| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-02 Medicare Benefit Policy | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 215** | **Date: December 18, 2015** |
| | **Change Request 9486** |

**SUBJECT: January 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

**I. SUMMARY OF CHANGES:** This Change Request implements several changes in the manual requirements of chapter 6 related to outpatient observation services, finalized in the CY 2016 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Final Rule.

**EFFECTIVE DATE: January 1, 2016**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 4, 2016**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 6/20.6/Outpatient Observation Services |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-02 | Transmittal: 215 | Date: December 18, 2015 | Change Request: 9486 |
|---|---|---|---|

**SUBJECT: January 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

**EFFECTIVE DATE: January 1, 2016**
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## I. GENERAL INFORMATION

**A. Background:** This Change Request implements several changes in the manual requirements of chapter 6 related to outpatient observation services, finalized in the CY 2016 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Final Rule.

**B. Policy: Comprehensive Observation Services C-APC (APC 8011)**

Effective January 1, 2016, CMS will provide payment for all qualifying extended assessment and management encounters through newly created C-APC 8011 (Comprehensive Observation Services). Any clinic visit, Type A ED visit, Type B ED visit, critical care visit, or direct referral for observation services furnished in a non-surgical encounter, by a hospital in conjunction with observation services of eight or more hours will qualify for comprehensive payment through C-APC 8011. Effective January 1, 2016, CMS will no longer provide payment for extended assessment and management encounters through APC 8009 (Extended Assessment and Management Composite) and APC 8009 is deleted effective January 1, 2016.

Also effective January 1, 2016, CMS has created new Status Indicator (SI) J2 to designate specific combinations of services that, when performed in combination with each other and reported on a hospital Medicare Part B outpatient claim, would allow for all other OPPS payable services and items reported on the claim (excluding all preventive services and certain Medicare Part B inpatient services) to be deemed adjunctive services representing components of a comprehensive service and resulting in a single prospective payment through C-APC 8011 for the comprehensive service based on the costs of all reported services on the claim.

CMS is updating Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 20.6 to reflect the latest policy for this new comprehensive APC.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 9486 - 02.1 | Medicare contractors shall refer to Pub.100-02, Medicare Benefit Policy Manual, chapter 6, section | X | | X | | | | | | BCRC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | 20.6 for the latest revisions. | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 9486 - 02.2 | MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | X | | X | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information: N/A**

## V. CONTACTS

**Pre-Implementation Contact(s):** Marina Kushnirova, marina.kushnirova@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

# Medicare Benefit Policy Manual
## Chapter 6 - Hospital Services Covered Under Part B
**(Rev.215, Issued: 12-18-15)**

### 20.6 - Outpatient Observation Services
***(Rev.* 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)**

**A. Outpatient Observation Services Defined**

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

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

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

Future updates will be issued in a Recurring Update Notification.

**B. Coverage of Outpatient Observation Services**

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

All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare. Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). *As of* January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378. In most circumstances, observation services are supportive and ancillary to the other separately payable services provided to a patient. *Beginning January 1, 2016, in* certain circumstances when observation care is billed in conjunction with a clinic visit, Type A emergency department visit (Level *1 through* 5), Type B emergency department visit (Level *1 through* 5), critical care services, or direct referral for observation services as an integral part of a patient's extended encounter of care, *comprehensive* payment may be made for *all services on the claim including, the entire extended care encounter* when certain criteria are met. For information about billing and payment methodology for observation services in years prior to CY 2008, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §§290.3-290.4. For information about payment for extended assessment and management under composite APCs *and comprehensive APCs*, see §290.5. Payment for all reasonable and necessary observation services is packaged into the payments for other separately payable services provided to the patient in the same encounter. Observation services packaged through assignment of status indicator N are covered OPPS services. Since the payment for these services is

included in the APC payment for other separately payable services on the claim, hospitals must not bill Medicare beneficiaries directly for the packaged services.

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

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

Second, if the item or service meets the definition of observation services or would be otherwise covered, then the provider must decide whether the item or service is "reasonable and necessary" for the beneficiary on the occasion in question, or if the item or service exceeds any frequency limitation for the particular benefit or falls outside of a timeframe for receipt of a particular benefit. In these cases, the ABN would be used to shift the liability to the beneficiary (see Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, "Financial Liability Protections," Section 20, at

http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf for information regarding Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed).

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