplemental Information

Definitions

Term	Definitions
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

State Exceptions

State	Exception
NV	Providers maybe excluded from some elements of this reimbursement policy per state guidelines.
MI	Michigan is excluded from the section of Observation Greater than 48 Hours.
TX	Emergency room (ER) and observation services are included in the inpatient payment, but they must be listed separately on the inpatient claim if the patient is admitted under one of these conditions:

	• The patient spent less than 24 hours in the ER without being put in observation status. • The patient spent less than 48 hours in observation status after going to the ER. The inpatient claim should show the date the patient first came to the hospital. If the patient is admitted as an inpatient more than 24 hours after visiting the ER without being put in observation status, or more than 48 hours after being placed in observation, the ER and observation services will be paid separately as outpatient services.

Documentation History

Type	Date	Action
Initial Creation Date	08/30/2022	New Policy
Revised Date	12/16/2024	References were updated
Revised Date	02/19/2025	State Exceptions updated
Revised Date	08/01/2025	Updated Template

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
I/OCE Quarterly Release File	I/OCE Quarterly Release Files - CMS
CMS	Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)
Texas Medicaid	Texas Medicaid Provider Procedures Manual

*__CODING DISCLAIMER.__ Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.