Hospital Services (Inpatient and Outpatient)

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Related Medicare Advantage Policy Guidelines
• 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)
• Wrong Surgical or Other Invasive Procedure Performed on a Patient (NCD 140.6)

Coverage Guidelines

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/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page. (Accessed August 9, 2021)


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 the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. 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 their 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 titled Observation Care
(Outpatient Hospital) for coverage information.

Refer to the:
• Medicare Benefit Policy Manual, Chapter 1, §10 – Inpatient Hospital Services Covered Under Part A.
• Quality Improvement Organization Manual, Chapter 4, §4110 – Admission/Discharge Review.
• National Coverage Determination (NCD) for Hospital and Skilled Nursing Facility Admission and Diagnostic Procedures
  (70.5)
(Accessed August 9, 2021)

Inpatient Level of Care Review:
For more detailed inpatient hospital services definitions/clinical criteria and guideline, refer to the UnitedHealthcare

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” can
• On December 2, 2020, CMS finalized the proposal to eliminate the Inpatient Only (IPO) list over a three-year transitional
  period, beginning with the removal of approximately 300 primarily musculoskeletal-related services, with the list completely
  phased out by CY 2024. This will make these procedures eligible to be paid by Medicare in the hospital outpatient setting
  when outpatient care is appropriate, as well as maintain our ability to pay for these services in the hospital inpatient setting
  when inpatient care is appropriate, as determined by the physician. Additionally, procedures removed from the IPO list may
  become subject to medical review activities related to the 2-midnight rule.

CMS has provided a table that includes services removed from the inpatient-only list for CY 2021 starting on page 709 of the

The fact sheet on the Calendar Year (CY) 2021 OPPS/ASC Payment System final rule (CMS-1736-F) can be accessed at
https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-
ambulatory-surgical-center-0
(Accessed August 9, 2021)

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. Refer to Chapter 11,
  “End Stage Renal Disease (ESRD)” of this manual, for rules on the coverage of these services.
Outpatient hospital services are covered.

- 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.
- 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).

Refer to the Medicare Benefit Policy Manual, Chapter 6, §20 – Outpatient Hospital Services. (Accessed August 9, 2021)

**Outpatient Surgical Procedures – Site of Service**

To determine the appropriate site of service, refer to the UnitedHealthcare Commercial Utilization Review Guideline titled Outpatient Surgical Procedure – Site of Service.

**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.


**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.

LTCHs must meet several criteria that have clinical implications. LTCHs must:

- Meet state licensure requirements for acute care hospitals under section 1886(d)(B)(iv) of the Social Security Act.
- Have an average length of stay greater than 25 days.
- Have an agreement with the Quality Improvement Organization (QIO) formerly known as the Peer Review Organization (PRO).

LTCHs can offer generalized services. (i.e., chronic disease care and specialized services such as physical rehabilitation or ventilator-dependent care.)

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.
A patient in a long-term acute care hospital is considered discharged when:
- The patient is formally released (CFR Pat 42 §412.23(e) (3)
- The patient stops receiving Medicare-covered long-term care services (CFR Part 42 §412.521(b)
- 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/Ltch_train.html
- CMS Long Term Care Hospital PPS Overview and Training Manual; available at http://www.cms.hhs.gov/LongTermCareHospitalPPS/03_Ltch_train.asp
- Medicare Claims Processing Manual, Chapter 3, §150 – LTCHs PPS
(Accessed August 9, 2021)

Never Events

Neither Medicare nor UnitedHealthcare Medicare will reimburse for the following services:

Note: The member is not responsible for coinsurance/copayment.
- Wrong surgical or invasive procedure performed on a patient; refer to the NCD for Wrong Surgical or Other Invasive Procedure NCD (140.6). (Accessed August 9, 2021)
- Surgical or other invasive procedure performed on the wrong body part; NCD Surgical or Other Invasive Procedure Performed on the Wrong Body Part NCD (140.7). (Accessed August 9, 2021)
- Surgical or other invasive procedure performed on the wrong patient; refer to the NCD for Surgical or Other Invasive Procedure Performed on the Wrong Patient NCD (140.8). (Accessed August 9, 2021)

Notes:
- Denial Notice Requirements: For notification of non-coverage, refer to the Parts C and D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. (Accessed August 9, 2021)
- 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.

Policy History/Revision Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Coverage Guidelines</th>
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<tbody>
<tr>
<td>08/17/2021</td>
<td>Added notation pertaining to COVID-19 Public Health Emergency Waivers &amp; Flexibilities to indicate:</td>
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<tr>
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<td>○ In response to the COVID-19 Public Health Emergency, the Centers for Medicare &amp; Medicaid (CMS) has updated some guidance for certain hospital services</td>
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<td>Replaced language indicating “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” with “physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation”</td>
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<td>Removed list of examples of covered/non-covered services, items, and treatments</td>
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<td>Summary of Changes</td>
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<td>● Added reference link to the National Coverage Determination (NCD) for <em>Hospital and Skilled Nursing Facility Admission and Diagnostic Procedures</em> (NCD 70.5)</td>
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**Supporting Information**

● Archived previous policy version MCS046.02

**Instructions for Use**

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.
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 are 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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