



## Medicare Utilization Review Version

### KEY CONCEPTS OUTLINE

#### Module 3: Coverage of Observation

##### I. Coverage of Observation Services

###### A. Definition

1. CMS defines observation as a set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or can be discharged from the hospital. <See *Medicare Benefit Policy Manual*, Chapter 6 § 20.6.A>
  - a. Observation services are commonly ordered for patients who present to the emergency department and require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. <See *Medicare Benefit Policy Manual*, Chapter 6 § 20.6.A>
2. CMS considers observation to be an outpatient service provided to patients in outpatient status. <See *Medicare Benefit Policy Manual*, Chapter 6 § 20.6.B>

While many hospitals treat observation as a status, CMS considers observation to be a service provided to patients in outpatient status.

###### B. Order Requirement

1. Observation services must be ordered by a physician or NPP authorized by state licensure laws and hospital bylaws to admit patients to the hospital or to order outpatient tests. <See *Medicare Benefit Policy Manual*, Chapter 6 § 20.6.A>

###### C. Documentation Requirements

1. The beneficiary must be in the care of a physician or NPP as documented in the medical record by progress notes at the time of registration and discharge, and other appropriate progress notes, that are timed, written, and signed by the physician. <See *Medicare Claims Processing Manual*, Chapter 4 § 290.5.3; 72 *Fed. Reg.* 66812>

2. The physician or NPP must also document an explicit assessment of the patient's risks to determine they would benefit from observation care. <See *Medicare Claims Processing Manual*, Chapter 4 § 290.5.3; 72 *Fed. Reg.* 66812>

### Case Study 1

**Facts:** A Medicare patient presents to the emergency department of a hospital early in the morning complaining of the flu with abdominal distress and vomiting. The ED physician evaluates the patient and refers them to the hospitalist for continued observation due to their complex history of diabetes as well as diverticulitis and gastrointestinal blockage.

The hospitalist sees the patient and writes an initial note on the patient's need for observation services, including an explicit assessment of the risks of discharge for the patient. The physician orders observation, anti-emetics, and diagnostic tests, including an abdominal x-ray.

The observation nurse does an initial assessment and implements the physician's orders. The physician sees the patient midday, writing a progress note on the results of the diagnostic tests and her plans to discharge the patient if they are able to tolerate liquids and their blood sugar remains stable.

The patient responds well to the anti-emetics and by evening is tolerating liquids and their blood sugar is normal. The physician discharges them home by early evening. Are the observation services covered?

#### D. Non-covered and Non-reportable Observation Services

1. Observation services are not covered if they are not reasonable and necessary for the diagnosis or treatment of the patient. <See *Medicare Benefit Policy Manual*, Chapter 6 § 20.6>
2. Observation services provided after medically necessary observation has ended and the patient is awaiting transportation are not covered. <*Medicare Claims Processing Manual*, Chapter 4 § 290.2.2>
3. Standing orders for observation following outpatient surgery are not recognized. <*Medicare Claims Processing Manual*, Chapter 6 § 290.2.2>
4. Observation services may not be reported separately if they are part of another Part B service, such as:
  - a. Observation provided concurrently with diagnostic or therapeutic services for which active monitoring is already part of the service;

- i. Course note: Accounting for actively monitored services when reporting observation will be discussed later in this outline.
- b. Routine preparation for and recovery from diagnostic tests; or
- c. Postoperative monitoring during a standard recovery period, (e.g., 4-6 hours). <Medicare Claims Processing Manual, Chapter 6 § 290.2.2>

### Case Study 2

**Facts:** A Medicare patient sees their physician in the office late in the afternoon. The patient requires a complex drug infusion titrated over three hours, but the hospital's outpatient infusion center is closing.

After consultation with hospital staff, it is determined that the patient will receive the infusion on the medical floor of the hospital. The physician enters orders into the computerized order entry system for observation, the drug infusion, and discharge once the drug infusion is complete.

The patient proceeds to the hospital for the infusion and is placed in a bed on the medical floor. The infusion is started shortly after the patient arrives and the patient is discharged shortly after completion of the infusion. Are the observation services ordered by the physician covered?

