

Coverage Summary

Hospital Services (Inpatient and Outpatient)

Policy Number: H-006	Products: UnitedHealthcare Medicare Advantage Plans	Original Approval Date: 07/16/2008
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee		Last Review Date: 11/17/2020
Related Medicare Advantage Policy Guidelines:		
<ul style="list-style-type: none"> • Surgical or Other Invasive Procedure Performed on the Wrong Body Part (NCD 140.7) • Surgical or Other Invasive Procedure Performed on the Wrong Patient (NCD 140.8) 	<ul style="list-style-type: none"> • Wrong Surgical or Other Invasive Procedure Performed on a Patient (NCD 140.6) 	

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

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I. COVERAGE

Coverage Statement: Hospital services (inpatient and outpatient) are covered when Medicare criteria are met.

All hospital services must be reasonable and necessary to be covered. Decisions on the setting for delivery of healthcare services should be based on nationally recognized guidelines and evidence-based medical literature.

The CMS Hospital Inpatient Patient Payment System (IPPS) Final Rule provides clarity when inpatient hospital admissions are generally appropriate for payment. Detailed information on the final rule is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page>. (Accessed September 8, 2020)

Guidelines/Notes:

1. Inpatient Hospital Services

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

If the physician or healthcare professional is uncertain if an inpatient admission is appropriate, then the physician or healthcare professional should consider admitting the patient for observation. Refer to the [Coverage Summary for Observation Care \(Outpatient Hospital\)](#) for coverage information.

- a. Acute care inpatient services are covered in Medicare certified facility (a non-certified Medicare Facility only when the services are part of an emergent or urgent situation) (see the [Coverage Summary for Emergent/Urgent Services, Post-Stabilization Care and Out-of-Area Services](#)). Examples include, but are not limited to:
 - 1) Semiprivate rooms (private room if medically necessary)
 - 2) Nursing services
 - 3) Inpatient physician and surgical services
 - 4) All meals, including special diets
 - 5) Drugs and medications while the member is an inpatient
 - 6) Laboratory X-rays and other radiology services (see the [Coverage Summary for Radiologic Therapeutic Procedures](#) and [Coverage Summary for Radiologic Diagnostic Procedures](#)).
 - 7) Necessary medical supplies and appliances
 - 8) Blood and its administration (see the [Coverage Summary for Blood, Blood Products](#))

and Related Procedures and Drugs)

- 9) Special care units and rehabilitation services, as medically necessary
 - 10) Use of appliances and equipment, e.g., wheelchairs and traction
 - 11) Medical supplies need to treat medical or surgical condition while hospitalized
 - 12) Inpatient hospital admission diagnostic procedures when criteria are met. *See the [NCD for Hospital and Skilled Nursing Facility Admission and Diagnostic Procedures \(70.5\)](#). (Accessed September 8, 2020)*
- b. Services, items and treatments not reasonable and medically necessary for the care and treatment of the hospitalized member are not covered. Examples include, but are not limited to:
- 1) Private rooms, unless medically necessary
 - 2) Personal or comfort items
 - 3) Private duty nursing care
 - 4) Non-medically necessary preoperative days, including:
 - a) Early admission for the convenience of the member or his/her family or physician
 - b) Early admission to perform preoperative testing except if complexity of test(s) prevents performance as an outpatient
 - 5) Continued stay in the hospital for services that could have been done on an outpatient basis
 - 6) Continued stay in the hospital when the member should have been discharged
 - 7) Hospitalization primarily to prevent a substance dependent member from access to or abuse of substance or to alter an member's behavior
 - 8) Hospitalization in a facility that has not been certified by Medicare, unless the member was transported for emergency services

See the [Medicare Benefit Policy Manual, Chapter 1, §10 – Inpatient Hospital Services Covered Under Part A](#). Also see the [Quality Improvement Organization Manual, Chapter 4, §4110 – Admission/Discharge Review](#). (Accessed September 8, 2020)

CMS Inpatient Only List: *The Social Security Act allows CMS to define services that are appropriate for payment under the Outpatient Prospective Payment System (OPPS). Under this authority, CMS also identifies services that should be performed in the inpatient setting. These services are itemized on the inpatient list, also known as the inpatient-only list. The “inpatient only list” is found in Addendum E in the CY 2018 OPPS Addenda: <https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1678-FC-2018-OPPS-FR-Addenda.zip> (Accessed September 8, 2020)*

2. **Outpatient Hospital Services**

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. Part B covers both the diagnostic and the therapeutic services furnished by hospitals to outpatients. The rules in this section pertaining to the coverage of outpatient hospital services are not applicable to the following services.

