



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 13: 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 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. <See *Medicare Claims Processing Manual*, Chapter 4 § 290.2.2>
3. Standing orders for observation following outpatient surgery are not recognized. <See *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). <See *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. Notice to Patients in Observation

A. General Rule

1. Hospitals 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; see *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; see *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. <81 Fed. Reg. 57043-44; see *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 medical 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 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 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 p.m.

What notice or notices, if any, is the hospital required to provide the patient?

C. Timing of the Notice

1. Notice may be provided prior to the 24th hour of observation and is required no later than 36 hours from the initiation of observation services. <81 Fed. Reg. 57047; see *Medicare Claims Processing Manual*, Chapter 30 §§ 400.3.4, 400.3.8>; 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; see *Medicare Claims Processing Manual*, Chapter 30 § 400.3.4>
 - a. If the patient is admitted, the provider must include Part A cost share information and the implications of the three-day window (i.e. there is no separate Part B cost share for observation and other outpatient service provided in the three days before admission) in the additional information section of the MOON form. <81 Fed. Reg. 57040; see *Medicare Claims Processing Manual*, Chapter 30 § 400.3.8>
 - b. If the patient is admitted, and the MOON form is delivered after admission, the provider must note the date and time of admission. <81 Fed. Reg. 57047; see *Medicare Claims Processing Manual*, Chapter 30 § 400.3.8>

Case Study 4

Facts: A Medicare patient presents to the emergency department at 3 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 p.m.

Tuesday afternoon the hospitalist is concerned the pneumonia is continuing to develop and orders a different antibiotic and repeat testing. At 9 p.m. Tuesday evening, the hospitalist writes an admission order. By Wednesday morning, the patient is doing much better and is discharged with family at 2 p.m.

What notice or notices if any is the hospital required to provide the patient? If notice is required, 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 19 is the MOON form. <81 Fed. Reg. 57044; see *Medicare Claims Processing Manual*, Chapter 30 § 400.1>

- a. The latest MOON form has an expiration date of 11/30/25 and can be downloaded from the Beneficiary Notice Initiative page. <cms.gov website, “Beneficiary Notice Initiative (BNI)” page, Medicare Outpatient Observation Notice (MOON)” page>
- b. CMS also published “Frequently Asked Questions” with the MOON form.

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; see *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. <See *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. <See *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; see *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). <See *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. <See *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. <See *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. <See *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. <See *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; see *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; see *Medicare Claims Processing Manual*, Chapter 30 § 400.3.5>

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. <See *Medicare Claims Processing Manual*, Chapter 30 § 400.3.9>

III. Billing for Observation Services

- A. Covered observation services are billed with two G-codes:
 - 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 8.2, Edit 58 (Supplement)>
- B. Observation services are reported with revenue code 0762 (“Observation Hours”). <See *Medicare Claims Processing Manual*, Chapter 4 § 290.2.1>
 - 1. Ancillary services performed while the patient is in observation status are reported using appropriate revenue codes and HCPCS codes as applicable. <See *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. <See *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. <See *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. <See *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. <See *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. <See *Medicare Claims Processing Manual*, Chapter 4 § 290.2.2>

4. Observation is reported by hour, rounded to the nearest hour. <See *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. <See *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 am, 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”. <“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. <See *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. <See *Medicare Claims Processing Manual*, Chapter 4 § 290.5.3>

IV. Payment for Observation Services

- A. There are three ways Medicare pays for covered observation services: <See *Medicare Claims Processing Manual*, Chapter 4 §§ 290.5.1, 290.5.2, and 290.5.3; 80 *Fed. Reg.* 70335-336>

1. Packaged into/paid as part of the C-APC for Comprehensive Observation Services (APC 8011);
2. Packaged into a visit APC for direct referral for observation; or
3. 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; see *Medicare Claim Processing Manual*, Chapter 4 § 290.5.3>
2. Criteria for payment of C-APC 8011 (\$2,607.99)
 - 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; see *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; see *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; see *Medicare Claims Processing Manual*, Chapter 4 § 290.5.3>
- 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. <See *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. <See *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. No service with status indicator T, J1 or V (visit) is billed on the same claim. <*IOCE Specifications*, Section 6.6.4, 6.6.4.1 (Supplement); see *Medicare Claims Processing Manual*, Chapter 4 § 290.5.2>
- 2. Payment is made under APC 5025 – “Level 5 Type A ED Visit.” (\$611.99) <*IOCE Specifications*, 6.6.4, 6.6.4.1 (Supplement), OPPI Addendum A>