## II. Billing for Observation Services

- A. Observation services are billed with two G-codes for all covered observation services.
  - 1. G0378 – “Hospital observation services, per hour”
  - 2. G0379 – “Direct admission of patient for hospital observation care”
    - a. Code G0379 must be reported with G0378. <IOCE Specifications, Section 7.2, Edit 58>
- B. Observation services are reported with revenue code 0762 (“Observation Hours”). <Medicare Claims Processing Manual, Chapter 25 § 60.4>
  - 1. Ancillary services performed while the patient is in observation status are reported using appropriate revenue codes and HCPCS codes as applicable. <Medicare Claims Processing Manual, Chapter 4 § 290.2.1>

### C. Counting Observation Hours

1. Observation time begins at the clock time documented in the patient's medical record, which coincides with the time observation care is initiated in accordance with a physician's order. <Medicare Claims Processing Manual, Chapter 4 §§ 290.2.2 and 290.5.1>
2. Observation time ends:
  - a. When the patient is actually discharged from the hospital or admitted as an inpatient; or
  - b. Prior to discharge, when all medically necessary services related to observation have been completed. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
  - i. Other covered services provided after observation has ended, should be billed separately or as part of appropriate E/M visit charges. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>

Tip: Medically necessary services such as therapy, wound care, or drug administration, provided after medically necessary observation has ended but the patient remains at the hospital awaiting placement or discharge, may be billed separately and may qualify for separate payment.

- c. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. <Medicare Claims Processing Manual, Chapter 4 §§ 290.2.2, 290.5.1>
3. Accounting for actively monitored procedures
  - a. Where active monitoring is part of a procedure that occurs during an observation stay, the time providing the procedure should be subtracted from the total observation time reported. The provide may:
    - i. Document the beginning and ending times of each period of observation and add the periods of observation together to get the total time; or
    - ii. Subtract an average length of time for interrupting procedures from the total time. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>

4. Observation is reported by hour, rounded to the nearest hour. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
  - a. CMS provides the example of observation from 3:03 pm to 9:45 pm reported as 7 hours of observation. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
  - b. There is a conflict in the guidance from MACs on what rounding to the nearest hour means:
    - i. One MAC, Novitas, indicates you calculate the total time, including carving out time for services that require active monitoring, and then round to the nearest hour. Novitas provides the following example on their website: Order placed for observation at 12:20 am, order to admit as inpatient at 11:45 pm, total 11 hours and 25 minutes, 1 hour and 40 minutes for a diagnostic test carved out yields 9 hours and 45 minutes, yielding 10 hours of billed time. <“How to clock observation time”, Novitas Part A website>
    - ii. Two MACs, Noridian and Palmetto, indicate you round the start time to the nearest hour and the stop time to the nearest hour and then calculate the hours. Noridian provides the following example on their website: “observation began at 3:29 pm and ended at 9:31 pm, the total hours would be calculated using the span of 3:00 pm to 10:00 pm for a total of 7 hours”. They do not address rounding after subtracting the time for “interrupting procedures” from the total duration of observation, but presumably the time would still need to be rounded as this would rarely equal a round number. <“ACT Questions and Answers – March 23, 2022 Revised”, Noridian Part A Website; “Observation Care”, published 01/10/2019, Palmetto GBA Part A website>

**Caution:** The example from the *Medicare Claims Processing Manual* would result in 7 hours as rounded under either of the contractor methodologies. Providers should seek further clarification from their MAC if they have questions on rounding and reporting observation.

#### D. Reporting Observation

1. All hours of observation should be reported on a single line. The line-item date of services is the date the observation services began, regardless of whether some of the services spanned the midnight hour and were provided on subsequent dates of service. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>

Tip: CMS has a published Medically Unlikely Edit (MUE) of 72 hours for G0378 which prevents reporting of more than 72 hours of observation. The edit may be appealed if more than 72 hours of medically necessary observation are provided. However, cases over 48 hours should be reviewed to confirm all observation care is medically necessary and identify missed inpatient admission opportunities for future improvement.

Additionally, for CAHs, the Common Working File (CWF) will edit TOB 085X and not allow the claim to be processed for payment when observation services reported with revenue code 0762 are greater than 48 hours (units). <Medicare Claims Processing Manual Transmittal 907>

2. All non-repetitive services occurring on the same day or in the same episode of care with the observation services, must be billed on the same claim to ensure payment logic can operate correctly. <Medicare Claims Processing Manual, Chapter 4 § 290.5.3>

### III. Payment for Observation Services under the Outpatient Prospective Payment System

- A. There are three ways Medicare pays for covered observation services under the Outpatient Prospective Payment System (OPPS). <Medicare Claims Processing Manual, Chapter 4 §§ 290.5.1, 290.5.2, and 290.5.3; 80 Fed. Reg. 70335-336>

Observation services have no separate payment rate under OPPS. For payment purposes, they are:

- Packaged into/paid as part of the C-APC for Comprehensive Observation Services (8011);
- Packaged into a visit APC for direct referral for observation; or
- Packaged into/paid as part of other services on the claim.

