Reimbursement/Billing Policy

Observation Status
Policy Number: RM043
Last Review: 12/15/2025

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:
☐ Professional
☒ Facility

Applicability:
☒ Commercial and Marketplace (Fully Insured and Self-Funded)
☒ Medicare Advantage

Definition:

Observation care is furnished to provide short-term outpatient medical services performed to observe a patient's condition and determine necessity of admission to inpatient facility. The key elements of observation care consist of clinically appropriate services including short-term treatment and assessment before a decision can be made about inpatient admission or discharge. For coverage appropriate for inpatient admission, a patient must exhibit signs and symptoms severe enough to warrant the need for medical care at the inpatient level.

The following reimbursement policy applies to facility charges for observation hours billed on a UB-04 claim.

Reimbursement Policy:

HCPCS codes G0378 and G0379 are used in facility UB-04 billing for hospital hourly observation services and direct referral for hospital observation care services. Paramount will not reimburse evaluation and management (E/M) codes when billed under revenue code 0762 by a facility on a UB-04 claim form.

Paramount considers charges† associated with observation status (HCPCS codes G0378, G0379; revenue code 0762) eligible for reimbursement when all of the following criteria are met:

- Referral and/or order for observation services (reported with HCPCS code G0379) made by a licensed medical professional; and
- Medically necessary observation for the ongoing assessment to determine need for further treatment or inpatient admission; and
- Observation care not expected to exceed 48 hours. Observation care beyond 48 hours will be denied.

†Charges not to exceed outpatient observation rates.

Hospitals should follow CMS guidelines when reporting observation hours on a UB-04 claim form under HCPCS code G0378 (Hospital observation service, per hour):

- Each unit of observation reported under G0378 is equal to one hour of observation time.
- Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order.
- Observation time ends when all medically necessary services related to observation care are completed.
- Hospitals should round to the nearest hour.
- If a period of observation spans more than 1 calendar day, all the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

Paramount considers the following services associated with observation status not eligible for reimbursement:

- Routine recovery and post-operative care or monitoring after ambulatory surgery; or
- Observation room used as a substitute for obstetrics labor room, treatment, or recovery room; or
- Observation status used as a substitute for inpatient admission unless otherwise authorized via concurrent review process††; or
- Patient discharged home after less than 8 hours of observation services.

††NOTE: There may be circumstances where observation services are approved in lieu of acute inpatient admission; however, no reimbursement will be made for observation services in excess of 48 hours regardless of the number of hours charged. Observation time over 48 hours will be denied.

Paramount considers charges associated with observation status limited to 48 hours. Reimbursement for the hourly observation room rate will not be provided in addition to the daily inpatient room rate when both occur on the same calendar day.

All outpatient observation services should be reasonable and medically appropriate to be considered for coverage

Sources of Information:

Centers for Medicare & Medicaid Services: Medicare Outpatient Observation Notice. In: Medicare Claims Processing Manual (§ 400.3). Revision effective February 21, 2017.

Feng Z, Jung HY, Wright B, Mor V. (2014). The origin and disposition of Medicare observation stays. Med Care, 52(9): 796–800.

Venkatesh AK, Wang C, Ross JS, Altaf FK, Suter LG, Vellanky S… Bernheim SM. (2016). Hospital Use of Observation Stays: Cross-sectional Study of the Impact on Readmission Rates. Med Care, 54(12): 1070–1077.

Centers for Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Pub. 100-04, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 290.2.2. Available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf. Accessed December 18, 2023.

American Medical Association (AMA) CPT 2024 Professional Edition. Evaluation and Management- Hospital Inpatient and Observation Care Services. Pages 17-19.

Applicable Code(s):	
HCPCS:	G0378, G0379
ICD10 Procedure Codes:	N/A
Revenue Codes:	0762

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE:

Date	**Explanation & Changes**
12/15/2025	• Policy Created
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