Observation –
Charging, Billing, Compliance and Reimbursement

December 2024

Observation Charging & Billing – Updated Nov 2024

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Overview of Billing Observation

1. **Payment for observation hours (G0378) is always "packaged" under Medicare OPPS to another payable procedure**. For example, 8 or more hours of observation care G0378 may "bump" Medicare's OPPS payment for an ED visit code 99285 from APC 5025 to a higher-paying APC 8011 – Comprehensive Observation Services. The remittance will not indicate additional payment on the G0378 line but a higher payment on the 99285 line.
2. **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.** As an example, in the Emergency Department the facility should not begin billing observation time while also performing procedures and active monitoring in that department.
3. **Observation care is reported on the claim with an hourly charge billed using HCPCS G0378**. At least 8 hours of observation is required for Medicare payment. Less than 8 hours of observation will not "bump" any payable service.
4. **Observation hours must be billed with an outpatient visit to qualify for reimbursement under OPPS APC 8011 – Comprehensive Observation Services.** Typically, a patient is referred to observation following a hospital emergency department visit. If the patient is referred directly by a community physician, the hospital may bill HCPCS code G0379 - Direct Admission of Patient for Hospital Observation Care; this is necessary to qualify for the observation APC payment.
5. **Medicare has established a maximum of 72 hours of observation as medically necessary.** Observation services rendered beyond 72 hours are considered medically unlikely and will be denied. The appeals process must be followed to have observation services exceeding 72 hours to be considered for payment.
6. **Observation time must not accrue when the patient is closely monitored for another payable service.** Separately reimbursed services which include "significant monitoring" should not be billed concurrently with observation care. (See Concurrent Procedures section below.)
7. **Reimbursement for observation care under APC 8011 is not payable** when billed on the same day or the day following a surgical APC status T procedure.

8. **Observation should not be routinely charged following surgical procedures**. Patients should not be placed in observation status following an outpatient procedure based on (a) a standing order, (b) an order given prior to the procedure, or (c) an order that does not articulate patient-specific physician findings indicating the need for observation services. It is not appropriate to categorize extended recovery as observation care.
9. **Observation hours may not be charged retroactively.** If the physician changes the patient status from inpatient to observation prior to discharge, the hospital may not add observation hours in lieu of the room rate; documentation must support the beginning of observation concurrent with the order for observation care.
10. **An inpatient stay that does not meet the criteria for inpatient billing cannot be changed to observation care after the patient is discharged.** In this instance, the hospital may bill Part B services only on bill type 012X.
11. **Medicare Outpatient Observation Notice (MOON)** must be provided no later than 36 hours after observation services begin to all patients receiving observation services in hospitals (including Critical Access Hospitals (CAHs))

Observation Defined

Both the Medicare Benefits Policy Manual Chapter 6, Section 20.6 and the Medicare Claims Processing Manual Chapter 4, Section 290) define observation care as follows:

> "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."

Documentation Requirements

Inpatient vs outpatient

Inpatient requirement includes:	Outpatient requirements include:
Order	Order
Authentication	Authentication
Medical Necessary Hospital Care	Medical Reason for Observation Status
Inpatient Certification	Time
Disposition Specificity	
Shorten Stay Rational if applicable	

Inpatient Requirements

Order: The documentation must state "Admit to inpatient" or related terminology to clearly indicate the admission is for inpatient status and not for observation status.

Authentication: The order must be written by a physician or other qualifying healthcare provider who is granted privileges by the hospital to admit inpatients. The order must be signed, dated and timed. In the case of verbal orders, the admitting physician signature or co-signature with date and time is required. The admitting physicians must be knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission. Orders by mid-levels and RNs must be authenticated by an MD/DO.

Medically Necessity supported by documentation for Hospital Care is essential. Supporting documentation for Inpatient Admission includes:

- History of comorbidities
- Current medical needs
- Severity of signs and symptoms, and
- Risk of an adverse event developing
- Plan of Care (POC) indicating rationale for an admission anticipate of at least two midnights. The two midnights includes time spent receiving care prior to the inpatient admission, including in the ED.
    - Example: Severe COPD exacerbation with hypoxemia and hypocapnia. The document plan includes the need for IV steroids for > 2 midnights.

