



POLICY INFORMATION

Table with 4 columns: Policy Number, Version Number, Policy Status, Original Effective Date, Revision Date, Next Revision Date.

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: https://providers.bluekc.com/ContactUs/PaymentPolicies.

PROVIDER/ENTITY IMPACTED

Table with 6 columns: PROFESSIONAL, FACILITY, DME, AMBULATORY SURGERY, LAB, OTHER.

LINES OF BUSINESS IMPACTED

Table with 7 columns: COMMERCIAL, BLUE MEDICARE ADVANTAGE, ACA QHP1, SMALL GROUP ACA, JAA2, FEP3, DENTAL.

1 ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family 2 JAA: Joint Administrative Account 3 FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
Centers for Medicare and Medicaid
American Medical Association
National Correct Coding Initiative
Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
Affordable Care Act Provider Hotline 866-859-3822
Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, which 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.

Policy

Observation Services (HCPCS code G0378)

Observation services must be reported by facilities utilizing the following guidelines:

- Observation services are submitted with bill type 13X, 78X, or 85X.
- Report HCPCS code G0378 (hospital observation service per hour) under the appropriate revenue code (0762) with units that represents 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, but not more than 48 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 before a decision is made to proceed to surgery, during surgical recovery or for routine preparation and recovery services required for a diagnostic test)

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.

If more than eight hours of observation are reported (see G0378, Hospital observation per hour), payment for G0379 is packaged. Thus, the only time that G0379 is separately payable is when there is a direct referral to observation and the patient is provided with less than eight hours of observation care.



In addition, code G0379 is not separately payable when a critical care service (CPT 99291), clinic service (HCPCS G0463), or emergency department visit (99282-99285), are reported on the same date of service.

Coding

G0378 - This code represents a hospital observation service, in which the provider assesses the patient to decide whether the patient should be admitted to the hospital or discharged home from the observation status.

G0379 - This code represents hospital observation care when the provider admits the patient directly to an observation status from the community setting.

Questions and Answers

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| 1 | <p>Q: Can observation G0378 be billed for care after outpatient surgery?</p> <p>A: No, the post-operative recovery is typically considered part of the global surgical package and cannot be billed separately as observation care. Observation services are not considered medically necessary for routine pre-operative preparation or recovery room services.</p> |
| 2 | <p>Q: Can observation be billed for routine monitoring that is part of a procedure or treatment?</p> <p>A: No, Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure</p> |
| 3 | <p>Q: Can physicians order observation services for future elective surgery using G0379?</p> <p>A: A physician should not order observation services for a future elective surgery or outpatient surgery cases. Neither pre-operative nor post-operative services meet the definition of observation care.</p> |

References and Resources

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| Centers for Medicare and Medicaid Services |
| Blue KC Provider Reference Guide |

Related Documents

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| Payment Policy POL-PP-111 Facility Routine Supplies and Services |
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Revision History

| Version | Date | Summary of Revisions |
|---------|------------|--|
| 001 | 08/01/2025 | Initial version |
| 002 | 5/21/2025 | Changed effective date from 7/1/2025 to 8/1/2025 |