

The background of the slide features a soft-focus image of pink cherry blossoms on dark branches, with green leaves interspersed. The blossoms are in various stages of bloom, with some showing distinct yellow centers. The overall color palette is a mix of soft pinks, light greens, and dark greys from the branches.

2026 Reimbursement: Can Observation Counter The Headwinds?

Michael Granovsky, MD, CPC, FACEP
President, LogixHealth

Disclosures:

Michael Granovsky MD CPC FACEP

President, LogixHealth

National ED Coding and Billing Company



Observation 2026 Documentation Guidelines

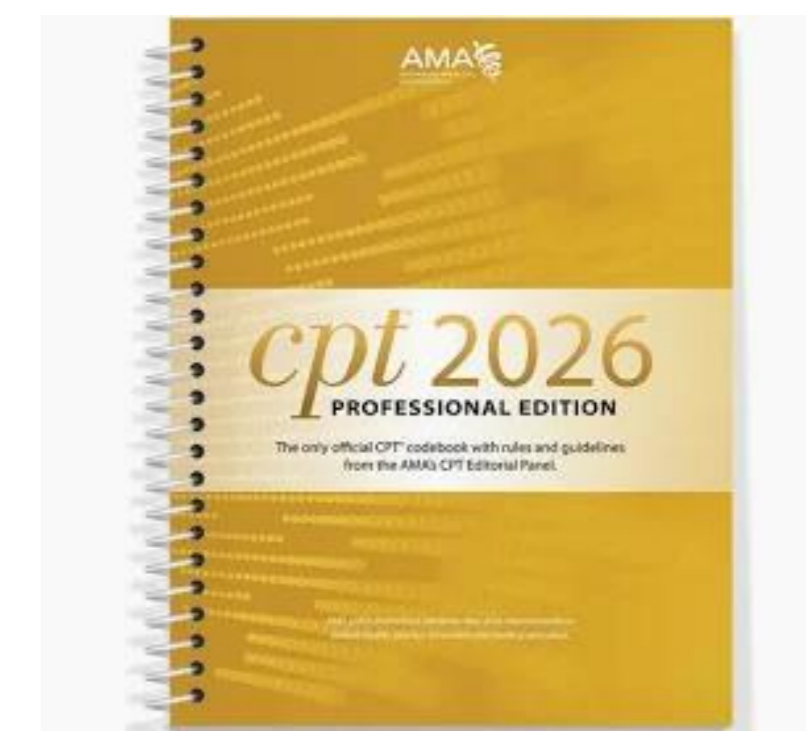
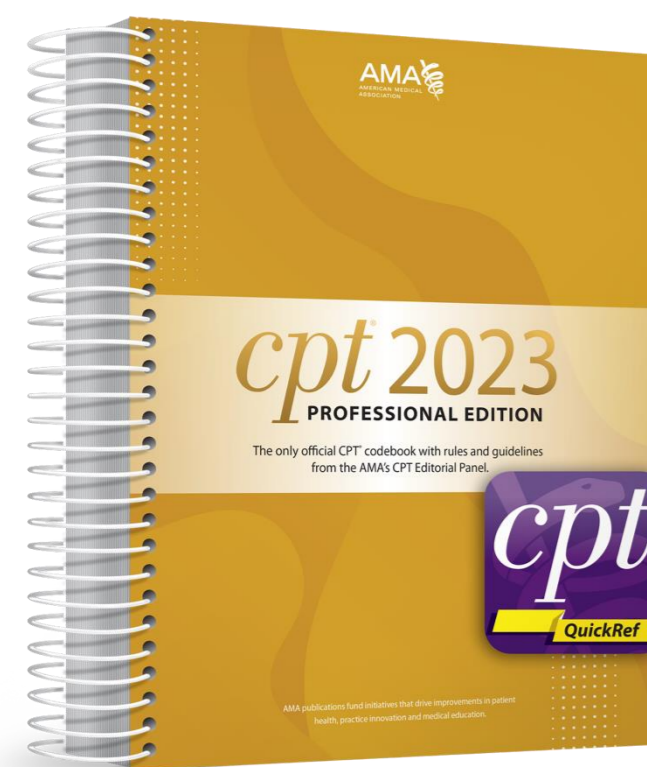
2023/2026 CPT E/M Guidelines for Observation



CPT® Evaluation and Management (E/M) Code and Guideline Changes



- Deletion of Hospital Observation Services E/M codes 99217–99220
- Revision of Hospital Inpatient and Observation Care Services E/M codes 99221–99223, 99231–99239 and guidelines



2026 Obs: History and Physical Exam Don't Score

“The nature and extent of the history and/or physical examination is determined by the treating physician reporting the service.”

“The extent of history and physical examination is NOT an element in selection of codes.”

