



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE Module 7: Observation Services

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 a CAH's emergency department 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 the patient's complex history of diabetes, diverticulitis, and prior gastrointestinal blockage.

The hospitalist sees the patient and writes an initial note for the patient's need for observation services, including an explicit assessment of the risks of discharge for the patient. The hospitalist orders observation at 9:00 a.m., IV infusion of antiemetics and pain medication, laboratory, and an abdominal CT scan.

The observation nurse does an initial assessment and implements the physician's orders. The physician sees the patient at 2:00 p.m., writing a progress note on the results of the diagnostic tests. The physician documents her plans to discharge the patient if the patient can tolerate liquids and his blood sugar remains stable. The patient responds well to the anti-emetics, is tolerating liquids, and his blood sugar is within normal limits. The physician discharges the patient home at 6:30 p.m.

- Are the observation services covered by Medicare?

D. Non-covered vs. 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;

- 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 patient sees their physician in the clinic at 4:00 p.m. The patient requires a complex drug infusion titrated over three hours. The CAH's outpatient infusion center closes at 5:00 p.m.

After consultation with infusion center staff, the physician orders the infusion to be performed on the medical floor of the hospital. The physician orders observation services with the drug infusion and to discharge the patient after the drug infusion is complete and the patient is stable.

The patient presents to the hospital and is placed in an inpatient bed on the medical floor. The infusion is started at 4:45 p.m. and is completed by 8:00 p.m. The patient is discharged home at 8:30 p.m.

- Are the observation services ordered by the physician during the drug infusion covered by Medicare?

II. Notice to Patients in Observation

A. General Rule

1. Hospitals and CAHs must provide oral and written notice, in the form of the Medicare Outpatient Observation Notice (MOON), regarding the outpatient nature of observation and its implications to Medicare patients who are in observation for more than 24 hours. <Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act; 81 *Fed. Reg.* 57038; *Medicare Claims Processing Manual*, Chapter 30 § 400.1>

B. Covered Individuals

1. Notice is required for patients receiving ordered observation for more than 24 hours who:
 - a. Are entitled to Medicare Part A or Part B, whether or not Medicare Part B pays for the observation services that are the subject of the notice; or
 - b. Are enrolled in Medicare Advantage plans or Medicare Health plans; or
 - c. Have Medicare Part A or Part B as a secondary payer. <81 *Fed. Reg.* 57038-041; *Medicare Claims Processing Manual*, Chapter 30 § 400.2>

2. For purposes of determining if a patient has received observation for more than 24 hours, observation time is started when care is initiated in accordance with the physician's order and is counted by elapsed time, without subtracting intervening procedures that require monitoring (discussed in more detail later). <81 *Fed. Reg.* 57043-44; *Medicare Claims Processing Manual*, Chapter 30 § 400.3.4>
 - a. This may result in a different number of hours of observation for purposes of application of the observation notice requirements and for billing. <81 *Fed. Reg.* 57043>
3. Notice is not required for:
 - a. Outpatients who do not receive ordered observation services for more than 24 hours, including patients who had less than 24 hours of medically necessary observation and remain in the hospital after all medically necessary observation has ended. <81 *Fed. Reg.* 57044>
 - b. Patients discharged or admitted before 24 hours have elapsed from the time observation services were ordered, (i.e., who did not have 24 hours of observation before they are admitted or discharged). <81 *Fed. Reg.* 57039, 57044>

Case Study 3

Facts: A Medicare patient presents to the emergency department at 3:00 p.m. on Monday with flu like symptoms. After diagnostic tests, the emergency department physician is concerned the patient may be developing pneumonia. She writes an order for observation, hydration, and IV antibiotics at 7:00 p.m.

The hospitalist sees the patient Tuesday morning in observation and orders repeat diagnostic tests. By afternoon, the patient is doing better. The hospitalist writes a discharge order and the patient goes home with family members at 5:00 p.m.

- Is a notice applicable in this scenario?
- If so, which notice(s) apply?

C. Timing of the Notice

1. Notice is required no later than 36 hours from the initiation of observation services; or

2. For patients who have received 24 hours of observation but are being transferred, discharged, or admitted prior to the 36th hour of observation, notice is required at the time of transfer, discharge, or admission. <81 *Fed. Reg.* 57041-44; *Medicare Claims Processing Manual*, Chapter 30 § 400.3.4>
 - a. If the patient is admitted, the provider must include Part A cost sharing information, as well as the date and time of admission, in the additional information section of the MOON form. <81 *Fed. Reg.* 57040; *Medicare Claims Processing Manual*, Chapter 30 § 400.3.8>
3. Notice may be provided prior to the 24th hour of observation. <*Medicare Claims Processing Manual*, Chapter 30 § 400.2>

Case Study 4

Facts: A Medicare patient presents to the emergency department at 3:00 p.m. on Monday with chest pain and shortness of breath. Diagnostic tests are completed at 7:00 p.m. and the emergency department physician writes an order for observation, IV pain medication, and IV antibiotics.