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Medically Unnecessary Care is defined as any care that can be provided outside of a hospital facility, such as a skilled nursing facility, clinic, home or other less intensive setting. Factors that result in an inconvenience in the terms of time and money needed to care for the beneficiary in a less intensive setting do not, by themselves, justify inpatient admission.

Certification: The certification is an attestation by the attending physician indicating the medical necessity of the inpatient services. The certification must be completed, signed, dated, and documented prior to discharge. This can be done anywhere in the medical record. The certification documentation should include:

- Inpatient admission order signed or co-signed by attending physician
- Reason for inpatient services
- Estimate length of stay
- Post-hospital care

Disposition: In the event that the decision to admit as inpatient was incorrect, report Condition Code 44. This allows the admitting physician to change the patient from inpatient to outpatient status prior to discharge.

Shortened Stay: If the patient leaves prior to anticipated 2 midnight stay, the provider must clearly document reason for the shortened stay. Some examples that the anticipated 2 midnight stay may not be met, however inpatient status is still appropriate includes:

- Unexpected Recovery
- Unexpected death
- Unexpected transfer
- AMA departure
- Unexpected hospice

Outpatient Observation Documentation

Order: The documentation must state “Admit to Observation“ or related terminology to clearly indicate the admission is for observation status and not for inpatient status. When documentation only states “Admit” the status is unclear of the intention.

Authentication: The order must be written by a physician or other qualifying healthcare provider who is granted outpatient privileges by the hospital. The order must be signed, dated and timed. In case of verbal orders, the outpatient observation order must be co-signed by the ordering provider prior to discharge.

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Medical Reason for the order to admit to observation status must be documented. Observation documentation Include:

- Complete admission note (This may be part of the History and Physical)
- Progress notes and/or discharge note that reflect the need to establish a probable or differential diagnosis and treatment plan.

Factors that result in an inconvenience in terms of time and money needed to care for the beneficiary in a less intensive setting do not, by themselves, justify hospital care. Observation admission are not medically necessary for:

- Patient awaiting nursing home placement as self-pay
- Routine outpatient surgical procedures - preparation or recovery
- Convenience of patient, family, or physician
- Routine therapeutic services (e.g. blood administration, chemotherapy)
- Substitution for appropriate inpatient admission

Timing: Observation is typically 24 to 48 hours for assessment/monitoring/treatment but can extend to 72 hours. Observation is intended to assess presenting signs and symptoms as they progress toward improvement, stabilization, or decline to determine if discharge or inpatient admission is appropriate.

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Inpatient Requirement	Outpatient Requirements
Order: The documentation must state **"Admit to inpatient"** or related terminology to clearly indicate the admission is for inpatient status and not for observation status.	**Order:** The documentation must state **"Admit to Observation"** or related terminology to clearly indicate the admission is for observation status and not for inpatient status.
Authentication: The order must be written by a physician or other qualifying healthcare provider who is granted privileges by the hospital to admit inpatients. The order must be signed and dated.	**Authentication:** The order must be written by a physician or other qualifying healthcare provider who is granted outpatient privileges by the hospital. The order must be signed, dated and timed.
Medical Necessity: · History of comorbidities · · Current medical needs · Severity of signs and symptoms, and · Risk of an adverse event developing · Plan of Care (POC) indicating rationale for an admission anticipate of at least two midnights. The two midnights includes time spent receiving care prior to the inpatient admission, including in the ED.	**Medical Reason:** · Complete admission note (This may be part of the History and Physical) · Progress notes and/or discharge note that reflect the need to establish a probable or differential diagnosis and treatment plan Note: Factors that result in an inconvenience in terms of time and money needed to care for the beneficiary in a less intensive setting do not, by themselves, justify hospital care.
Certification: An attestation by the attending physician indicating the medical necessity of the inpatient services.	**Time:** Observation is typically 24 to 48 hours for assessment/monitoring/treatment Observation is intended to be for one midnight to assess presenting signs and symptoms as they progress toward improvement, stabilization, or decline. A second midnight is allowed with documentation that supports the continued need for re-assesment to determine if discharge or inpatient admission is appropriate. In rare cases observation time can extend up to 72 hours.
Disposition: In the event that the decision to admit as inpatient was incorrect, report Condition Code 44. This allows the admitting physician to change the patient from inpatient to outpatient status prior to discharge.	
Shortened Stay Rationale: Typically an inpatient admission is >2 midnights. If the admission is <2 midnights, clearly document the rationale such as unexpected recover, death transfer, departure or hospice.	