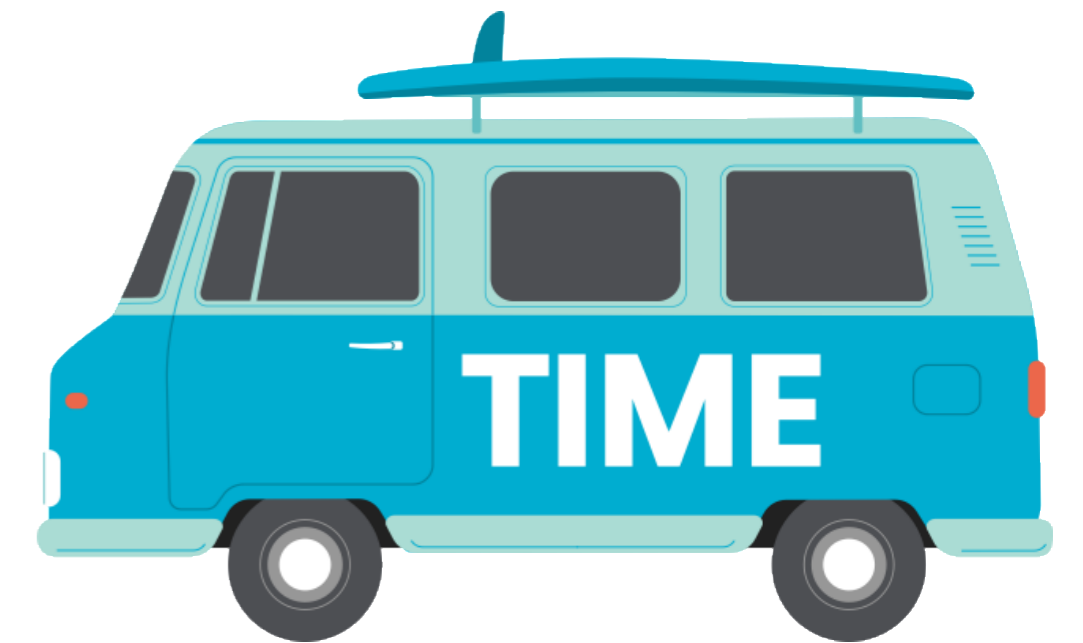
“The main purpose of documentation is to support care of the patient by current and future health care team(s).”

How Will Observation Be Scored? MDM or Time Determine Code Choice

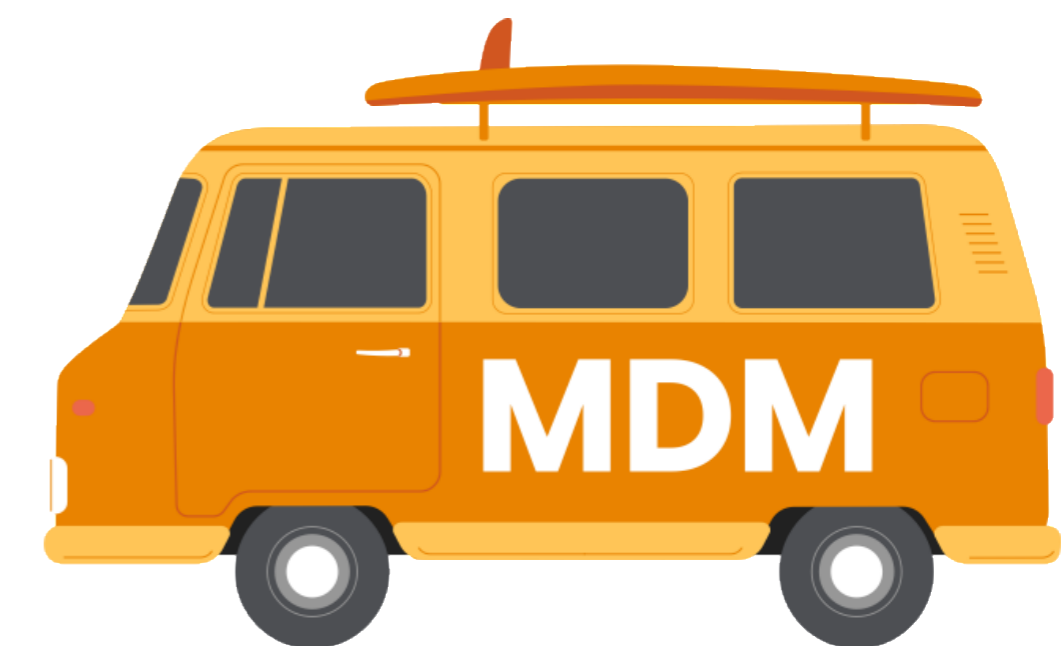
Observation Service Scoring

“The CPT code changes allow clinicians to choose the Observation visit level based on either medical decision making or time.”

CMS Physician Final Rule Press Release



- Requires performance of history and exam only as medically appropriate
- Allows clinicians to choose the E/M visit level:
 - Medical Decision Making; or
 - Time



Scoring by Time per CMS



“We propose that, when a physician or practitioner selects CPT codes 99221 through 99223 and 99231 through 99236 based on time, the number of minutes specified in the descriptor for the relevant CPT code must be met or exceeded.”