#### B. Comprehensive-APC (C-APC) for Comprehensive Observation Services

1. The C-APC for Comprehensive Observation Services (C-APC 8011) makes a single payment for all services provided during an encounter that includes at least 8 hours of observation and meets other criteria. <80 Fed. Reg. 70335-336; Medicare Claim Processing Manual, Chapter 4 § 290.5.3>
  - a. Course note: C-APCs will be discussed in greater detail in a later module.

## 2. Criteria for payment of C-APC 8011 (\$2,439.02)

- a. An assessment visit, assigned status indicator J2, with a date of service on the day of or the day before observation services:
  - i. A clinic visit billed with G0463; or
  - ii. A Type A ED visit billed with 99281 - 99285; or
  - iii. A Type B ED (urgent care) visit billed with G0380 – G0384; or
  - iv. A critical care visit billed with 99291; or
  - v. Direct referral for observation billed with G0379. <80 Fed. Reg. 70335-336; Medicare Claim Processing Manual, Chapter 4 § 290.5.3>
- b. At least 8 hours of observation care billed with G0378. <80 Fed. Reg. 70335-336; Medicare Claims Processing Manual, Chapter 4 § 290.5.3>
- c. No surgical procedure assigned status indicator T or J1 reported on the same claim as the observation services. <80 Fed. Reg. 70335-336; Medicare Claims Processing Manual, Chapter 4 § 290.5.3>

Status indicator T procedures are surgical procedures subject to a multiple procedure reduction and status indicator J1 procedures are surgical procedures paid as part of a surgical C-APC.

3. If all criteria for C-APC 8011 are not met, the observation will be packaged into the other services on the claim and no additional payment will be made for the observation. <Medicare Claims Processing Manual, Chapter 4 § 290.5.3>
  - a. Any other separately payable HCPCS (i.e., the clinic visit, ER visit, etc.) will be paid separately according to their “usual associated” APCs. <Medicare Claims Processing Manual, Chapter 4 § 290.5.3>

## C. Payment for Direct Referral for Observation

1. Separate payment is available for direct referral for observation (G0379) if the following criteria are met:
  - a. The services on the claim do not qualify for payment under C-APC 8011;

- b. There is no service with status indicator T, J1 or V (visit) billed on the same claim. <IOCE Specifications, Section 6.5.7.1; Medicare Claims Processing Manual, Chapter 4 § 290.5.2>
2. Payment is made under APC 5025 – “Level 5 Type A ED Visit.” (\$548.11) <IOCE Specifications, Section 6.5.7.1; OPPS Addendum A>

#### D. Packaged Observation Services

Examples of packaged observation services (i.e., no additional payment for observation is made), include

- Observation services provided during an encounter with a surgical procedure (i.e., services with status indicators T or J1)
- Observation stays of less than 8 hours, unless they are the result of a direct referral for observation

1. Covered observation services that do not qualify for payment as part of the C-APC for Comprehensive Observation Services or direct referral for observation are packaged to other separately payable services. <Medicare Claims Processing Manual, Chapter 4 § 290.5.1>

#### IV. Payment for Observation Services at Critical Access Hospitals

1. A Critical Access Hospital (CAH)<sup>1</sup> is paid on a reasonable cost basis less applicable Part B deductible and coinsurance amounts for outpatient services, including medically necessary observation services (G0378) and direct referral for observation (G0379). <42 CFR 413.70>
  - a. A CAH is not limited to providing at least 8 hours of observation to be considered for separate payment. All hours of covered observation should be reported, and all reported hours are paid. <Integrated Outpatient Code Editor, Processing Conditions Applied to OPPS Claims Only, 6.6.4.1 Comprehensive Observation APC Assignment Criteria>

**Caution:** CAHs are paid for all hours of reported observation. Care should be taken to only report covered hours of observation to prevent potential over payments.

<sup>1</sup> Critical Access Hospitals must be located in rural areas and generally be 35 miles from another like hospital. They have a maximum of 25 beds and an average length of stay of no more than 96 hours.

### Case Study 3

**Facts:** A Medicare patient presented to an emergency department at 10 pm complaining of chest pain. The ED physician evaluated the patient and called in the patient's cardiologist.