By Tuesday afternoon, the patient was still short of breath and the hospitalist is concerned the pneumonia may be developing. He orders a different antibiotic and repeat testing. At 9:00 p.m., the hospitalist writes an order to admit as an inpatient. By Wednesday morning, the patient had significantly improved and was discharged home at 2:00 p.m.

- In this scenario, is the hospital required to provide the patient a notice?
- If notice is required, which notice is applicable and what is the deadline for providing the notice?

D. Format and Content of the Notice

1. The Medicare Outpatient Observation Notice (MOON) is the required form for providing notice to Medicare beneficiaries under the NOTICE Act. Handout 13 is a copy of the MOON form. <81 *Fed. Reg.* 57044; *Medicare Claims Processing Manual*, Chapter 30 § 400.1>
 - a. CMS published an updated MOON, with expiration date of 11/30/2025, which is required beginning April 1, 2020. Only the expiration date was changed on the new version.

- b. CMS also issued "Notice Instructions: Medicare Outpatient Observation Notice" and "Frequently Asked Questions" with the MOON form. <cms.gov, "Beneficiary Notice Initiative (BNI), Medicare Outpatient Observation Notice (MOON)" website>

Link: Beneficiary Notice Initiative under Medicare-Related Sites - General

2. Notice is required by providing both the written MOON form and oral explanation of the information on the MOON. <81 *Fed. Reg.* 57047-051; *Medicare Claims Processing Manual*, Chapter 30 § 400.1, 400.3.3>
 - a. Oral notice can be in the form of a video, provided a staff person is always available to answer questions about the written and oral explanation. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.3>
3. The MOON may be issued electronically, but the beneficiary must be given the option of a paper form and be provided a paper copy of the MOON after signing. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.3>
4. Content of the written notice and oral explanation
 - a. The notice must explain that the patient is receiving outpatient observation services, is not an inpatient and why. <Notice of Observation Treatment and Implication for Care Eligibility Act; 81 *Fed. Reg.* 57044-57048; Medicare Outpatient Observation Notice>
 - i. The clinical rationale for why the patient is receiving outpatient observation rather than inpatient services must be included in the "free text" field at the top of the MOON form. <Medicare Outpatient Observation Notice, Frequently Asked Questions, March 8, 2017>
 - ii. The information in the "free text" field should be reasonably understandable to the beneficiary and generally explain:
 - a) The physician has ordered outpatient observation services in order to evaluate the beneficiary's symptoms and diagnosis; and
 - b) The beneficiary's condition and symptoms will continue to be evaluated to assess whether they will need to be admitted as an inpatient or transferred or discharged from the hospital. <Medicare Outpatient Observation Notice, Frequently Asked Questions, March 8, 2017>

E. Delivery

1. Comprehension

- a. Hospitals must use translators, interpreters, and assistive devices, if necessary, to ensure the patient understands the notice. <81 *Fed. Reg.* 5704; *Medicare Claims Processing Manual*, Chapter 30 § 400.3.7; Medicare Outpatient Observation Notice, Frequently Asked Questions, March 8, 2017>

2. Beneficiary Representative

- a. Notice may be delivered to a beneficiary's appointed representative designated by the beneficiary to act on their behalf or an authorized representative under state law (e.g., legal guardian or durable power of attorney). <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.6>
- b. For patients who are temporarily or permanently incompetent, hospitals must provide notice to an authorized representative or a person the hospital has determined could reasonably represent the beneficiary, and acts in their best interests, in a manner protective of the beneficiary's rights and who has no conflict of interest. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.6>
- c. Notice to a Representative
 - i. When delivering notice to a representative, document the details in the "Additional Information" section. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.6>

For delivery to a representative, document:

 - *The name of the staff person initiating the contact;*
 - *The name of the person contacted; and*
 - *The date, time, and method of contact (e.g. in person or by telephone), including telephone number.*
 - ii. If telephone delivery is required, the information provided by telephone must include the entire contents of the MOON, which must be documented in the "Additional Information" section of the MOON. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.6>
 - iii. The date and time of the contact, or good faith attempt to contact the representative, is considered the date and time of the receipt of the MOON. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.6>

- iv. The copy sent to the representative must be sent by certified mail, return receipt requested or other delivery method that can provide signed verification of the delivery (e.g., Fed Ex, UPS). <Medicare Claims Processing Manual, Chapter 30 § 400.3.6>