Medicare Physician Fee Schedule Proposed Rule 306/2066



2026 CPT Published Times for Observation

Same Day Obs

Same Day CPT Code	Typical Times
99234	45 minutes
99235	70 minutes
99236	85 minutes

Initial Day Obs

Initial Day CPT Code	Typical Times
99221	40 minutes
99222	55 minutes
99223	75 minutes

Subsequent Day Obs

Subsequent Day CPT Code	Times
99231	25 minutes
99232	35 minutes
99233	50 minutes

Discharge Day Obs

Discharge Day CPT Code	Typical Times
99238	Obs DC \leq 30 minutes
99239	Obs DC $>$ 30 minutes

Obs Medical Decision Making

CPT Code	Medical Decision Making Complexity
<u>INITIAL DAY</u>	
99221	Straight Forward/Low
99222	Moderate
99223	High
<u>SUBSEQUENT DAY</u>	
99231	Straight Forward/Low
99232	Moderate
99233	High
<u>SAME DAY</u>	
99234	Straight Forward/Low
99235	Moderate
99236	High

Clinical Benchmarks of Patient Complexity

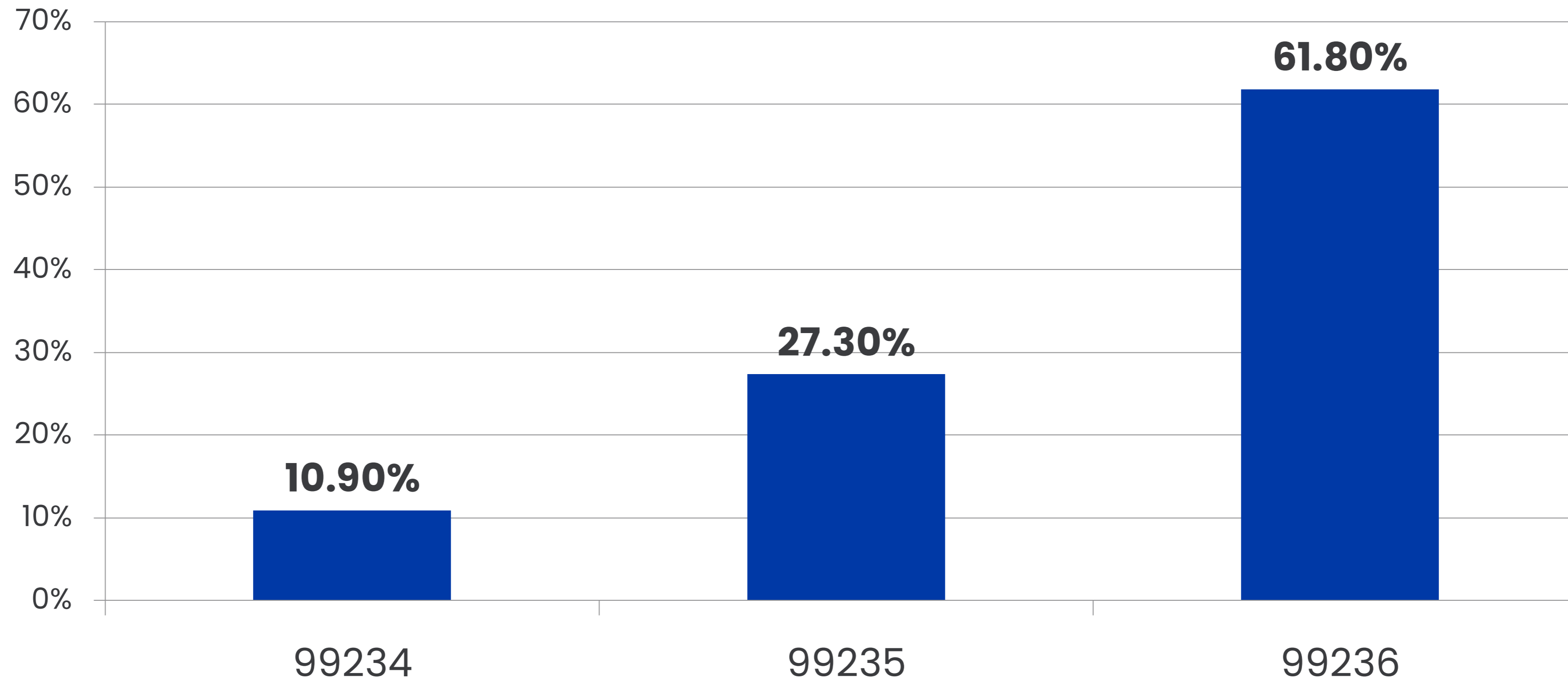
- No more AMA CPT Appendix C Obs code vignettes

CMS RUC database vignettes

- **99234**: 19 y.o. pregnant patient (9 weeks gestation) presents to the ED with **vomiting** X 2 days. The patient is admitted for observation and discharged later on the same day.
- **99235**: 48 y.o. presents with an **asthma exacerbation** in moderate distress.
- **99236**: 52 y.o. patient comes to the ED with **chest pain**.