At 1 am the next morning, the cardiologist assessed the patient's risks, wrote an initial note on the patient's need for observation services and wrote an order for observation. The observation nurse did an initial assessment and made the patient comfortable. The cardiologist saw the patient in observation at 3 am, wrote a progress note, and ordered various diagnostic tests.

At 6 am, the cardiologist wrote an order discharging the patient to home with instructions to see her back in the office the following day. At 7 am, observation care was completed and the patient left the hospital. The hospital assigned the emergency department visit a level 4 (99284) visit code.

How will the hospital be paid for the emergency department and observation services provided in this encounter?

**Modified Facts:** If the patient continues in medically necessary observation until 10am and is discharged home, how much will the hospital be paid for the emergency department and observation services provided in this encounter?

**Modified Facts:** If the patient was ready for discharge at 7am, but did not leave the hospital until 10 am because they were waiting for transportation home, what payment is the hospital entitled to from Medicare for the emergency department and observation services provided in this encounter?

## CASE STUDIES WITH ANALYSIS

### Case Study 1

**Facts:** A Medicare patient presents to the emergency department of a hospital early in the morning complaining of the flu with abdominal distress and vomiting. The ED physician evaluates the patient and refers them to the hospitalist for continued observation due to their complex history of diabetes as well as diverticulitis and gastrointestinal blockage.

The hospitalist sees the patient and writes an initial note on the patient's need for observation services, including an explicit assessment of the risks of discharge for the patient. The physician orders observation, anti-emetics and diagnostic tests, including an abdominal x-ray.

The observation nurse does an initial assessment and implements the physician's orders. The physician sees the patient midday, writing a progress note on the results of the diagnostic tests and her plans to discharge the patient if they are able to tolerate liquids and their blood sugar remains stable.

The patient responds well to the anti-emetics and by evening is tolerating liquids and their blood sugar is normal. The physician discharges them home by early evening. Are the observation services covered?

**Analysis:** Yes, the observation is provided for the purpose of determining whether the patient will need further treatment as an inpatient for recurrent diverticulitis and/or intestinal blockage or will be able to be discharged home. Additionally, the order and physician documentation requirements are met.

Refer to *Medicare Benefit Policy Manual*, Chapter 6 § 20.6.

## Case Study 2

**Facts:** A Medicare patient sees their physician in the office late in the afternoon. The patient requires a complex drug infusion titrated over three hours, but the hospital's outpatient infusion center is closing.

After consultation with hospital staff, it is determined that the patient will receive the infusion on the medical floor of the hospital. The physician enters orders into the computerized order entry system for observation, the drug infusion, and discharge once the drug infusion is complete.

The patient proceeds to the hospital for the infusion and is placed in a bed on the medical floor. The infusion is started shortly after the patient arrives and the patient is discharged shortly after completion of the infusion. Are the observation services ordered by the physician covered?

**Analysis:** No, although the physician ordered observation services, the physician had already determined the patient needed a drug infusion and that the patient could be discharged following the infusion. The purpose of these services was not to determine if the patient needed to be admitted as an inpatient or could be discharged home, rather it was already determined that once the infusion was complete the patient would be discharged home. Further, the documentation requirements for covered observation care were not met and these services were provided concurrently with another service requiring active monitoring.

Refer to *Medicare Benefit Policy Manual*, Chapter 6 § 20.6.

### Case Study 3

**Facts:** A Medicare patient presented to an emergency department at 10 pm complaining of chest pain. The ED physician evaluated the patient and called in the patient's cardiologist.

At 1 am the next morning, the cardiologist assessed the patient's risks, wrote an initial note on the patient's need for observation services and wrote an order for observation. The observation nurse did an initial assessment and made the patient comfortable. The cardiologist saw the patient in observation at 3 am, wrote a progress note, and ordered various diagnostic tests.

At 6 am, the cardiologist wrote an order discharging the patient to home with instructions to see her back in the office the following day. At 7 am, observation care was completed and the patient left the hospital. The hospital assigned the emergency department visit a level 4 (99284) visit code.

How will the hospital be paid for the emergency department and observation services provided in this encounter?

**Analysis:** Only 6 hours of observation were provided so the encounter does not qualify for the Comprehensive Observation Services C-APC payment. The hospital will be paid for the emergency department visit and the observation services will be packaged. The payment rate for a level 4 ED visit is \$381.61.

Refer to *IOCE Specifications, Sections 6.6.4.1 and 6.6.4.2; OPPS Addendum B.*

**Modified Facts:** If the patient continues in medically necessary observation until 10am and is discharged home, how much will the hospital be paid for the emergency department and observation services provided in this encounter?