3. Signature and Retention

- a. The MOON form should be signed by the patient or their authorized representative. <81 Fed. Reg. 57051, Medicare Claims Processing Manual, Chapter 30 § 400.3.3>
- b. If the patient or their representative refuse to sign the notice, the staff member who provided the notice must note the following in the "Additional Information" section:
 - i. The date and time the notice was presented;
 - ii. A certifying statement that the notice was presented and the patient or their representative refused to sign, including the name of the person who refused;
 - iii. The name, title and signature of the staff member who presented the notice. <81 Fed. Reg. 57051, Medicare Claims Processing Manual, Chapter 30 § 400.3.5, See Notice Instructions: Medicare Outpatient Observation Notice>

Example of documentation if patient refuses to sign MOON: I, John Doe, staff nurse, certify that this notice was presented and explained to the patient, Jane Smith, on 08/06/16 at 11:00 p.m. and the patient refused to sign the notice. Signed: John Doe, RN.

- c. The signed MOON must be retained in the patient's medical record, in hard copy or electronically. <Medicare Claims Processing Manual, Chapter 30 § 400.3.9>

III. Billing and Payment for Observation Services

- A. Observation services are billed with two G-codes for all covered services.
 - 1. G0378 – "Hospital observation services, per hour"
 - 2. G0379 – "Direct referral of patient for hospital observation care"

- a. Code G0379 must be reported with G0378. <See Handout 11 - *IOCE Specifications, 6.2 Edit Descriptions and Reason for Edit Generation Table Edit 58*>
 - i. Edit 58 does not apply to a CAH; however, the hospital should be aware of the appropriate reporting of G0379 with G0378. <See Handout 11 - *IOCE Specifications, 6.2 Edit Descriptions and Reason for Edit Generation Table Edit 58*>
- b. Hospitals should not report G0379 when observation services are the result of a direct referral for observation care with an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. <*Medicare Claims Processing Manual, Chapter 4 § 290.5.2*>
 - i. 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. <*Medicare Claims Processing Manual, Chapter 4 § 290.5.2*>
- 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 receiving observation services are reported using appropriate revenue codes and HCPCS codes as applicable. <*Medicare Claims Processing Manual, Chapter 4 § 290.2.1*>
- C. The unit of service for observation is hours, rounded to the nearest hour. <*Medicare Claims Processing Manual, Chapter 4 § 290.2.2*>
 - 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 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 an appropriate E/M visit charge.

Tip: Medically necessary services such as therapy, wound care, or drug administration, provided after medically necessary observation has ended and 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 and before the patient is discharged.
 - i. However, reported observation time would not include the time a patient remains 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. Where active monitoring is part of a procedure that occurs during observation services, the time providing the procedure should be subtracted from the total observation time reported. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>

When determining the amount of time to be subtracted for actively monitored services, the provider may:

- Document the beginning and end times for services with active monitoring; or
- Subtract an average length of time for the service with active monitoring.

- 4. All hours of observation should be reported on a single line. The line item date of service 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>

IV. Payment for Observation Services

- 1. A CAH 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. <Integrated Outpatient Code Editor, Processing Conditions Applied to OPPS Claims Only, 6.6.4.1 Comprehensive Observation APC Assignment Criteria>

Tip: CMS has implemented a Medically Unlikely Edit (MUE) of 72 hours for G0378 preventing reporting of more than 72 hours of observation. However, 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).

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Case Study 5

Facts: A patient presented to an emergency department at 10:00 p.m. complaining of chest pain. The ED physician evaluated the patient and requested a consult with a cardiologist. At 1:00 a.m. the next morning, the cardiologist assessed the patient's risks, wrote an order for observation, and an initial note regarding the need for observation services. The observation nurse did an initial assessment and made the patient comfortable. The cardiologist saw the patient in observation at 3:00 a.m., wrote a progress note, and ordered various diagnostic tests. At 6:00 a.m., the cardiologist wrote an order discharging the patient home with instructions to see her in the office later that day. At 7:00 a.m., observation care was completed, and the patient left the hospital. The CAH assigned the emergency department visit a level 4 (99284).

- Are the observation services covered?
- What HCPCS codes should be reported for the emergency department visit?
- What HCPCS code and total units should be reported for the observation services?
- Will the CAH be paid for both the ER visit and the observation hours?

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient presents to a CAH's emergency department 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 the patient's complex history of diabetes, diverticulitis, and prior gastrointestinal blockage.

The hospitalist sees the patient and writes an initial note for the patient's need for observation services, including an explicit assessment of the risks of discharge for the patient. The hospitalist orders observation at 9:00 a.m., IV infusion of antiemetics and pain medication, laboratory, and an abdominal CT scan.

The observation nurse does an initial assessment and implements the physician's orders. The physician sees the patient at 2:00 p.m., writing a progress note on the results of the diagnostic tests. The physician documents her plans to discharge the patient if the patient can tolerate liquids and his blood sugar remains stable. The patient responds well to the anti-emetics, is tolerating liquids, and his blood sugar is within normal limits. The physician discharges the patient home at 6:30 p.m.

