Hospital Services (Outpatient, Observation, and Inpatient)

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Instructions for Use

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Related Medicare Advantage Policy Guideline

- Wrong Surgical or Other Invasive Procedure

Coverage Guidelines

Hospital services (inpatient, outpatient, and observation services) 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-2023-ipps-final-rule-home-page.

COVID-19 Public Health Emergency Waivers & Flexibilities: In response to the COVID-19 Public Health Emergency, CMS has updated some guidance for certain hospital services. For a comprehensive list of Coronavirus Waivers & Flexibilities, refer to https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers. (Accessed March 24, 2023)

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 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:
- 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 Diagnostic Procedures (70.5).

(Accessed March 24, 2023)

Inpatient Level of Care Review

For more detailed inpatient hospital services definitions/clinical criteria and guideline, refer to the UnitedHealthcare Commercial Medical Policy titled Elective Inpatient Services.

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 be accessed at Addendum E. - Final HCPCS Codes that Would Be Paid Only as Inpatient Procedures for 2023.
- 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 added and removed from the inpatient-only list for CY 2021 starting on page 709 of the final rule. The final rule can be accessed at https://public-inspection.federalregister.gov/2022-23918.pdf.
  - The fact sheet on the Calendar Year (CY) 2023 OPPS/ASC Payment System final rule (CMS-1736-F 1772-FC) can be accessed at https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2.

(Accessed March 24, 2023)

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. Refer to 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 March 24, 2023)

Outpatient Observation Services

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

All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered.

Refer to the Medicare Benefit Policy Manual, Chapter 6, §20.6 - Outpatient Observation Services.

Notes:

- For more detailed observation care services definitions/clinical criteria and guideline, refer to the UnitedHealthcare Commercial Medical Policy titled Hospital Services: Observation and Inpatient.
- For coverage to be appropriate for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. Refer to the Quality Improvement Organization Manual, Chapter 4, §4110 - Admission/Discharge Review.
- Copayment or coinsurance may apply as either emergency room services or observation; check member’s Evidence of Coverage/Schedule of Benefit document.
- For billing and coding guidelines, refer to the Medicare Claims Processing Manual, Chapter 4, §290 - Observation Services.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These policies are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

(Accessed March 24, 2023)

Examples of Non-Covered Services

- Services that are not reasonable and necessary for the diagnosis or treatment of the member. Refer to the Medicare Benefit Policy Manual, Chapter 6, §10.1 – Reasonable and Necessary Part A Hospital Inpatient Claim Denials.
- Services that are covered under Part A, such as a medically appropriate inpatient admission, or services that are part of another Part B service, such as postoperative monitoring during a standard recovery period, (e.g., 4-6 hours), which should

be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services. Observation should not be billed concurrently with therapeutic services such as chemotherapy. Refer to the Medicare Claims Processing Manual, Chapter 4, §290.2.2 - Reporting Hours of Observation.
- Standing orders for observation following outpatient surgery. Refer to the Medicare Claims Processing Manual, Chapter 4, §290.2.2 – Reporting Hours of Observation.

(Accessed March 24, 2023)

Outpatient Surgical Procedures – Site of Service

To determine the appropriate site of service, refer to the UnitedHealthcare Commercial Medical Policy titled Outpatient Surgical Procedures – 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.

Refer to the Medicare Benefit Policy Manual, Chapter 1, §130 – Religious Nonmedical Health Care Institution (RNHCI) Services.
(Accessed March 24, 2023)

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.
- Code of Federal Regulations (e-CFR) 42CFR § 412.23 at http://www.ecfr.gov.

(Accessed March 24, 2023)

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 Performed on a Patient (140.6).
- Surgical or other invasive procedure performed on the wrong body part; NCD Surgical or Other Invasive Procedure Performed on the Wrong Body Part (140.7).
- 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 (140.8).

(Accessed March 24, 2023)

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 March 24, 2023)
- 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

Date	Summary of Changes
08/03/2022	**Title Change** • Previously titled *Hospital Services (Inpatient and Outpatient)* **Coverage Guidelines** • Added language to indicate hospital observation services are covered when Medicare criteria are met ***Outpatient Observation Services*** • Added language [previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Observation Care (Outpatient Hospital)*] to indicate: ○ 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 plan, concerning their admission or discharge

Date	Summary of Changes
	○ 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 "direct referrals" to observation ▪ A "direct referral" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED) ▪ Effective for services furnished on or after Jan. 1, 2003, hospitals may bill for patients directly referred for 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 ○ All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered ○ Refer to the *Medicare Benefit Policy Manual, Chapter 6, §20.6 - Outpatient Observation Services* ○ Notes: ▪ For more detailed observation care services definitions/clinical criteria and guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Hospital Services: Observation and Inpatient* ▪ For coverage to be appropriate for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis; refer to the *Quality Improvement Organization Manual, Chapter 4, §4110 - Admission/Discharge Review* ▪ Copayment or coinsurance may apply as either emergency room services or observation; check member's Evidence of Coverage/Schedule of Benefits document ▪ For billing and coding guidelines, refer to the *Medicare Claims Processing Manual, Chapter 4, §290 - Observation Services* ▪ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable **Examples of Non-Covered Services** ○ Examples of non-covered services include: ▪ Services that are not reasonable and necessary for the diagnosis or treatment of the member; refer to the *Medicare Benefit Policy Manual, Chapter 6, §10.1 – Reasonable and Necessary Part A Hospital Inpatient Claim Denials* ▪ Services that are covered under Part A, such as a medically appropriate inpatient admission, or services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services – Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services – Observation should not be billed concurrently with therapeutic services such as chemotherapy; refer to the *Medicare Claims Processing Manual, Chapter 4, §290.2.2 – Reporting Hours of Observation* ▪ Standing orders for observation following outpatient surgery; refer to the *Medicare Claims Processing Manual, Chapter 4, §290.2.2 – Reporting Hours of Observation*

Date	Summary of Changes
	Supporting Information • Archived previous policy versions MCS046.03 and MCS067.02

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).