D. Packaged Observation Services

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. <See *Medicare Claims Processing Manual*, Chapter 4 § 290.5.1>

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

Case Study 5

Facts: A Medicare patient presented to an emergency department 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. Are the observation services covered? What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Modified Facts: The patient in the prior question continued in medically necessary observation until 10 a.m. and was discharged home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Modified Facts: The patient was ready for discharge at 7 a.m. but did not leave the hospital until 10 a.m. because they were waiting for transportation home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

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. <See *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. 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, these services were provided concurrently with another service requiring active monitoring. <See *Medicare Benefit Policy Manual*, Chapter 6 § 20.6>

Case Study 3

Facts: A Medicare patient presents to the emergency department at 3 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 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 p.m.

What notice or notices, if any, is the hospital required to provide the patient?

Analysis: No notice is required for this patient. The MOON would not to 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. <Medicare Claims Processing Manual, Chapter 30 § 400.3.4>

Case Study 4

Facts: A Medicare patient presents to the emergency department at 3 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 p.m.

Tuesday afternoon the hospitalist is concerned the pneumonia is continuing to develop and orders a different antibiotic and repeat testing. At 9 p.m. Tuesday evening, the hospitalist writes an admission order. By Wednesday morning, the patient is doing much better and is discharged with family at 2 p.m.

What notice or notices, if any is the hospital required to provide the patient? If notice is required, 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), even though the patient was eventually admitted. The MOON must be delivered no later than 7 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 the Part A cost share and the three-day payment window. <Medicare Claims Processing Manual, Chapter 30 § 400.3.4>

Note: The hospital should also deliver an Important Message from Medicare, discussed later in this module.

Case Study 5

Facts: A Medicare patient presented to an emergency department 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. Are the observation services covered? What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Analysis: The observation services meet the order and documentation requirements and are not excluded from coverage so they will be covered. The emergency department visit should be billed with 99284 and the observation services should be billed with G0378 with units of 6. The services do not qualify for payment of the Observation C-APC because 8 hours of observation were not provided. The hospital will be paid for the emergency department visit (99284) and the observation will be packaged into the emergency department visit. The payment rate for 99284 is \$422.00 which will be adjusted by the hospital's wage index. <See *Medicare Claims Processing Manual*, Chapter 4 § 290, OPPS Addendum B>

Modified Facts: The patient in the prior question continued in medically necessary observation until 10 a.m. and was discharged home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Analysis: The emergency department visit should be billed with 99284 and the observation services should be billed with G0378 with units of 9. The services qualify for payment of the Observation C-APC, with a payment rate of \$2,607.99. <See *Medicare Claims Processing Manual*, Chapter 4 § 290, OPPS Addendum B>

Modified Facts: The patient was ready for discharge at 7 a.m., but did not leave the hospital until 10 a.m. because they were waiting for transportation home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

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. The hospital should only bill for 6 hours of covered observation. The hospital will be paid for the emergency department visit (\$422.00) and the observation will be packaged. <See *Medicare Claims Processing Manual*, Chapter 4 § 290, OPPS Addendum B, *Medicare Benefit Policy Manual*, Chapter 6 § 20.6>

Version 03/25/2024
Check for Updates

Version 03/25/2024
Check for Updates

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 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 <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.

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)

Excerpt from Medicare Claims Processing Manual, Chapter 30

Extensions. A beneficiary who requests an expedited reconsideration may request (either in writing or orally) that an IRE grant such additional time as the beneficiary specifies (not to exceed 14 days) for the reconsideration. If an extension is granted, the deadlines described above under notification, do not apply.

300.3 - The Responsibilities of the QIO

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When an IRE notifies the QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the IRE needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the IRE notifies the QIO of the request for the reconsideration.

At the beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the IRE. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

300.4 - The Responsibilities of the Provider

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The provider may, but is not required to, submit evidence to be considered by an IRE in making its decision. If a provider fails to comply with an IRE's request for additional information beyond that furnished by the QIO for purposes of the expedited determination, the IRE makes its reconsideration decision based on the information available.