- Are the observation services covered by Medicare?

Analysis: Yes, the observation services are provided to determine 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.

Case Study 2

Facts: A patient sees their physician in the clinic at 4:00 p.m. The patient requires a complex drug infusion titrated over three hours. The CAH's outpatient infusion center closes at 5:00 p.m.

After consultation with infusion center staff, the physician orders the infusion to be performed on the medical floor of the hospital. The physician orders observation services with the drug infusion and to discharge the patient after the drug infusion is complete and the patient is stable.

The patient presents to the hospital and is placed in an inpatient bed on the medical floor. The infusion is started at 4:45 p.m. and is completed by 8:00 p.m. The patient is discharged home at 8:30 p.m.

- Are the observation services ordered by the physician during the drug infusion covered by Medicare?

Analysis: No. The purpose of the observation services was not to determine if the patient needed to be admitted as an inpatient or could be discharged home. Prior to the patient leaving the physician's office, it was already determined that once the infusion was complete the patient would be discharged home. Also, the observation services were provided concurrently with another Part B service requiring active monitoring.

Case Study 3

Facts: A Medicare patient presents to the emergency department at 3:00 p.m. on Monday with flu like symptoms. After diagnostic tests, the emergency department physician is concerned the patient may be developing pneumonia. She writes an order for observation, hydration, and IV anti-biotics at 7:00 p.m.

The hospitalist sees the patient Tuesday morning in observation and orders repeat diagnostic tests. By afternoon, the patient is doing better. The hospitalist writes a discharge order and the patient goes home with family members at 5:00 p.m.

- Is a notice applicable in this scenario?
- If so, which notice(s) apply?

Analysis: No notice is required for this patient. The MOON would not be required because the patient was only in observation for 22 hours. Further, an ABN would not be required because the observation services were covered.

Case Study 4

Facts: A Medicare patient presents to the emergency department at 3:00 p.m. on Monday with chest pain and shortness of breath. Diagnostic tests are completed at 7:00 p.m. and the emergency department physician writes an order for observation, IV pain medication, and IV antibiotics.

By Tuesday afternoon, the patient was still short of breath and the hospitalist is concerned the pneumonia may be developing. He orders a different antibiotic and repeat testing. At 9:00 p.m., the hospitalist writes an order to admit as an inpatient. By Wednesday morning, the patient had significantly improved and was discharged home at 2:00 p.m.

- In this scenario, is the hospital required to provide the patient a notice?
- If notice is required, which notice is applicable and what is the deadline for providing the notice?

Analysis: The MOON is required because the patient had more than 24 hours of observation (26 hours) regardless that the patient was eventually admitted. The MOON must be delivered no later than 7:00 a.m. on Wednesday morning, 36 hours after observation was ordered on Monday evening.

The date and time of admission should be noted in the additional information section, along with information about Part A cost sharing.

Case Study 5

Facts: A patient presented to an emergency department at 10:00 p.m. complaining of chest pain. The ED physician evaluated the patient and requested a consult with a cardiologist. At 1:00 a.m. the next morning, the cardiologist assessed the patient's risks, wrote an order for observation, and an initial note regarding the need for observation services. The observation nurse did an initial assessment and made the patient comfortable. The cardiologist saw the patient in observation at 3:00 a.m., wrote a progress note, and ordered various diagnostic tests. At 6:00 a.m., the cardiologist wrote an order discharging the patient home with instructions to see her in the office later that day. At 7:00 a.m., observation care was completed, and the patient left the hospital. The CAH assigned the emergency department visit a level 4 (99284).

- Are the observation services covered?
- What HCPCS codes should be reported for the emergency department visit?
- What HCPCS code and total units should be reported for the observation services?
- Will the CAH be paid for both the ER visit and the observation hours?

Analysis: The observation services meet the order and documentation requirements and will be considered covered. The emergency department visit should be billed with 99284 and the observation services should be billed with G0378 with units of 6. The hospital will be paid for the emergency department visit (99284), medically necessary diagnostic tests, and the observation services.

Modified Facts: The patient was ready for discharge at 7:00 a.m., but did not leave the hospital until 12:00 p.m. because the patient was waiting for transportation home

- Are the additional hours of observation services covered?
- What HCPCS code and total units should be reported for the observation services?

Analysis: No, the additional 5 hours of observation while the patient is waiting for transportation are not covered and should not be billed to Medicare. The hospital should only bill Medicare for 6 hours of covered observation. The hospital could have issued an ABN to make the patient financially responsible for the time spent waiting for transportation.

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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 <http://www.cms.hhs.gov/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 OPPS 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

<http://www.cms.hhs.gov/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.

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Medicare Claims Processing Manual, Chapter 4**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.