Observation Services

Guideline Number: URG-18.01
Effective Date: May 1, 2021

Coverage Rationale

Observation services are considered medically necessary for an individual who requires the following in any location within a hospital:

- Short-term monitoring that is not expected to exceed 24 hours but would generally be no longer than 48 hours; and
- Acute treatment and reassessment are required; or
- Monitoring of an event (e.g., cardiac dysrhythmia) or response to therapy (e.g., from drug ingestion) that may require immediate intervention; or
- Diagnostic evaluation to establish a treatment plan

Observation services are considered medically necessary when they meet the criteria above and include one of the following conditions (List is not all-inclusive):

- Abdominal pain
- Allergic reaction (generalized)
- Altered mental status (confusion)
- Asthma
- Back pain
- Bronchiolitis
- Bronchitis
- Cellulitis
- Chest pain
- Croup
- Dehydration
- Diabetes mellitus
- Epistaxis
- Febrile illness
- Gastroenteritis
- Hemoptysis
- Migraine
- Poisoning/Toxic ingestions
- Renal colic, kidney stone
- Seizures
- Syncope
- Transient ischemic attack (TIA)
- Urinary tract infection

Community Plan Policy
- Observation Services

Medicare Advantage Coverage Summary
- Observation Care (Outpatient Hospital)
• Vaginal bleeding (non-obstetrical)

Observation services are not medically necessary for the convenience of the hospital, physicians, patients, or patient's families, or while awaiting placement to another health care facility.

Note: This policy does not apply to obstetric conditions.

References


GINA Report, Global Strategy for Asthma Management and Prevention. 2020

InterQual® Criteria 2020 Release. Level of Care Adult and Level of Care Pediatric.


Guideline History/Revision Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/01/2021</td>
<td>• New Utilization Review Guideline</td>
</tr>
</tbody>
</table>

Instructions for Use

This Utilization Review Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Utilization Review Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.