**Analysis:** The hospital would bill for 9 hours of observation, and the encounter would qualify for the Comprehensive Observation Services C-APC (\$2,439.02).

Refer to *IOCE Specifications, Sections 6.6.4.1 and 6.6.4.2; OPPS Addendum B.*

**Modified Facts:** If the patient was ready for discharge at 7am, but did not leave the hospital until 10 am because they were waiting for transportation home, what payment is the hospital entitled to from Medicare for the emergency department and observation services provided in this encounter?

**Analysis:** The additional 3 hours of observation while the patient is waiting for a ride home is not covered and should not be billed as covered to Medicare. Because there are only 6 hours of covered observation, the hospital is only entitled to payment for the emergency department visit, with a payment rate of \$381.61 and the observation services are packaged.

Refer to *IOCE Specifications, Sections 6.6.4.1 and 6.6.4.2; OPPS Addendum B.*

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## Excerpt from Medicare Benefit Policy Manual, Chapter 6

The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure or provide additional orders. CMS would not expect that the supervisory physician or nonphysician practitioner would make all decisions unilaterally without informing or consulting the patient's treating physician or nonphysician practitioner. In summary, the supervisory physician or nonphysician practitioner must be clinically able to supervise the service or procedure.

### **20.5.3 - Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2020 – Changes to Supervision Requirements**

*(Rev. 10541; Issued: 12-31-20; Effective: 01-01-21; Implementation: 01-04-21)*

Starting January 1, 2020, CMS requires, as the minimum level of supervision, general supervision by an appropriate physician or non-physician practitioner in the provision of all therapeutic services to hospital outpatients, including CAH outpatients. "General supervision" means the definition specified at 42 CFR 410.32(b)(3)(i), that is, the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. CMS may assign certain hospital outpatient therapeutic services either direct supervision or personal supervision. When such assignment is made, "direct supervision" means the definition specified at 42 CFR 410.32(b)(3)(ii), that is, the physician must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or must be present in the room when the procedure is performed. "Personal supervision" means the definition specified at 42 CFR 410.32(b)(3)(iii), that is, the physician must be in attendance in the room during the performance of the service or procedure.

*The list of services starting January 1, 2020 and ending December 31, 2020 that are defined as non-surgical extended duration therapeutic services where the initiation of the service must be performed under direct supervision is available on the OPPTS Website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>. Starting January 1, 2021, the minimum level of supervision for non-surgical extended duration therapeutic services will be general supervision for the entire service including for the initiation of the service.*

### **20.6 - Outpatient Observation Services**

**(Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)**

#### **A. Outpatient Observation Services Defined**

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.

Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. 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. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Hospitals may bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department (ED) visit. Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly referred for observation services.

See, Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 290, at <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf> for billing and payment instructions for outpatient observation services.

Future updates will be issued in a Recurring Update Notification.

## **B. Coverage of Outpatient Observation Services**

When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 10 "Covered Inpatient Hospital Services Covered Under Part A" at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf>). For more information on correct reporting of observation services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 290.2.2.)

All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare. Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). As of January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378. In most circumstances, observation services are supportive and ancillary to the other separately payable services provided to a patient. Beginning January 1, 2016, in certain circumstances when observation care is billed in conjunction with a clinic visit, Type A emergency department visit (Level 1 through 5), Type B emergency department visit (Level 1 through 5), critical care services, or direct referral for observation services as an

integral part of a patient's extended encounter of care, comprehensive payment may be made for all services on the claim including, the entire extended care encounter when certain criteria are met. For information about billing and payment methodology for observation services in years prior to CY 2008, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §§290.3-290.4. For information about payment for extended assessment and management under composite APCs and comprehensive APCs, see §290.5.

Payment for all reasonable and necessary observation services is packaged into the payments for other separately payable services provided to the patient in the same encounter. Observation services packaged through assignment of status indicator N are covered OPPTS services. Since the payment for these services is included in the APC payment for other separately payable services on the claim, hospitals must not bill Medicare beneficiaries directly for the packaged services.

### **C. Services Not Covered by Medicare and Notification to the Beneficiary**

In making the determination whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services related to an encounter that includes observation care, the provider should follow a two step process. First, the provider must decide whether the item or service meets either the definition of observation care or would be otherwise covered. If the item or service does not meet the definitional requirements of any Medicare-covered benefit under Part B, then the item or service is not covered by Medicare and an ABN is not required to shift the liability to the beneficiary. However, the provider may choose to provide voluntary notification for these items or services.

