
Observation Facility Payment Policy

Policy Statement

This policy outlines Neighborhood's guidelines for Observation Status. Observation status is when a member has a condition that needs to be monitored in the hospital, potentially overnight, but not admitted.

Scope

This policy applies to:

- ☒ **Medicaid** *excluding Extended Family Planning (EFP)*
- ☒ **Commercial**
- ☒ **Dual CONNECT (Coordination only D-SNP)**
- ☒ **INTEGRITY for Duals (Fully Integrated D-SNP)**

Prerequisites

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific [Prior Authorization Reference page](#).
- Neighborhood's [Clinical Medical Policies](#).

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Coverage Limitations

Per CMS, only in rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. ¹

Reimbursement Requirements

Refer to your current contract for details regarding observation reimbursement provisions as your contract may supersede this policy.

Emergency Room to Observation

- The higher level of reimbursement shall apply

¹ <https://www.cms.gov/files/document/r11842cp.pdf>



Ambulatory Surgery Center to Observation

- Ambulatory Surgery includes 4 hours of recovery. If Observation is required beyond the 4 hours of Ambulatory Surgery recovery, Neighborhood shall reimburse for Ambulatory Surgery and Observation if observation is required for an additional 4 hours or more, post recovery.

Observation to Inpatient

- Inpatient reimbursement applies

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

For Dual CONNECT (Coordination only D-SNP plan), providers must submit claims to Neighborhood and any remaining copays/coinsurance amounts and Medicaid covered benefits to EOHHS for reimbursement.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

Neighborhood processes Dual CONNECT in accordance with CMS Medicare guidelines. Neighborhood processes INTEGRITY for Duals in accordance with CMS Medicare and Rhode



Island Executive Office of Health and Human Services (RI EOHHS) guidelines. Refer to [CMS Medicare guidance](#) and [RI EOHHS Provider Manuals & Guidelines](#) for rules and claims processing policies.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Coding

Observation services are billed with revenue code 762 and one of the HCPCS below. G0378 should be reported with the number of hours in the units field;

CPT Code	Description
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care

Document History

Date	Action
09/01/2026	Updated policy template to include new lines of business. Updated Member Responsibility and Disclaimer language.
10/27/2025	Annual review date. No content changes.
07/01/2024	Policy Create Date