Historic CMS E Med Obs E/M Distribution

**Medicare E Med Obs Codes Reported
RUC Data Base Analysis**





Patient Selection Drives Throughput and Revenue

Patient Selection for Observation Services

Selecting correct patients is key to the operational success of an observation unit

- Select patients with diagnoses that have that have associated clinical protocols
- Expedite throughput
- Achieve decreased length of stay
- Reach a successful clinical endpoint
- Prolonged stays drag down RVU efficiency



The Spectrum of Complexity

Easier

- Chest pain
- Abdominal pain
- Headache
- Cellulitis
- Pyelonephritis
- Asthma
- Dehydration
- Renal colic
- Hypoglycemia
- Allergic reaction
- Pharyngitis

Harder

- Closed head injury
- Vertigo
- Hematuria
- Pancreatitis
- Back pain
- Non-ambulatory
- Extremes of age
- Mental Health
- Substance abuse




Picking The Right Patients: Case Study – Academic Managed Community Site

- 40K ED with a 22% admission rate
- 110 patients per day
- 24 daily admissions
- 30% qualified for Obs over first 6 months
- Average of 7 Obs patients per day
- Chest pain, syncope, cellulitis, pyelo, allergic reaction, Asthma, dehydration...
- 10 bed unitfully occupied 28 days a month
- 2,555 patients treated
- Average LOS decreased 16 hours
- Prior LOS for cohort 25 hours



23,000
Bed Hours
Saved

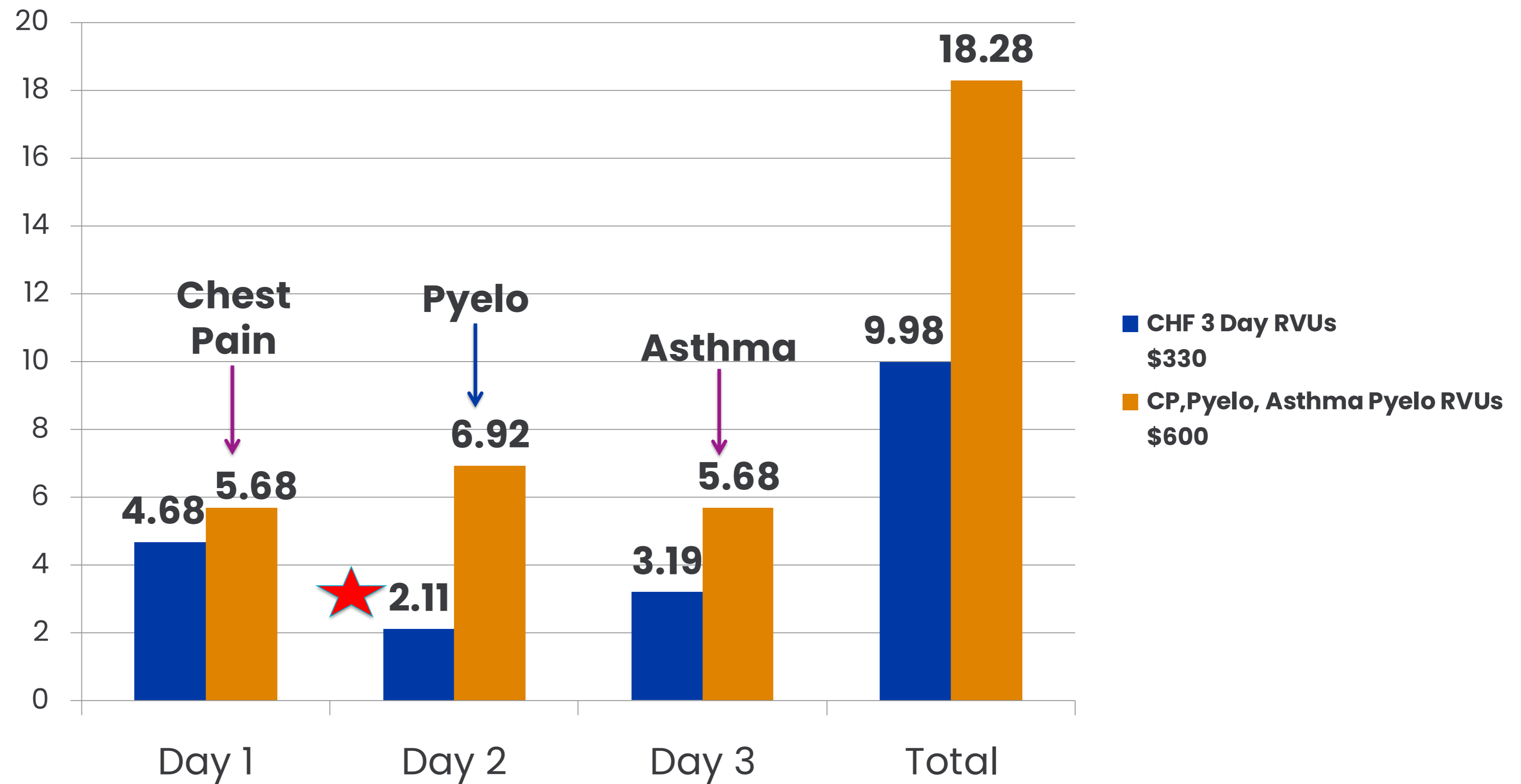
RVU Modelling: LOS and Bed Use

- CHF 3 day stay
 - Htn, Creat. 2.4 & BS 492
- Tuesday placed in CDU
- Wednesday slow diuresis
 - BS, K+ abnormal,  BP
- Home late Thursday
- Alternative bed use
- Day 1- Chest pain patient
 - 15 hour LOS
- Day 2 – Pyelo
 - Stays overnight
 - Dc'd in the AM
- Day 3 Asthma
 - 15 hour LOS