Second, if the item or service meets the definition of observation services or would be otherwise covered, then the provider must decide whether the item or service is "reasonable and necessary" for the beneficiary on the occasion in question, or if the item or service exceeds any frequency limitation for the particular benefit or falls outside of a timeframe for receipt of a particular benefit. In these cases, the ABN would be used to shift the liability to the beneficiary (see Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, "Financial Liability Protections," Section 20, at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf> for information regarding Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed).

If an ABN is not issued to the beneficiary, the provider may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not have reasonably been expected to know that Medicare would not pay for the item or service.

## **20.7 - Non-Surgical Extended Duration Therapeutic Services**

**(Rev.267, Issued: 02-04-2020, Effective: 01-01-2020, Implementation: 01-06-2020)**

CMS can designate certain therapeutic services meeting specific criteria as nonsurgical extended duration therapeutic services (“extended duration services”), defined in 42 CFR 410.27(a)(1)(v). These are outpatient therapeutic services that can last a significant period of time, have a substantial monitoring component that is typically performed by auxiliary personnel, have a low risk of requiring the supervisory practitioner’s immediate availability to furnish assistance and direction after the initiation of the service, and that are not primarily surgical in nature. In the provision of these services, CMS requires a minimum of direct supervision during the initiation of the service which may be followed by general supervision for the remainder of the service at the discretion of the supervisory practitioner. The CMS OPPTS Website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> includes a table listing the current extended duration services for the payment year.

For these services, direct supervision means the definition specified for all outpatient therapeutic services in 410.27(a)(1)(iv), that is, immediate availability to furnish assistance and direction throughout the performance of the procedure. General supervision means the definition specified in the physician fee schedule at 410.32(b)(3)(i), that the service is performed under the supervisory practitioner’s overall direction and control but his or her presence is not required during the performance of the procedure.

“Initiation” means the beginning portion of the extended duration service, ending when the supervisory practitioner believes the patient is stable enough for the remainder of the service to be safely administered under general supervision. The point of transition to general supervision must be documented in the patient’s progress notes or medical record. The manner of documentation is otherwise at the discretion of each supervisory practitioner.

## **30 - Drugs and Biologicals**

**(Rev. 1, 10-01-03)**

**A3-3112.4.B, HO-230.4.B**

See the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” §50 for a description of conditions for coverage for drugs and biologicals.

Notwithstanding the instructions in the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” drugs and biologicals furnished to hospital or SNF inpatients who have exhausted Part A benefits, or who are not eligible under Part A, are not covered under Part B except the following:

## Excerpt from Medicare Claims Processing Manual, Chapter 4

The RHC/FQHC services remain subject to the encounter rate payment methodology and are billed using the RHC/FQHC provider number, bill type and revenue codes.

See the Medicare Benefit Policy Manual for a description of covered RHC/FQHC services.

See chapter 9, in this manual for billing instructions for provider based and independent RHC/FQHC services.

### **290 - Outpatient Observation Services**

(Rev. 1, 10-03-03)

A3-3663, A3-3112.8.D, A-01-91

#### **290.1 - Observation Services Overview**

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that 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. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. 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.

#### **290.2 - General Billing Requirements for Observation Services**

(Rev. 787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

##### **290.2.1 - Revenue Code Reporting**

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Hospitals are required to report observation charges under the following revenue codes:

Revenue Code	Subcategory
0760	General Classification category
0762	Observation Room

Other ancillary services performed while the patient receives observation services are reported using appropriate revenue codes and HCPCS codes as applicable.

### **290.2.2 - Reporting Hours of Observation**

**(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)**

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's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

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. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, 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 or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, 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.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

### **290.3 - Reserved**

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

### **290.4 - Billing and Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007**

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

#### **290.4.1 - Billing and Payment for All Hospital Observation Services Furnished Between January 1, 2006 and December 31, 2007**

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Since January 1, 2006, two G-codes have been used to report observation services and direct referral for observation care. For claims for dates of service January 1, 2006 through December 31, 2007, the Integrated Outpatient Code Editor (I/OCE) determines whether the observation care or direct referral services are packaged or separately payable. Thus, hospitals provide consistent coding and billing under all circumstances in which they deliver observation care.

Beginning January 1, 2006, hospitals should not report CPT codes 99217-99220 or 99234-99236 for observation services. In addition, the following HCPCS codes were discontinued as of January 1, 2006: G0244 (Observation care by facility to patient), G0263 (Direct Admission with congestive heart failure, chest pain or asthma), and G0264 (Assessment other than congestive heart failure, chest pain, or asthma).

