



Policy	REIMB_038
Effective Date	01/01/2026
Reviewed/Revised Date	10/27/2025
Next Review Date	10/27/2026
Origination Date	09/01/2024
Originated Department	Clinical Operations

Observation Policy

Audience
Medical Management

Purpose
<p>Payment policies provide general support for applying Mountain Health CO-OP member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this payment policy. If there is a conflict between a member-specific policy document and the Mountain Health CO-OP payment policy, the member-specific policy document supersedes this policy. Any person(s) applying this payment policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this payment policy, including the existence of any state or federal guidance. Mountain Health CO-OP payment policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health CO-OP reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>Observation care is defined as a clinically appropriate, short-term assessment and management service, initiated under a physician's or authorized practitioner's order when inpatient needs are being determined.</p> <p>Observation must be patient-specific and is only reimbursable when medically necessary and typically exceed 48 hours.</p> <p>The policy applies to patients designed as "observation" status</p> <p>This policy addresses the use of:</p> <ul style="list-style-type: none"> Initial Hospital Inpatient or Observation Care CPT® codes (99221 – 99223)

- Subsequent Hospital Inpatient or Observation Care CPT codes (99231 – 99233)
- Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services) CPT codes (99234 – 99236)
- Hospital Inpatient or Observation Discharge Day Management CPT codes (99238 – 99239)
- Hospital Outpatient Observation Services HCPCS codes (G0378 and G0379)

Policy/Procedure

This policy applies to all observation claims and is designed to guide providers, health plan personnel, and utilization management teams in evaluating claims involving observation occurring within 30 days of admission or readmission.

Mountain Health requires a valid observation services order from the physician or other qualified health care professional (QHP) documented prior to or at initiation of services. Absence of such order may result in denial of reimbursement.

Reimbursement may be denied or reduced if it is determined there is an observation inpatient stay within 30 days of admission or readmission.

Initial Hospital Inpatient or Observation Care (99221-99223)

Codes are used for the first hospital inpatient or observation encounter with the patient and are applicable if a patient is admitted and discharged on the same day within 8 hours. Only one of these codes should be billed per calendar year. All related E/M services performed on the same day as the admission are considered part of this initial observation care services. The appropriate code reported should include these related services and in the inpatient or observation setting. Modifier AI should be appended to the initial care code to identify the primary physician or QHP. Additional codes may be considered for reimbursement for the same date of service and patient by physicians or QHPs with different primary specialties or from different group practices.

Initial Hospital Inpatient or Observation Care (99221-99223)

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Subsequent Hospital Inpatient or Observation Care CPT codes (99231 – 99233)

Codes are used when the patient has received services from the physician or QHP. Only one of these codes should be billed per calendar year and should reflect all services provided for the date

of service. Additional codes may be considered for reimbursement for the same date of service and patient by physicians or QHPs with different primary specialties or from different group practices.

Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services) CPT codes (99234 – 99236)

Codes are used when the patient is admitted and discharged on the same day after receiving a minimum of 8 hours of hospital inpatient or observation care. Only the primary physician may perform and bill these codes and must write the admission and discharge notes documenting duration of stay between 8 to 24 hours.

Hospital Inpatient or Observation Discharge Day Management CPT codes (99238 – 99239)

Codes are used to document the total time spent on discharge from inpatient to observation, covering all services performed by the primary physician on the discharge date and should be reported for the date of the actual visit. Only one of these codes should be billed per patient for each hospital stay. Non-primary physicians should use codes 99231-99233.

Hospital Outpatient Observation Services HCPCS codes (G0378 and G0379)

Code G0378 is used when ED visit, clinical visit, critical care, or direct referral for observation care was also provided on the same or previous observation date of service reported. Facilities should bill G0378 for hospital observation service, per hour under the 0762 revenue code, with units of hours in observation care. The code will be eligible for reimbursement if observation period is a minimum of 8 hours.

Code G0379 is used for a direct referral/admission to observation after being seen by a physician without associated ED visit, clinical visit, or critical care on the first day of observation services.

Exclusions

- Code G0378 should not be reported for monitoring for a surgical, diagnostic, or therapeutic procedure
- Code G0378 will not be eligible for reimbursement when reported with procedure codes assigned status indicator J1 or T.
- Code G0379 is not reimbursable if not submitted on the same date of service as G0378.
- Code G0379 is not reimbursable if ER visit, clinical visit, critical care, or service with status indicator of T or V is reported on the same date of service.

References

1. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
2. Center for Medicare and Medicaid Services (CMS), Manual System and other CMS publications and services
3. Center for Medicare and Medicaid Services (CMS) Integrated Outpatient Code Edit (IOCE)

4. Center for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS)

Vendors

- HPS

Review/Revision/Approval History

Date	Description
10/27/2025	Adopted

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This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member’s benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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