OPPS Reimbursement

When a procedure is assigned status indicator "J2," all services provided during the outpatient visit (including observation services) will be packaged into a single, bundled payment under Comprehensive APC 8011 ($2,607.99 in 2024). The comprehensive payment represents the extended care encounter, including expensive status indicator G (passthrough) and K (separately payable) drugs.

Procedures with status indicator "T" are considered significant but **do not bundle** with observation services unless performed with a procedure or service assigned the "J2" indicator. Typically, a separate APC payment is made for these procedures, and observation services may receive separate reimbursement if the criteria for an observation stay (e.g., 8 or more hours) are met. When multiple procedures are on the same claim, the highest procedure is paid the full rate, and secondary procedures are subject to a reduced rate.

Observation claims that include procedures assigned status indicator “S” (significant) are paid separately from observation services except when other procedures on the claim qualify for the Comprehensive APC payment.

Procedures and services on an observation claim that are assigned status indicator “N” are bundled into the overall APC payment.

CPT®	Long Description
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **low level** of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate level** of medical decision making

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CPT®	Long Description
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99291	Critical care, evaluation and management of the critically ill or critically injured patient; **first 30-74** minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each **additional 30 minutes** (List separately in addition to code for primary service)
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care
G0380	**Level 1** hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 cfr 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)

CPT®	Long Description
G0381	**Level 2** hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 cfr 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0382	**Level 3** hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 cfr 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)

CPT®	Long Description
G0383	**Level 4** hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 cfr 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0384	**Level 5** hospital emergency department visit provided in a type b emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 cfr 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0463	Hospital outpatient clinic visit for assessment and management of a patient

Additional Reimbursement Considerations

1. **Medicare Reimbursement will be packaged into another payable service:** Most commonly, observation services are provided after an emergency department evaluation (E/M) 9928x. When observation (G0378) is billed with an evaluation and management code or the direct-to-observation nursing assessment (G0379), the Medicare remittance will list the payment next to the E/M code line item, not on the G0378 line.

2. **Change from Observation to Inpatient Status:** The Hospital's Utilization Review Team should evaluate every patient in observation status to determine whether the patient meets the criteria for inpatient status assignment. Status changes must be performed before discharge based on an appropriate physician order. Inpatient payment under Medicare IPPS DRGs is typically much higher than the alternative APC reimbursement as an outpatient claim.

3. **The "Two Midnights" Rule:** Under the OPPS Medicare 72-hour rule, outpatient services for conditions related to the inpatient admission and provided up to three days before the admission (including observation hours) should be billed on the inpatient claim and reimbursed via DRG methodology. Hospitals should report Occurrence Code 72 - First/Last Visit Dates to signify the entire episode of care is not represented by the From/Through service dates of Form Locator 06 (Statement Covers Period). The Occurrence Code allows facilities to defend against medical review by indicating contiguous outpatient hospital services that preceded the inpatient admission.

4. **Change from Inpatient to Observation Status:** Before discharge, the attending physician and the hospital's UR Committee may determine whether the patient's condition or intensity of service does not meet the medical necessity and criteria of an inpatient status. When the attending physician agrees, the physician may order a status change to observation. The observation claim must include Condition Code 44, indicating the patient status was outpatient before discharge. Condition Code 44 on the outpatient claim (13x or 85x) allows the hospital to receive payment for the medically necessary Medicare Part B services. For more information, see Condition Codes 44 and W2 and refer to Chapter 4 of the Medicare Claims Processing Manual beginning at paragraph 290.1.

Direct referral to Observation - G0379

HCPCS code G0379 is billed in lieu of an evaluation and management code for patients referred to observation by a community physician. Therefore, the patient bypasses the emergency department. G0379 represents the nursing resources required in a facility-based outpatient evaluation service. G0379 is reimbursed at a lower APC **5025** (**$611.99 in 2024**) when less than 8 hours of G0378 are reported and no APC Status Indicator T procedure is reported on the claim.

Observation as Extended Recovery Time

Many hospitals and physicians struggle with whether observation status is appropriate when a patient requires an extended recovery of more than 4 to 6 hours after outpatient surgery.