The three discontinued G-codes and the CPT codes that were no longer recognized were replaced by two new G-codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct referral for observation care, whether separately payable or packaged:

- G0378- Hospital observation service, per hour; and
- G0379- Direct admission of patient for hospital observation care.

The I/OCE determines whether observation services billed as units of G0378 are separately payable under APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter. Therefore, hospitals should bill HCPCS code G0378 when observation services are ordered and provided to any patient regardless of the patient's condition. The units of service should equal the number of hours the patient receives observation services.

Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or hospital outpatient surgical procedure (status indicator T procedure) on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly for observation care after being seen by a physician in the community (see §290.4.2 below)

Some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service. See chapter 1, section 50.2.2 of this manual. It is vitally important that all of the charges that pertain to a non-repetitive, separately paid procedure or service be reported on the same claim with that procedure or service. It should also be emphasized that this relaxation of same day billing requirements for some non-repetitive services does not apply to non-repetitive services provided on the same day as either direct referral to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including diagnostic tests, lab services, hospital clinic visits, emergency department visits, critical care services, and status indicator T procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

#### **290.4.2 - Separate and Packaged Payment for Direct Referral for Observation Services Furnished Between January 1, 2006 and December 31, 2007**

**(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)**

In order to receive separate payment for a direct referral for observation care (APC 0604), the claim must show:

1. Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service;
2. That no services with a status indicator T or V or Critical care (APC 0617) were provided on the same day of service as HCPCS code G0379; and
3. The observation care does not qualify for separate payment under APC 0339.

Only a direct referral for observation services billed on a 13X bill type may be considered for a separate APC payment.

Separate payment is not allowed for HCPCS code G0379, direct admission to observation care, when billed with the same date of service as a hospital clinic visit, emergency room visit, critical care service, or “T” status procedure.

If a bill for the direct referral for observation services does not meet the three requirements listed above, then payment for the direct referral service will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

### **290.4.3 - Separate and Packaged Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007**

**(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)**

Separate payment may be made for observation services provided to a patient with congestive heart failure, chest pain, or asthma. The list of ICD-9-CM diagnosis codes eligible for separate payment is reviewed annually. Any changes in applicable ICD-9-CM diagnosis codes are included in the October quarterly update of the OPPS and also published in the annual OPPS Final Rule. The list of qualifying ICD-9-CM diagnosis codes is also published on the OPPS Web page.

All of the following requirements must be met in order for a hospital to receive a separate APC payment for observation services through APC 0339:

#### **1. Diagnosis Requirements**

- a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.
- b. Qualifying ICD-9-CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

#### **2. Observation Time**

- a. Observation time must be documented in the medical record.
- b. Hospital billing for observation services begins at the clock time documented in the patient’s medical record, which coincides with the time that observation

services are initiated in accordance with a physician's order for observation services.

- c. A beneficiary's time receiving observation services (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.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

### 3. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
  - An emergency department visit (APC 0609, 0613, 0614, 0615, 0616) or
  - A clinic visit (APC 0604, 0605, 0606, 0607, 0608); or
  - Critical care (APC 0617); or
  - Direct referral for observation care reported with HCPCS code G0379 (APC 0604); must be reported on the same date of service as the date reported for observation services.
- b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

### 4. Physician Evaluation

- a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Only observation services that are billed on a 13X bill type may be considered for a separate APC payment.

Hospitals should bill all of the other services associated with the observation care, including direct referral for observation, hospital clinic visits, emergency room visits, critical care services, and T status procedures, on the same claim so that the claims

processing logic may appropriately determine the payment status (either packaged or separately payable) of HCPCS codes G0378 and G0379.

If a bill for observation care does not meet all of the requirements listed above, then payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

## **290.5 - Billing and Payment for Observation Services Furnished on or After January 1, 2008**

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

### **290.5.1 - Billing and Payment for Observation Services Furnished Between January 1, 2008 and December 31, 2015**

(Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. From January 1, 2014 through December 31, 2015, in certain circumstances when observation care was billed in conjunction with a clinic visit, high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through APC 8009 (Extended Assessment and Management Composite) when certain criteria are met. Prior to January 1, 2014, in certain circumstances when observation care was billed in conjunction with a high level clinic visit (Level 5), high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment could be made for the entire extended care encounter through one of two composite APCs (APCs 8002 and 8003) when certain criteria were met. APCs 8002 and 8003 are deleted as of January 1, 2014 and APC 8009 is deleted as of January 1, 2016. For information about payment for extended assessment and management composite APC, see §10.2.1 (Composite APCs) of this chapter.

