Observation Services
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

This policy applies to the facility and professional reimbursement of clinically appropriate and medically necessary observation services.

Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge. Patients may also be referred directly to the hospital for observation services. A direct referral occurs when a physician or qualified non-physician practitioner (NPP) refers a patient to the hospital for outpatient observation care, bypassing the emergency department (Medicare Benefit Policy Manual, Chapter 6, Section 20.6, MassHealth Acute Outpatient Hospital Manual 130 CMR 410.402).

Documentation for observation services must reflect care relative to the condition for which the patient is being observed, as performed within the context of the physician's orders and an acceptable, medically necessary standard of care. The notes written during the period of observation must support the medical necessity for ongoing care, provide the details of how that care is being rendered and, ultimately, provide a record of how a decision was reached to either discharge or admit the patient beyond the observation period. Documentation requirements for observation services include a medically necessary history and/or examination, pertinent to the patient's presenting clinical status and the provider's medical judgement.

Observation services require a written order by a physician or qualified NPP authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The written order must clearly identify inpatient or observation status.

When a physician or qualified nonphysician practitioner (NPP) orders observation care for a patient, the patient's status is outpatient.

Reporting Hours of Observation
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 or qualified NPP's order, regardless of the patient's location in the facility.

Observation services may not be reported for care that are part of another covered service, such as postoperative monitoring during a standard recovery period, which should be billed as recovery room services. Similarly, observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time.

Observation time ends when all medically necessary services related to observation care are completed. This could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately. Reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

Hospitals should round to the nearest hour when billing for observation services.

Definitions

Outpatient Observation Services (applies to Fallon Medicare Plus, NaviCare, Summit Eldercare PACE, Fallon Health Weinberg PACE and Community Care) - Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be 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. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours (Medicare Benefit Policy Manual, Chapter 6, Section 20.6).

Observation Services (Applies to MassHealth ACO) - Outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member’s condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours (MassHealth Acute Outpatient Hospital Program Regulations 130 CMR 410.402).

Reimbursement

Facility reimbursement

Observation is an acute outpatient hospital service. Reimbursement for observation/outpatient hospital services is based on the terms of the facility's contract.

For MassHealth ACO members, the Plan reimburses observation based on the Executive Office of Health and Human Services (EOHHS) Adjudicated Payment per Episode of Care (APEC) payment methodology.

For Community Care and Medicare (including Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, Summit ElderCare PACE and Fallon Health Weinberg PACE) members, the Plan reimburses observation based on the Medicare Outpatient Prospective Payment System (OPPS) payment methodology, unless the facility’s contract memorializes a different payment methodology.

For case rates other than those based on a prospective payment methodology or percent of billed charges, reimbursement for observation will be limited to 48 hours unless otherwise specified in the contract.

The Plan does not reimburse the following services in an observation setting:

- Routine therapeutic services routinely performed in outpatient settings such as blood transfusions, chemotherapy, or dialysis.
- Routine pre- or post-operative care following an outpatient diagnostic or outpatient surgical service. These services are considered recovery room services and are not separately payable.
- Separately billed diagnostic tests.

- Time for members who are awaiting nursing home placement, or other socioeconomic factors.
- A routine “stop” between the emergency department and an inpatient admission.
- Custodial care.
- Obstetrical observation stays when an obstetric patient is placed in observation care and delivers prior to discharge.
- Labor and delivery.

If an observation patient is admitted to inpatient status, the observation services billed charges shall be denied and included in the reimbursement for inpatient services billed.

All changes in level of care will be reviewed by Inpatient Care Services to determine medical necessity.

Professional reimbursement
The Plan reimburses evaluation and management services provided to plan members admitted to observation status in an acute care hospital. Physicians and qualified (NPPs) should follow CMS billing guidelines as described in the Medicare Claims Processing Manual, Chapter 12, Section 30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services) and the codes specified under Billing/coding guidelines below.