Controlling Bed Flow to Maximize RVUs

2026 RVU Comparison Over 3 Days





2026 RVUs and Scenarios



RVU Values 2026 Same Day Observation Services

Same Day Observation

Same Day Obs	2026 Work RVU	2026 Total RVU
99234	2.00	2.64
99235	3.24	4.28
99236	4.30	5.68
99285	4.00	5.13

RVU Values 2026 Multi Day Observation Services

Multi Day Observation

2026 Multi Day Obs Coding	2026 Total RVUs
99221+99238/39	4.47/5.42
99222+99238/39	5.74/6.69
99223+99238/39	6.92/7.87
99285	5.13

Obs Vignette Potential Examples with RVUs

Same Day

- Chest pain patient begins observation at 8am Monday and DC'd Monday 6pm
 - 99236 (Hospital initial inpatient or observation, admission and discharge on the same date high complexity) **5.68 RVUs**

Crosses Midnight

- COPD patient begins observation at 8am Monday and is discharged Tuesday at 12 noon. The discharge services are < 30 minutes
 - 99223 (Initial inpatient or observation high complexity) **4.68 RVUs**
 - 99238 (Obs/Inpatient discharge services < 30 minutes) **2.24 RVUs**

Total RVUs 4.68 + 2.24 = 6.92 RVUs

Obs Vignette Potential Example 3 Day Stay with RVUs

Multi Day

- Hyperglycemia patient begins observation at 8pm Monday, is rounded on with a full note Tuesday morning, and discharged Wednesday at 6pm. The discharge services are >30 minutes.
 - Monday 99223 (Initial inpatient/observation high complexity) **4.68 RVUs**
 - Tuesday 99233 (Subsequent inpatient/Obs high complexity) **3.20 RVUs**
 - Wednesday 99239 (Obs/Inpatient discharge services > 30 minutes) **3.19 RVUs**
 - Total RVUs for the stay: **11.07 RVUs**
 - Average RVUs per day: **3.69 RVUs**



2026 Observation Reimbursement Changes & Challenges



2026 Practice Expense Problem

Background

- Many services are paid differently depending on where they are furnished.
 - In a non-facility setting (e.g., a physician's office), payment includes Practice Expense that captures the full cost of operating the office.
 - Older model that's not as common anymore



Practice Expense Evolution Problem

“As we noted in the proposed rule, data suggests that fewer than half of physicians currently own their practices, but the underlying assumption embedded in the payment methodology presumed that physicians generally maintained office practices (and incurred associated **indirect costs**) even when they furnished care in facility settings.

For these reasons, for each service valued in the facility setting under the PFS, we proposed to reduce the facility PE RVUs.”

2026 Physician Final Rule

Practice Expense Components

- Direct Practice Expense
 - Clinical labor
 - Medical supplies
 - Medical equipment
- Indirect Practice Expense
 - Administrative labor
 - Office expenses
 - All other Expenses
 - Legal, Accounting, Billing



Practice Expense “Efficiency” Downward Adjustment

- Previously most physicians maintained office-based practices even if they also furnished care in hospitals.
- Under that model, the PE methodology included the full indirect cost of running their office regardless of site of service.
- Physicians in private practice steadily declined, while hospital employment and facility-based practice have grown.

CMS will reduce the PE RVUs in the facility setting based on the assumption that office expenses are not common.



CMS Final Rule On Practice Expense

“Indirect Costs Allocated In the facility setting are meant to reflect the typical costs associated with practice expenses in that setting of care.”

CMS 2026 Final Rule page 68/2375

“In cases where clinicians practice exclusively, or almost exclusively, in a facility, or where a facility is financing indirect PE for clinicians, payment to both the facility (under OPPS) and physicians may be duplicative and unnecessary.”

MedPac June 2025 Report



Practice Expense Observation RVU Impact

CPT Code	2025 PE	2026 PE	2025 Total RVUs	2026 Total RVUs
99234	0.74	0.46	2.90	2.64
99235	1.24	0.79	4.72	4.28
99236	1.54	1.02	6.17	5.68
99221	0.66	0.41	2.46	2.23
99222	1.06	0.67	3.88	3.50
99223	1.39	0.90	5.17	4.68
99238	0.80	0.62	2.42	2.24
99239	1.11	0.88	3.42	3.19

Practice Expense Payment Impact: 2025 vs 2026

HCPCS	Short Descriptor	2025 Facility Based Payment Rate	2026 Facility Based Payment Rate	Payment Change (2025 vs. 2026)	2025 vs. 2026 Percentage Change
10061	I&d abscess comp/multiple	\$179.85	\$173.35	\$(6.50)	-4%
31500	Insert emergency airway	\$136.83	\$132.94	\$(3.89)	-3%
99291	Critical care first hour	\$205.72	\$199.07	\$(6.65)	-3%
99214	Office o/p est mod 30 min	\$93.80	\$84.50	\$(9.30)	-10%
99215	Office o/p est hi 40 min	\$138.77	\$125.59	\$(13.18)	-9%
99204	Office o/p est new mod 45 min	\$129.06	\$116.90	\$(12.16)	-9%
99205	Office o/p est new hi 60 min	\$175.64	\$160.32	\$(15.32)	-9%
99223	1 st hosp ip/obs high 75	\$167.23	\$156.32	(\$10.92)	-7%
99232	Sbsq hosp ip/obs moderate 35	\$76.34	\$70.48	\$(5.86)	-8%
99233	Sbsq hosp ip/obs high 50	\$113.86	\$106.88	(\$6.98)	-6%
99238	Hosp ip/obs dschrg mgmt 30/<	\$78.28	\$74.82	\$(3.46)	-4%
99239	Hosp ip/obs dschrg mgmt >30	\$110.63	\$106.55	(\$4.08)	-4%
99234	Hosp ip/obs sm dt sf/low 45	\$93.80	\$88.18	\$(5.63)	-6%
99235	Hosp ip/obs same date mod 70	\$152.68	\$142.96	\$(9.72)	-6%
99236	Hosp ip/obs same date hi 85	\$199.58	\$189.72	(\$9.86)	-5%