There is no limitation on diagnosis for payment of APC 8009; however, 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. The I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

### 1. Observation Time

- a. Observation time must be documented in the medical record.
- b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
- c. A beneficiary's time receiving observation services (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.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

### 2. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
  - A Type A or B emergency department visit (CPT codes 99284 or 99285 or HCPCS code G0384); or
  - A clinic visit (HCPCS code G0463 beginning January 1, 2014; CPT code 99205 or 99215 prior to January 1, 2014); or
  - Critical care (CPT code 99291); or
  - Direct referral for observation care reported with HCPCS code G0379 (APC 0633) must be reported on the same date of service as the date reported for observation services.
- b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

### 3. Physician Evaluation

- a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration,

discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that the criteria will be met for payment of the extended encounter through extended assessment and management composite payment.

Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

### **290.5.2 - Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008**

**(Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)**

Direct referral for observation is reported using HCPCS code G0379 (Direct referral for hospital observation care). Prior to January 1, 2010, the code descriptor for HCPCS code G0379 was (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct referral 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. Hospitals should only report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Payment for direct referral for observation care will be made either separately as a hospital visit under APC 5013 (Level 3 Examinations & Related Services) or packaged into payment for comprehensive APC 8011 (Comprehensive Observation Services) or packaged into the payment for other separately payable services provided in the same

encounter. For information about comprehensive APCs, see §10.2.3 (Comprehensive APCs) of this chapter.

The criteria for payment of HCPCS code G0379 under either APC 5013 or APC 8011 include:

1. Both HCPCS codes G0378 (Hospital observation services, per hr.) and G0379 (Direct referral for hospital observation care) are reported with the same date of service.
2. No service with a status indicator of T or V or Critical Care (APC 5041) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

Only a direct referral for observation services billed on a 13X bill type may be considered for a comprehensive APC payment through the Comprehensive Observation Services APC (APC 8011).

### **290.5.3 - Billing and Payment for Observation Services Furnished Beginning January 1, 2016** (Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. Beginning January 1, 2016, in certain circumstances when observation services are billed in conjunction with a clinic visit, Type A emergency department visit (Level 1 through 5), Type B emergency department visit (Level 1 through 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, comprehensive payment may be made for all services on the claim including, the entire extended care encounter through comprehensive APC 8011 (Comprehensive Observation Services) when certain criteria are met. For information about comprehensive APCs, see §10.2.3 (Comprehensive APCs) of this chapter.

There is no limitation on diagnosis for payment of APC 8011; however, comprehensive 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. The I/OCE evaluates every claim received to determine if payment through a comprehensive APC is appropriate. If payment through a comprehensive APC

is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive a comprehensive APC payment through the Comprehensive Observation Services APC (APC 8011):

#### 1. Observation Time

- a. Observation time must be documented in the medical record.
- b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
- c. A beneficiary's time receiving observation services (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.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

#### 2. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
  - A Type A or B emergency department visit (CPT codes 99281 through 99285 or HCPCS codes G0380 through G0384); or
  - A clinic visit (HCPCS code G0463); or
  - Critical care (CPT code 99291); or
  - Direct referral for observation care reported with HCPCS code G0379 (APC 5013) must be reported on the same date of service as the date reported for observation services.
- b. No procedure with a T status indicator or a J1 status indicator can be reported on the claim.

#### 3. Physician Evaluation

- a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that the criteria will be met for payment of the extended encounter through the Comprehensive Observation Services APC (APC 8011).

Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a comprehensive APC payment through the Comprehensive Observation Services APC (APC 8011).

Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

### **290.6 - Services Not Covered as Observation Services**

**(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)**

Hospitals must not bill beneficiaries directly for reasonable and necessary observation services for which the OPPS packages payment for observation as part of the payment for the separately payable items and services on the claim. Hospitals should not confuse packaged payment with non-coverage or nonpayment. See the Medicare Benefit Policy Manual, Pub 100-02, chapter 6, section 20.6 for further explanation of non-covered services and notification of the beneficiary in relation to observation care.

### **300 - Medical Nutrition Therapy (MNT) Services**

**(Rev. 2127, Issued: 12-29-10, Effective: 01-01-2002, Implementation: 03-29-11)**