Referral/notification/prior authorization requirements

Prior authorization is not required for observation services.

Billing/coding guidelines

Facility coding
G-codes to be used by hospitals reporting observation services under revenue code 0762 (Observation Room):
- G0378- Hospital observation services, per hour
- G0379- Direct admission of patient for hospital observation care.

Facilities reimbursed under either the EAPG (Enhanced Ambulatory Patient Grouping) or Medicare OPPS payment methodology are expected to bill using the appropriate MassHealth/Medicare billing standards and will be reimbursed as such.

Professional coding
The following codes should be used when billing observation status:
- CPT codes -
    - To report initial observation care, new or established patient, use 99221, 99222, 99223. The Plan will reimburse initial observation care billed by only the physician or qualified NPP (practitioner) who ordered hospital outpatient observation services and was responsible for the patient during their observation care. Payment for an initial observation care code is for all the care rendered by the ordering practitioner on the date the patient’s observation services began.
    - To report subsequent observation care, use 99231, 99232, 99233.
    - To report observation care services provided to patients admitted and discharged on the same date of service, use 99234, 99235, 99236.
    - To report observation care discharge services, use 99238, 99239. When a patient receives observation care for fewer than 8 hours, only the initial observation care codes (99221, 99222, 99223) may be reported for the encounter. Observation care discharge day management (99238, 99239) may not be reported. To report prolonged observation care for Medicare members, use G0316. HCPCS code G0316 may be reported separately in addition to CPT codes 99223, 99233, and 99236. Do not report G0316 for any time unit less than 15 minutes.

- To report prolonged observation care for MassHealth ACO and Community Care members, use 99418. CPT 99418 maybe reported separately in addition to CPT codes 99223, 99233, and 99236. Do not report G0316 for any time unit less than 15 minutes.

- Place of Service - If a patient was in observation, for the entire encounter, report POS 22. But if the patient was admitted, even if the patient was discharged on the same day, report POS 21.

A billing practitioner shall bill only one of the hospital inpatient or observation care codes for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date. The practitioner selects a code that reflects all of the practitioner's services provided during the date of the service.

In the rare circumstance when a patient receives observation services for more than two calendar dates, the practitioner shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

Observation services are ordered, performed and billed by the practitioner (or group), who is responsible for the patient's care during the observation period. Services by other consulting providers during the observation period are billed using the office/outpatient code set.For a practitioner to bill observation care codes, there must be documentation in the medical record for the patient which contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the practitioner while the patient received observation services.

Place of service

This policy applies to the facility and provider payment of observation status in the outpatient hospital setting.

Policy history

Origination date:	08/29/03
Previous revision date(s):	09/01/04, 08/01/07, 02/25/08, 07/01/08 07/01/2009 - Updated verbiage under Reimbursement and Billing/coding guidelines to clarify FCHP reimbursement of services that move between Observation and Emergency Department, Ambulatory Surgery, and Inpatient. 09/01/2011 - Updated policy section to indicate the maximum amount of time FCHP will authorize for observation level of care; updated billing guidelines section to reflect CPT code updates. 01/01/2014 - Added discussion about billing G0738 when reimbursed according to APC. 11/01/2015 - Annual review and moved to new Plan template.
Connection date & details:	July 2016 – Added POS 19; added requirement that physician orders clearly identify patient status. November 2017 – Annual Review, no updates. April 2018 – Updated authorization section July 2018 – Added EAPG billing language. October 2018 – Updated the authorization section. October 2019 – Annual review, no updates. July 2022 - Clarified reimbursement for observation services under the Executive Office of Health and Human Services (EOHHS) Adjudicated Payment per Episode of Care (APEC) payment methodology; clarified reimbursement for observation services under the Medicare Outpatient Prospective Payment System (OPPS) payment methodology.

October 2025 – Under Policy, added new section for Reporting Hours of Observation; under Billing/coding guidelines, updated CPT codes for professional observation services.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.