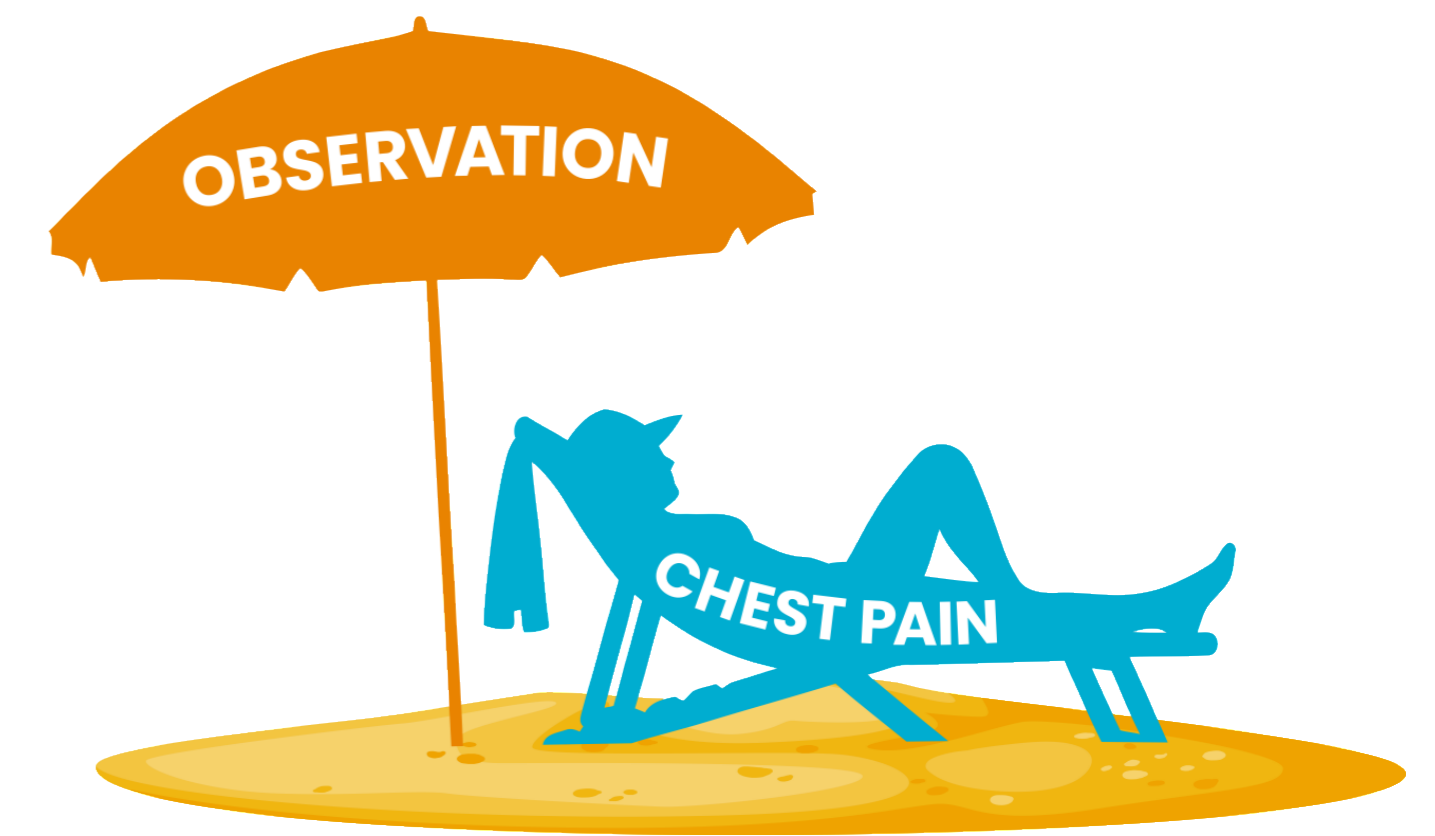


Finance Issues: Staffing Cost and Patient Cost



Optimizing Unit Size for Profit

- Typical nurse to patient ratio 1:5
- Physician coverage 1:12
- Fixed costs: Bed space, secretary, medication administration
 - Minimum 6 bed CDU requires 36k ED feeder
 - Profitability optimized steady census of 12 daily
 - Adjust your protocols to creep census up
- 50k ED...137/day...34 admits...want 12 for obs
 - 2 chest pain + 3 Dehydration + 2 GU (colic & pyelo)
 - Need 5: abd pain/asthma



