

Coverage Summary

Observation Care (Outpatient Hospital)

Policy Number: H-005	Products: UnitedHealthcare Medicare Advantage Plans	Original Approval Date: 07/16/2008
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee		Last Review Date: 08/18/2020

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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 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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I. COVERAGE

Coverage Statement: Outpatient hospital observation services are covered when Medicare coverage criteria are met.

All outpatient hospital observation 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 August 10, 2020)

1. Coverage of 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 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 “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 by Medicare.

See the [Medicare Benefit Policy Manual, Chapter 6, §20.6 - Outpatient Observation Services](#). (Accessed August 10, 2020)

Notes:

- For coverage to be appropriate under Medicare 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. See the [Quality Improvement Organization Manual, Chapter 4, §4110 - Admission/Discharge Review](#). (Accessed August 10, 2020)
 - 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, see [Medicare Claims Processing Manual, Chapter 4, §290 - Observation Services](#). (Accessed August 10, 2020)
 - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These policies are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.
2. The following services are not covered as the services are not medically reasonable or necessary:
- a. Services that are not reasonable and necessary for the diagnosis or treatment of the member. See the [Medicare Benefit Policy Manual, Chapter 6, §10.1 – Reasonable and Necessary Part A Hospital Inpatient Claim Denials](#). (Accessed August 10, 2020)
 - b. 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. See the [Medicare Claims Processing Manual, Chapter 4, §290.2.2 - Reporting Hours of Observation](#). (Accessed August 10, 2020)
 - c. Standing orders for observation following outpatient surgery. See the [Medicare Claims](#)

II. DEFINITIONS

None.

III. REFERENCES

See above.

IV. REVISION HISTORY

08/18/2020 • Routine review; no change to coverage guidelines