The following Medicare claims processing manual excerpt is commonly cited:

Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

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."

CorroHealth recommends that hospitals bill outpatient recovery services as recovery room charges under revenue code 0710, whether or not the patient's recovery time exceeds 4 to 6 hours**.** Following outpatient surgery, a change to observation status may be appropriate only if the patient's condition deteriorates or a complication from surgery has developed, which calls into question whether the patient may be safely discharged and requires inpatient care.

Revenue Codes

Codes and/or Descriptions: **0710,0762**

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Code	Description
0710	Recovery Room - General Classification
0762	Specialty Services - Observation Hours

Concurrent Procedures

Facilities are cautioned to be conservative in charging observation hours for diagnostic or therapeutic procedures requiring the patient to leave the unit, such as radiology or cardiology testing. CMS requires reducing observation hours for procedures requiring "active monitoring." Medicare Administrator Noridian JF offers ACT Questions and Answers – March 22, 2023:

"Q9: If a patient was Observation Patient Class for medically necessary condition, and during the stay has an interventional procedure, does the facility need a new order for observation post the surgical procedure to report observation hours, or does the facility simply subtract the standard post op recovery time before reporting observation hours again?

A9: No, a new observation order is not needed. Observation services should not be billed along with diagnostic or therapeutic services for which active monitoring is a part of the procedure. In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. 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 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."

Medicare Administrator Novitas JH offers references Chapter 4 of the Medicare Claims Processing Manual in Observation Services.

"A patient is in observation status and goes to other areas of the hospital for ordered tests, procedures, etc. Is the time getting these tests/procedures excluded from observation time?

The CMS IOM Pub. 100-04 Medicare Claims Processing Manual, Chapter 4, section 290.2.2 states:

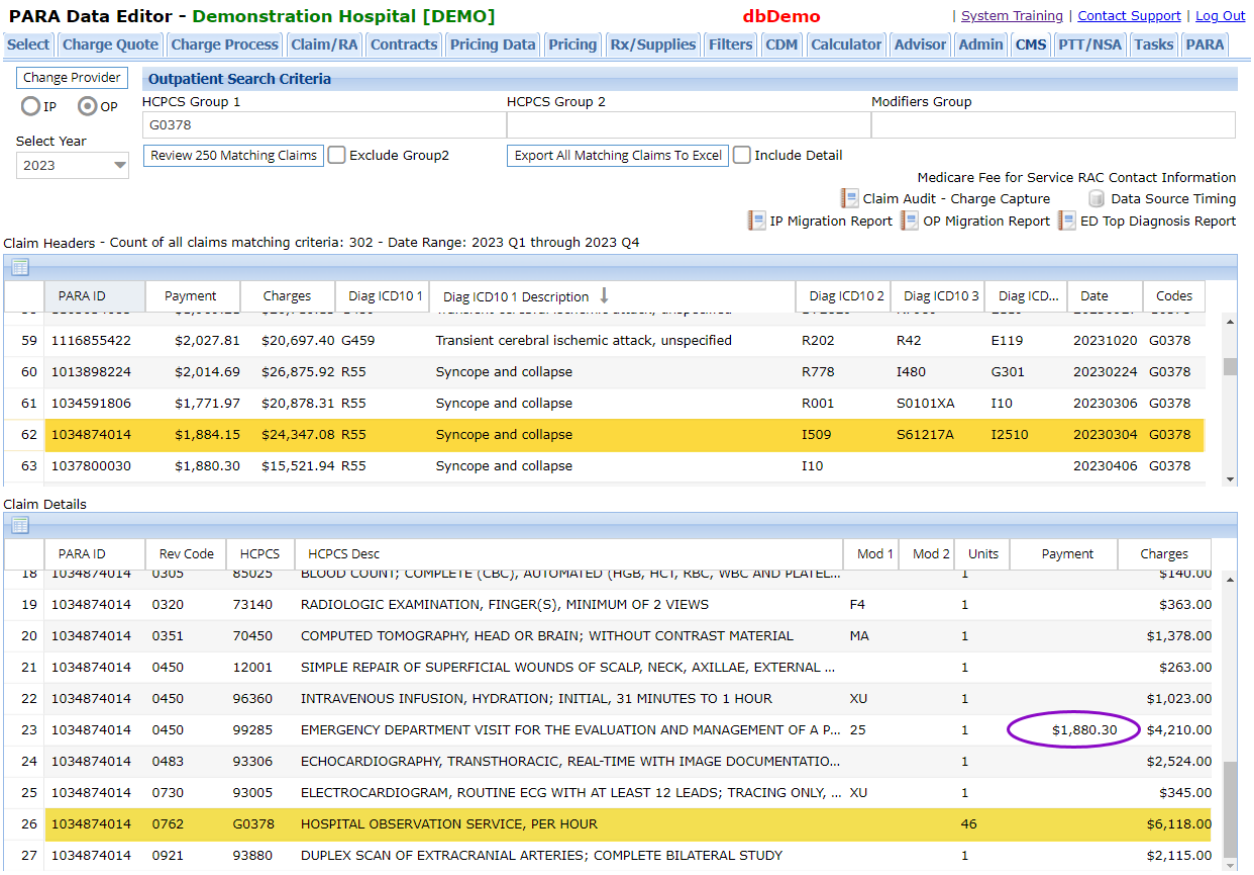
"Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate 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"."