Observation Unit Provider Staffing for Profit

- 10 bed unit...turned 1.3 times daily
 - Blend of moderate and high ...6.0 RVUs per case
 - 78 RVUs...\$40/RVU...\$3,120 daily = \$130/hr
 - Cost: salary, benefits, overhead...?tough to cover costs

Innovative Profit Solutions

- MD coverage in the morning and evening
 - New admits and discharges
 - 10hrs X \$200 = \$2000
- PA/NP interim coverage
 - 12hrs X \$100 = \$1200
- Protocol driven at night
- Creep up volume to be profitable
 - Expand beyond chest pain to include protocol driven complaints such as Dehydration, Pyelonephritis, Asthma, Cellulitis



Patient Financial Considerations

- Obs is an outpatient service covered under Medicare part B
- Concerned beneficiaries may pay more as outpatients than if they were admitted as inpatients
 - 80/20 co-insurance under part B
- If not inpatient then responsible for SNF charges
 - In OIG study, 11% of Obs was > 3 days
- Self administered (P.O.) medications not covered

Patient Financial Detail



- 20% co pays add up for longer complex Obs stays
 - Inpatient expense: Part A 2026 inpatient deductible \$1,736
- SNF
 - Obs stay...no qualifying SNF Medicare coverage
 - Patient may be entirely responsible - \$5,000
 - Typical stay starts at roughly \$250 per day
 - Qualifying inpatient stay spanning 3 nights
 - No patient SNF cost sharing for first 20 days
 - After 20 days co-payment is \$145 per day
- Self administered meds- “uncovered service” - gross hospital charges are in play (average bill \$528)

ACEP Now Syncope

Patient Cost Comparison Inpatient vs Observation

SERVICE	INPATIENT	OBSERVATION
Facility Fees	Patient pays Part A deductible: \$1,288 Medicare Part A pays Diagnosis Related Group (DRG) 312: \$4,101* (pre deductible \$2,813)	Patient pays 20% of C-APC 8011: \$434.83 Medicare Part B pays 80% of C-APC 8011: \$1,739.31
Professional Fees	Patient pays 20% of fees: \$110.21 Medicare Part B pays 80%: \$440.83	Patient pays 20% of fees: \$78.82 Medicare Part B pays 80%: \$315.29
<ul style="list-style-type: none"> • Initial evaluation • Subsequent evaluation • Discharge evaluation • Computed tomography (CT) interpretation • Echocardiogram (ECG) interpretation • ECG interpretation x3 	CPT 99223: \$204.22 CPT 99233: \$104.98 CPT 99239: \$108.20 HCPCS 70450: \$43.35 HCPCS 93306: \$64.49 CPT 93010: \$8.60 x3 (\$25.80)	CPT 99220: \$187.02 - CPT 99217: \$73.45 HCPCS 70450: \$43.35 HCPCS 93306: \$64.49 CPT 93010: \$8.60 x3 (\$25.80)
Medications	Patient pays \$0 Medicare Part A pays DRG payment	Patient pays entire cost: \$127** Medicare Part B pays \$0
Laboratory	Patient pays \$0 Medicare Part A pays DRG payment	Patient pays \$0 Medicare Part B pays C-APC payment
Facility Diagnostics	Patient pays \$0	Patient pays \$0
<ul style="list-style-type: none"> • Cardiac monitoring x48 hours • CT of the brain • Trans-thoracic echocardiogram • ECG x3 	Medicare Part A pays DRG payment	Medicare Part B pays C-APC payment
Total Payments:	Patient: \$1,398.21 ← Medicare Part A: \$2,813 Medicare Part B: \$440.83	Patient: \$640.65 ← Medicare Part A: \$0 Medicare Part B: \$2,054.60
Total Revenue:	Hospital: \$4,101 Professional: \$551.04	Hospital: \$2,301.14 Professional: \$394.11
TOTAL COST:	\$4,652.04	\$2,695.25

ACEP Now: Baugh, Granovsky et al



Strategies To Recover

Get The Coding Right

- Chart Construct Update
- Provider Education Program
- Meaningful management level reports
 - Coding and Billing
- Correct Obs E/M Distribution

Key 2026 Obs MDM Drivers



1. Document appropriate consideration of escalation to inpatient hospitalization if patient is not improving
 - Chest pain, COPD, Asthma, CHF
2. Document discussion of management with other providers
 - Consultant (Cardiology, GI, Neuro...)
3. Document independent interpretations
 - EKGs, CT scans, Ultrasounds, Plain X ray

Key 2026 Obs MDM Drivers



4. Document prescription medications appropriately considered, even if not given
 - Pain medication, anticoagulation, antibiotics

5. Document diagnostic tests appropriately considered even if not ultimately performed
 - CT scan
 - CTA to r/o PE; PERC criteria applied