- Physical therapy, speech-language pathology or occupational therapy services when they are furnished “as therapy” meaning under a therapy plan of care. See chapter 15, sections

220 and 230 of Medicare Benefit Manual for coverage and payment rules for these services, which are paid at the applicable amount under the physician fee schedule.

- Services that are covered and paid under the End Stage Renal Disease Prospective Payment System. See Chapter 11, “End Stage Renal Disease (ESRD)” of this manual, for rules on the coverage of these services.
 - a. Outpatient hospital services are covered.
 - 1) The services and supplies must be furnished as an integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an illness or injury.
 - 2) The services and supplies must be furnished on a physician's order and under physician supervision (physician is on the premise and involved in evaluation of the patient).
 - b. Other covered services and items include, but are not limited to:
 - 1) Hospital facilities including the use of the emergency room
 - 2) Services of non-physician anesthetists, therapists and other aides
 - 3) Medical supplies, such as gauze, oxygen, ointments and surgical dressings
 - 4) Casts, splints and other devices used for the reduction of fractures and dislocations
 - 5) Prosthetic devices (e.g., leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes)
 - 6) Anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting; *see the [Coverage Summary for Dental Services, Oral Surgery and Treatment of Temporomandibular Joint \(TMJ\)](#)*.
 - 7) Complications of non-covered services requiring medically necessary treatment
 - c. Non-covered outpatient hospital services include, but are not limited to:
 - 1) Cosmetic surgery for the purpose of improving appearances (*see the [Coverage Summary for Cosmetic and Reconstructive Procedures](#)*)
 - 2) Non-medically necessary surgery
 - 3) Unauthorized outpatient surgery
 - 4) Rehabilitation that does not meet Medicare coverage criteria
 - 5) Outpatient eating disorder programs
 - 6) Experimental/investigational treatment on an outpatient basis
 - 7) Biofeedback for tension or stress headaches or any psychosomatic illness (*also see the [Coverage Summary for Biofeedback](#)*)

See the [Medicare Benefit Policy Manual, Chapter 6, §20 – Outpatient Hospital Services](#). (Accessed September 8, 2020)

3. **Outpatient Surgical Procedures – Site of Service**

To determine the appropriate site of service, see the [UnitedHealthcare Commercial Utilization Review Guideline for Outpatient Surgical Procedure – Site of Service](#).

4. **Religious Nonmedical Health Care Institutions (RNHCIs)**

Services in a Medicare certified Religious Nonmedical Health Care Institutions (RNHCIs) are

covered under UnitedHealthcare Medicare. However, religious aspects of care provided in RNHCIs are not covered.

In order to be eligible for care in a RNHCI, an individual must have a condition that would allow them to receive inpatient hospital or extended care services. In addition, the individual must make an election that they are conscientiously opposed to the acceptance of “nonexcepted” medical treatment.

“Excepted” medical treatment is medical care or treatment that is received involuntarily or that is required under Federal, State or local law.

“Nonexcepted” medical treatment is any other medical care or treatment other than excepted medical treatment.

Notes:

- *RNHCI services equivalent to a hospital or extended care level of care in a qualified RNHCIs are limited to those who elected RNHCI services. The same benefit restrictions and requirements such as benefit period, prior authorization and all copayment/coinsurance will apply.*
- *Any RNHCI provider that does not have a contract with UnitedHealthcare Medicare must accept, as payment in full, the amounts that the provider could collect if the member was enrolled in original Medicare.*

See the [Medicare Benefit Policy Manual, Chapter 1, §130 – Religious Nonmedical Health Care Institution \(RNHCI\) Services](#). (Accessed September 8, 2020)

5. **Long Term Care Hospitals (LTCH)**

LTCHs are certified under Medicare as short-term acute care hospitals that have been excluded from the acute care hospital inpatient prospective payment system (PPS) under §1886(d)(1)(B)(iv) of the Act and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days.