Facilities should avoid billing observation hours concurrently with other billable services that require "direct" or "personal" physician supervision.

There is no specific list of billable services which duplicate the care required for observation. Hospitals should be particularly careful not to bill observation time when services are rendered away from the medical unit, such as an imaging study performed in the radiology suite.

Using the PARA Data Editor (PDE)

The PDE CMS Tab is useful in auditing observation claims and payments. The following **2023** claim was paid at the higher APC. More than 8 observation hours were billed with an Emergency Room facility evaluation and management level code. Medicare paid 99285 the higher "composite" **2023** APC rate of **$2,439.02** (less patient coinsurance and deductible):



Without the 8 hours of observation, the visit code 99285 would have been reimbursed at **$548.11** (less patient coinsurance and deductible).

Billing Hospital Hours Beyond MUE

Medicare Administrative Contractor Novitas JL instructs hospitals to bill hours beyond the 72-hour MUE under revenue code 0762 with HCPCS code with remaining charges in the non-covered fields and appealing those services with the patient's medical record.

Billing Outpatient Observation Services

"Observation hours

- Not expected to exceed 48 hours in duration.
- Greater than 48 hours in duration are seen as rare and exceptional cases.
- Cover up to 72 hours if medically necessary.
- Observation services rendered by non-OPPS providers beyond 72 hours is considered medically unlikely and should be submitted as non-covered on a second line of service

(i.e., one revenue code line with 72 hours of covered observation units and charges, a second revenue code line with hours exceeding medically necessary observation services with non-covered units and charges).

- Follow the appeals process to have observation services exceeding 72 hours considered for payment."

The -GY modifier should only be appended to services or items statutorily excluded from Medicare coverage. Observation hours do not meet that definition.

Modifier	Description
GY	Item or service statutorily excluded or does not meet the definition of any Medicare benefit

Further, Medicare indicates that admitting or discharging an observation patient rarely takes over 48 hours.

Although Observation patients receive a Medicare Outpatient Observation Notice (MOON) – see CorroHealth's Medicare Outpatient Observation Notice (MOON), Chapter 6 of the Medicare Benefit Policy Manual discusses coverage and when an ABN may be appropriate.

> "**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, 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."

See also CorroHealth's Paper Medicare Outpatient Observation Notice (MOON)

Medicare Change of Status Notice

When a hospital reclassifies eligible Medicare patient from an inpatient to an outpatient receiving observation services, the patient or their representative have the right to appeal their status change to a Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO).

To be eligible for the expedited determination process, the reclassification must happen while the patient is still in the hospital and 1 of the following applies:

- The patient has Medicare Part B and their hospital stay was at least 3 days
- The patient doesn't have Part B

MM13846 - Medicare Change of Status Notice Instructions

References

- Chapter 4 of the Medicare Claims Processing Manual
- Medicare Outpatient Observation Notice (MOON)
- ACT Questions and Answers – March 22, 2023
- Novitas JL Billing Outpatient Observation Service
- Condition Codes 44 and W2
- Novitas JH FAQ: Observation Services
- MM13846 - Medicare Change of Status Notice Instructions