Key 2026 MDM Drivers



6. Document review of external records
 - Inpatient hospital, clinic notes, nursing home

7. Document if history is obtained from an independent historian
 - Family, caregiver, PCP

Key 2026 MDM Drivers

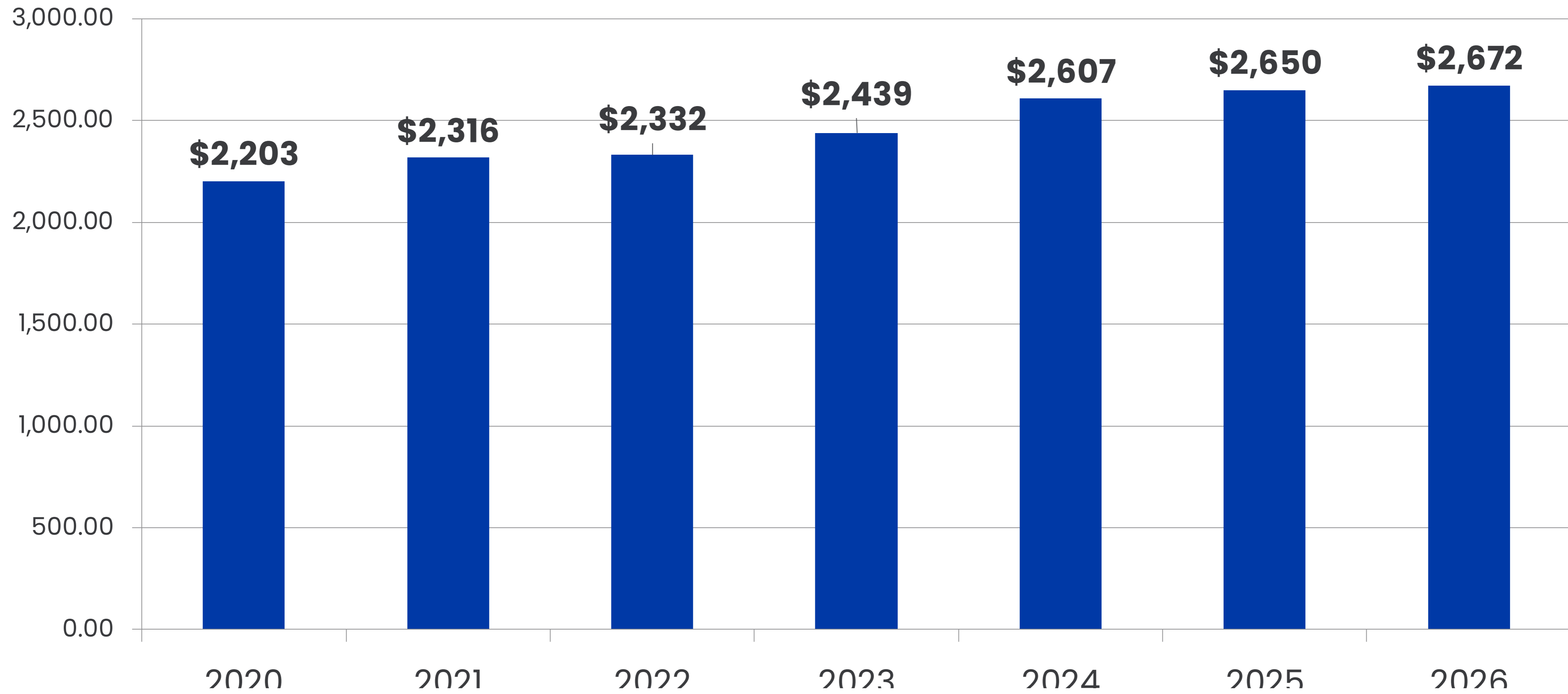


8. Document chronic illnesses impacting care
 - DM, hypertension, chemotherapy

9. Document if care is affected by social determinants of health
 - Homeless, literacy, access to medical care

10. Document discussion of test interpretation with external physician/provider
 - D/W radiology re abdominal CT . After relaying my concern image #39 c/w early diverticulitis

Facility Reimbursement Is Robust!



Recognize Critical Care In Your Obs Unit

MLN006764 September 2025



Same-Day E/M Visit and Critical Care

A patient receives a separate, non-critical E/M service earlier in the day AND later requires critical care

THEN: The E/M service must:

- Be medically necessary
- Be distinct and non-duplicative
- Occur before the critical care began
- Include modifier 25 on the E/M service code

Review Your Contracted Rates



- Private Payers
- Where are you in the contract anniversary cycle
- Rates tied to Medicare/% of RBRVS
 - Adjust each year
 - Anchored to a prior year
 - Good news!
- Reopen negotiations!
- Must advocate for the safety net

Michael Granovsky MD, FACEP, CPC

President, LogixHealth

mgranovsky@logixhealth.com



Educational Appendix



Historic Published Example



- Mr. Marks, a 79 year old comes to the emergency room with vague joint pains and lethargy. His primary care physician visits the ER and admits Mr. Marks to the observation unit for monitoring, and diagnostic and laboratory tests. In observation Mr. Marks has a cardiac arrest. His primary care physician provides 50 minutes of critical care services. Mr. Marks' is admitted to the intensive care unit. On the same calendar day Mr. Marks' condition deteriorates and he requires intermittent critical care services. In this scenario the primary care physician should report both an initial hospital visit and critical care services.

Michael Granovsky MD, FACEP, CPC

President, LogixHealth

mgranovsky@logixhealth.com