Priority Health	BILLING POLICY No. 199
Observation Services	
Date of origin: May 2026	**Review dates: None yet recorded**

DEFINITION
This policy outlines billing and payment requirements associated with observation services.

FOR MEDICARE
For indications that don't meet criteria of NCD, local LCD, or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coverage of observation services

Observation services are covered only when:

- Provided by the order of a physician or another individual authorized by State licensure and hospital staff bylaws to admit patients to the hospital or to order outpatient tests, or
  Clinical data presented by the hospital doesn't support inpatient status. Additionally, observation services must be patient-specific and not part of a standard facility protocol for a given diagnosis or service. Observation services must also be medically necessary.

Length of observation services
The observation stay must span a minimum of 8 hours. In most cases, the decision to either discharge a patient from the hospital when the reason for observation care is resolved or to admit the patient as inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.
We won't reimburse observation services exceeding 72 hours.

Reporting observation hours
Observation time starts at the clock time documented in the member's medical record, which coincides with the time a physician order-initiated observation care. Hospitals should round to the nearest hour, within the72-hour limit.

Inpatient admission following observation stay

- **DRG-based or inpatient case rate-based reimbursement**: All related observation services occurring within three days of the date of admission are inclusive to case rate or DRG.
- **Percent-of-charge payment methodology**: Observation services occurring on the same date as an inpatient admission (before midnight) will be inclusive of inpatient reimbursement. The observation bed charge on the same day as the inpatient admission isn't separately reimbursed. The observation bed charge prior to the date of admission is separately reimbursed.
- **Inpatient per-diem payment methodology**: Any observation services provided within one day of inpatient admission would be separately reimbursed. The observation bed charge on the same day as the inpatient admission isn't separately reimbursed.

- **Fee schedule or per hour payment methodology**: Observation services occurring on the same date as an inpatient admission (before midnight) will be inclusive to inpatient reimbursement. The observation bed charge on the same day as the inpatient admission isn't separately reimbursed. The observation bed charge prior to the date of admission may be separately reimbursed.

We require notification when an observation stay converts to an inpatient admission. See the links below for direction on inpatient admission:

- Non-Medicare elective inpatient authorization reviews & appeals
- Non-Medicare acute inpatient, urgent, emergent authorization reviews & appeals

Observation services following emergency department services or outpatient services:

- Emergency department services prior to an observation stay are inclusive to the observation services. The emergency department services won't be reimbursed separately.
- Observations associated with outpatient or surgical services are inclusive to routine recovery services. These services aren't separately reimbursed.

CODING SPECIFICS

Commercial and individual billing and coding

- Observation services are submitted with type of bill 13X or 85X.
- All hospitals are required to report observation charges under 0760 (General classification category) or 0762 (Observation room).
- All related services performed while the member receives observation services are reported using the applicable revenue codes and HCPCS codes.
- Reimbursement methodology may determine if observation stay services are separately reimbursed. Services reimbursed through APC payment methodology would follow the applicable guidelines associated with the applied APC or composite APC reimbursement criteria.

G0378: Hospital observation service, per hour (72-unit limit)

- Service should be coded on one claim line with total units of observation for stay

G0379: Direct admission of patient for hospital observation care

- G0379 should only be reported when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visits, or critical care service on the day of initiation of services.
- Hospitals should only report G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Medicare and Medicaid billing and coding

Also see: Medicare observation/Condition Code 44

In addition to the observation service guidelines above, reference information for Medicare and Medicaid can be found in Section 20.6, Chapter 6, of the Medicare Benefit Policy Manual. MDHHS references CMS guidelines for billing and coding purposes.

All hospitals are required under Medicare billing rules to report observation charges under 0760 (General classification category) or 0762 (Observation room).

Ancillary services performed while the member receives observation services are reported using the applicable revenue codes and HCPCS codes. See Section 290.2. 1, Chapter 4, of the Medicare Claims Processing Manual.

G0378: No separate payment is made for observation services reported with G0378 and APC 0339. In most circumstances, observation services are ancillary to the other services provided to a patient. Reimbursement is subject to APC payment methodology.

Composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. See Section 290.5.1, Chapter 4, of the Medicare Claims Processing Manual.
G0379: Should only be reported when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visits or critical care service on the day of initiation of services.

- Hospitals should only report G0379 when a patient is referred directly to observation care after being seen by a physician in the community.
- Payment may be made separately as a low-level hospital clinic visit under appropriate APC or composite APC based on applicable guidelines. Refer to CMS and APC related guidelines for further detail.

Only direct referral for observation services billed on bill type 13X may be considered for composite APC payment. See Section 290.5.2, Chapter 4, of the Medicare Claims Processing Manual.
Reporting hours of observation
Observation time starts at the clock time documented in the member's medical record, which coincides with the time a physician orders initiated observation care. Hospitals should round to the nearest hour, within the 72-hour limit. See Section 290.2.2 Chapter 4 of the Medicare Claims Processing Manual.

Medicare Outpatient Observation Notice (MOON) requirement
Per CMS regulations, hospitals and critical access hospitals (CAH) must give the standardized MOON form to individuals receiving observation services as outpatients for more than 24 hours. The form explains the individual's status as an outpatient (rather than inpatient) and the implications that an outpatient status has for Medicare cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services.
Get more information on this requirement in CMS's Medicare Claims Processing Manual (starting on page 172).
Get a copy of the MOON form on our Provider Forms webpage, under Miscellaneous Administrative Forms.

Services not covered as observation services by Medicare
Providers must determine whether an item or service either meets (1) the definition of observation care or would be otherwise covered and/or (2) is 'reasonable and necessary' for the treatment the member is receiving or if the item or service exceeds any frequency limitation or falls outside of timeframe for receipt of a particular benefit.
If the item isn't covered under Part B or if the service isn't reasonable and/or necessary, including exceeding frequency or benefit limitations, then a notice of non-coverage must be provided to Part C (Medicare Advantage) members. Learn more about this requirement for notices of non-coverage.

Coverage for medications during observation
Generally, only medications related to observation services are covered under a member's Medicare Part C benefit. Maintenance medications not part of an observation stay are covered under the member's Part D benefit.
Note: Medicare allows members to bring their maintenance medications if allowed by hospital policy.

Resources

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural

Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
May 2026	New Policy