

Reimbursement Policy

Title: Facility Observation Services	
Policy Number: RP09	Applies to: <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Level Funded <input checked="" type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid <input checked="" type="checkbox"/> Medicare Select <input checked="" type="checkbox"/> Medicare Supplement
Effective Date: * 7/1/2026	
Last Updated: *	

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines, including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities unless a specific exception is stated in the policy.

If proper coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Policy

Quartz will consider reimbursement for observation services up to 48 hours. Upon medical record review; in rare and carefully documented circumstances, the limit may be increased to 72 hours. Additionally, observation services billed for less than 8 hours will not be reimbursed. Observation services do not apply to clinics, physician offices, urgent care centers, mental health or substance abuse care and cannot be used for a planned or elective admission.

The member's medical record documentation for Observation status must indicate the need for Observation services stating the specific problem, treatment and/or frequency of the skilled service and requires a written order by the physician clearly documented in the medical record indicating "Admit to Observation". A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or

medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

The billed units of service should equal the number of hours the patient receives observation services. Facilities are instructed to use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Facilities are also reminded not to report CPT codes 99221-99223 and 99231-99239 for observation services. Additional information and discussion regarding hospital observation services can be found in the Medicare Claims Processing Manual, Chapter 4 - Part B Hospital, 290.2.2

Observation services are reported with revenue code 0762 (Observation Room) and HCPCS code G0378 (Hospital observation service, per hour). When a patient is referred directly to observation care after being seen in the physician office or other community setting, code G0379 (Direct admission of patient for observation care) should be used in addition to code G0378.

When observation services are provided by the same hospital on the day of, or immediately prior to an inpatient admission, the observation services are to be reported on the inpatient claim. Reimbursement will be included in the payment for the inpatient stay.

Related Policies

N/A

Resources

- CMS Medicare Claims Processing Manual, Chapter 4 - Part B Hospital, 290.2.2 for Observation Services
- CMS NCCI Manual (edits and policies)

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

Document History

4/12/2026	Document created	Payment Integrity Department