300.5 - Coverage During an Expedited Reconsideration

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When a beneficiary makes a timely request for an expedited determination, the provider may not bill the beneficiary for any disputed services until the IRE makes its determination. Beneficiary liability for continued services is based on the QIO's decision.



400 - Part A Medicare Outpatient Observation Notice

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON informs all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or critical access hospital (CAH).

400.1 - Statutory Authority

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) Public Law 114-42, amending Section 1866(a)(1) of the Social Security Act (the Act) (42 U.S.C. 1395cc(a)(1)), by adding a new subparagraph (Y). The NOTICE Act requires hospitals and CAHs to provide written and oral explanation of such written notification to individuals who receive observation services as outpatients for more than 24 hours.

The process for delivery of this notice, the Medicare Outpatient Observation Notice (MOON), was addressed in rulemaking, including a final rule, CMS-1655-F (81 FR 56761, 57037 through 57052, August 22, 2016), effective October 1, 2016. The resulting regulations are located at 42 CFR Part 489.20(y).

400.2 - Scope

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON.
- Beneficiaries for whom Medicare is either the primary or secondary payer.

NOTES:

- For purposes of these instructions, the term “beneficiary” means either beneficiary or representative, when a representative is acting for a beneficiary.
- Please see Chapter 13 of the Medicare Managed Care Manual for Medicare Advantage instructions.

The statute expressly provides that the MOON be delivered to beneficiaries who receive observation services as an outpatient for more than 24 hours. In other words, the statute does not require hospitals to deliver the MOON to all beneficiaries receiving outpatient services. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin. However, hospitals and CAHs may deliver the MOON to an individual receiving observation services as an outpatient before such individual has received more than 24 hours of observation services. Allowing delivery of the MOON before an individual has received 24 hours of observation services affords

hospitals and CAHs the flexibility to deliver the MOON consistent with any applicable State law that requires notice to outpatients receiving observation services within 24 hours after observation services begin. The flexibility to deliver the MOON any time up to, but no later than, 36 hours after observation services begin also allows hospitals and CAHs to spread out the delivery of the notice and other hospital paperwork in an effort to avoid overwhelming and confusing beneficiaries.

Hospitals Affected by these Instructions. These instructions apply to hospitals as well as CAHs per section 1861(e) and section 1861(mm) of the Social Security Act.

400.3 - Medicare Outpatient Observation Notice

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The MOON may only be modified as per their accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized MOON. The notice and accompanying instructions may be found online at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI>

400.3.1 - Alterations to the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

In general, the MOON must remain two pages, unless inclusion of additional information per section 400.3.8 or State-specific information per section 400.5 below results in additional page(s). Hospitals and CAHs subject to State law observation notice requirements may attach an additional page to the MOON to supplement the “Additional Information” section in order to communicate additional content required under State law, or may attach the notice required under State law to the MOON. The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

Hospitals may include their business logo and contact information on the top of the MOON. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, or any other information.

400.3.2 - Completing the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals must use the OMB-approved MOON (CMS-10611). Hospitals must type or write the following information in the corresponding blanks of the MOON:

- Patient name;
- Patient number; and
- Reason patient is an outpatient.

400.3.3 - Hospital Delivery of the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals and CAHs must deliver the MOON to beneficiaries in accordance with section 400.2 above. Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification.

Oral notification must consist of an explanation of the standardized written MOON. The format of such oral notification is at the discretion of the hospital or CAH, and may include, but is not limited to, a video format. However, a staff person must always be available to answer questions related to the MOON, both in its written and oral delivery formats.

The hospital or CAH must ensure that the beneficiary or representative signs and dates the MOON to demonstrate that the beneficiary or representative received the notice and understands its contents. Use of assistive devices may be used to obtain a signature.

Electronic issuance of the MOON is permitted. If a hospital or CAH elects to issue a MOON viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the MOON, as specified in 400.3.9, and the required beneficiary specific information inserted, at the time of notice delivery.

400.3.4 - Required Delivery Timeframes

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON must be delivered to a beneficiary who receives observation services as an outpatient for more than 24 hours, and must be delivered not later than 36 hours after observation services begin. The MOON must be delivered before 36 hours following initiation of observation services if the beneficiary is transferred, discharged, or admitted. The MOON may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.