Long Term Care Hospitals (LTCH) are covered when the following criteria are met:

- a. The facility must meet the Medicare requirements for accreditation and licensure in the state in which the LTCH is doing business.
 - 1) LTCHs can offer generalized services. (i.e., chronic disease care and specialized services such as physical rehabilitation and/or ventilator-dependent care.)
 - 2) LTCH patients receive a range of acute care hospital and “post-acute care” services, which could include:
 - Comprehensive rehabilitation
 - Cancer treatment
 - Head trauma treatment
 - Pain management
 - Burn treatments
- b. The patient’s need for nursing and rehabilitative services are such that only an inpatient LTCH setting can meet the requirements (b-1 & b- 2):
 - 1) The expected patient length of stay is 25 days (for shorter stays consider Skilled Nursing Facility or Rehabilitation Facility)
 - 2) Patient requires one or more acute or post acute skilled services for a complex medical or mental condition. For ventilator dependent patients a minimum of 4 hours of care per day.

Examples of the types of patients that may require LTCH level of care, include those with one or more of the following (this list may not be all inclusive):

- Ventilator dependent patient
- Complex wounds requiring extensive therapy (whirlpool and debridement)
- Frequent diagnostic lab, radiologic procedures to diagnose and treat disease or injuries.
- Psychiatric and psych-medical care
- Interavenous medication therapy 3 or more drugs
- Failure of treatment in a lower level of care, e.g., SNF or Intensive Home Health Care

- c. LTCH stay must be determined to be medical necessary for the length of stay (LOS). (*Note: For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review procedure.*)

A patient in a long-term acute care hospital is considered discharged when:

- 1) The patient is formally released (CFR Pat 42 §412.23(e) (3)).
- 2) The patient stops receiving Medicare-covered long-term care services (CFR Part 42 §412.521(b)); Patient no longer requires the LTCH level of care and patient needs can be handled in an alternative setting (rehab facility, SNF or home). Examples include but are not limited to the following:
 - Hemodynamically stable to be transferred to a lower level of care setting, e.g. electrolytes, blood loss, and airway
 - Neurological status is stable and needs, can be met in alternative setting.
 - No longer requires multiple interavenous drug therapy
 - Ventilator weaning is completed or can be safely done in another lower level of care setting; or
 - Permanent mechanical ventilation is planned.
- 3) The patient dies in the long-term care facility

For more information, refer to the following:

- *CMS Long Term Care Hospital PPS Training Material and Policy Fact Sheets (download LTCH Training Guide zip file) at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/lrch_train.html.*
- *CMS Long Term Care Hospital PPS Overview and Training Manual; available at http://www.cms.hhs.gov/LongTermCareHospitalPPS/03_lrch_train.asp#TopOfPage.*
- *[Medicare Claims Processing Manual, Chapter 3, §150 – LTCHs PPS.](#)*
- *Code of Federal Regulations (e-CFR) 42CFR § 412.23 at <http://www.ecfr.gov>.*

(Accessed September 8, 2020)

6. **Never Events**

Neither Medicare nor UnitedHealthcare Medicare will reimburse for the following services: (Note: The member is not responsible for coinsurance/copayment.)

- a. *Wrong surgical or invasive procedure performed on a patient; see the [NCD for Wrong Surgical or Other Invasive Procedure NCD \(140.6\)](#). (Accessed September 8, 2020)*
- b. *Surgical or other invasive procedure performed on the wrong body part; see the [NCD for Surgical or Other Invasive Procedure Performed on the Wrong Body Part NCD \(140.7\)](#).*

(Accessed September 8, 2020)

- c. Surgical or other invasive procedure performed on the wrong patient; see the [NCD for Surgical or Other Invasive Procedure Performed on the Wrong Patient NCD \(140.8\)](#).
(Accessed September 8, 2020)

Notes:

- **Denial Notice Requirements:** For notification of non-coverage, refer to the [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#).
(Accessed September 8, 2020)
- **Bloodless Medicine and/or Surgery (For UnitedHealthcare Medicare Complete Members Only):** Bloodless medicine and/or surgery for members who choose not to receive blood or selected blood products may be covered, only when available through the contracting provider. All bloodless medicine or surgery must be authorized by the Member's Participating Medical Group/IPA or the member may be financially responsible. Authorization requests for bloodless medicine cannot be guaranteed because the capabilities and resources vary depending on the member's chosen Participating Medical Group/IPA.

II. DEFINITIONS

III. REFERENCES

IV. REVISION HISTORY

- 11/17/2020 **Guideline 3 (Outpatient Surgical Procedures - Site of Service)** (new to policy)
- Added instruction to refer to the UnitedHealthcare Commercial Utilization Review Guideline titled *Outpatient Surgical Procedure – Site of Service* to determine appropriate site of service