The start time of observation services, for purposes of determining when more than 24 hours of observation services have been received, is the clock time observation services are initiated (furnished to the patient), as documented in the patient's medical record, in accordance with a physician's order. This follows the elapsed clock time, rather than the billed time, associated with the observation services.

400.3.5 - Refusal to Sign the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital or CAH who presented the written notification. The staff member's signature must include

the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the “Additional Information” section of the MOON to include the staff member’s signature and certification of delivery. The date and time of refusal is considered to be the date of notice receipt.

400.3.6 - MOON Delivery to Representatives

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON may be delivered to a beneficiary’s appointed representative. Appointed representatives are individuals designated by beneficiaries to act on their behalf. A beneficiary may designate an appointed representative via the “Appointment of Representative” form, the CMS-1696. <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>. See Chapter 29 of the Medicare Claims Processing Manual, section 270.1, for more information on appointed representatives.

The MOON may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary’s behalf (e.g., the beneficiary’s legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary. However, if a beneficiary is temporarily incapacitated, a person (typically, a family member or close friend) whom the hospital or CAH has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MOON. Such a representative should act in the beneficiary’s best interests and in a manner that is protective of the beneficiary and the beneficiary’s rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital or CAH annotates the MOON with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

NOTE: There is an exception to the in-person notice delivery requirement. If the MOON must be delivered to a representative who is not physically present to receive delivery of the notice, the hospital or CAH is not required to make an off-site delivery to the representative. The hospital or CAH must complete the MOON as required and telephone the representative.

- The information provided telephonically includes all contents of the MOON;

- Note the date and time the hospital or CAH communicates (or makes a good faith attempt to communicate) this information telephonically, per 400.2 above, to the representative is considered the receipt date of the MOON;
- Annotate the “Additional Information” section to reflect that all of the information indicated above was communicated to the representative; and
- Annotate the “Additional Information” section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

Mail a copy of the annotated MOON to the representative the day telephone contact is made.

A hard copy of the MOON must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g., FedEx, UPS). The burden is on the hospital or CAH to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital or CAH and the representative both agree, the hospital or CAH may send the notice by fax or e-mail; however, the hospital or CAH’s fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

400.3.7 - Ensuring Beneficiary Comprehension

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The OMB-approved standardized MOON is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies. Hospitals and CAHs are reminded that recipients of Federal financial assistance have an independent obligation to provide language assistance services to individuals with limited English proficiency (LEP) consistent with section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of Federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973.

400.3.8 - Completing the Additional Information Field of the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

This section may be populated with any additional information a hospital wishes to convey to a beneficiary.

Such information may include, but is not limited to:

- Contact information for specific hospital departments or staff members.
- Additional content required under applicable State law related to notice of observation services.
- Part A cost-sharing responsibilities if a beneficiary is admitted as an inpatient before 36 hours following initiation of observation services.
- The date and time of the inpatient admission if a patient is admitted as an inpatient prior to delivery of the MOON.
- Medicare Accountable Care Organization information.
- Hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs.
- Any other information pertaining to the unique circumstances regarding the particular beneficiary.

If a hospital or CAH wishes to add information that cannot be fully included in the "Additional Information" section, an additional page may be attached to supplement the MOON.

400.3.9 - Notice Retention for the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The hospital or CAH must retain the original signed MOON in the beneficiary's medical record. The beneficiary receives a paper copy of the MOON that includes all of the required information described in section 400.3.2 and, as applicable, sections 400.3.5, 400.3.6 and 400.3.8. Electronic notice retention is permitted.

400.4 - Intersection with State Observation Notices

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

As noted in sections 400.3.1 and 400.3.8 above, hospitals and CAHs in States that have State-specific observation notice requirements may add State-required information to the "Additional Information" field, attach an additional page, or attach the notice required under State law to the MOON.

500 - Glossary

(Rev. 10862; Issued: 07-14-21; Effective: 10-14-21; Implementation: 10-14-21)

The following terms are defined only for purposes of this Chapter 30 of the Medicare Claims Processing Manual.

Advance notice of non-coverage— 42 CFR 418.408(d)(2) states that if Medicare would