Coverage Summary

Observation Care (Outpatient Hospital)

<table>
<thead>
<tr>
<th>Policy Number: H-005</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 07/16/2008</th>
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<tr>
<td>Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 08/21/2018</td>
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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/FY2018-IPPS-Final-Rule-Home-Page.html. (Accessed August 6, 2018)

1. Coverage of Outpatient Observation Services

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

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.

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.

**Notes:**

- 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.

- Copayment or coinsurance may apply as either Emergency Room Services or Observation, check member’s Evidence of Coverage/Schedule of Benefit document.

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

For billing and coding guidelines, see Medicare Claims Processing Manual, Chapter 4, §290 - Observation Services. (Accessed August 6, 2018)

Also see the Quality Improvement Organization Manual, Chapter 4, §4110 - Admission/Discharge Review. (Accessed August 6, 2018)

Local Coverage Determinations (LCDs) 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. (Accessed August 6, 2018)

2. **Change of Status from Inpatient to Outpatient**

When an inpatient admission is changed to outpatient, consistent with Medicare billing guidelines, a provider may submit an outpatient claim for all medically necessary services furnished during the stay only if all code 44 criteria are met (including any member notice requirements). For more detailed information, refer the following Medicare references:

- Medicare Managed Care Manual, Chapter 13, § 150.2 - Special Considerations. (Accessed August 6, 2018)
- Medicare Claims Processing Manual, Chapter 1, § 50.3.2 - Policy and Billing Instructions for Condition Code 44. (Accessed August 6, 2018)
- Medicare Learning Network (MLN) Matters, Number SE0622. (Accessed August 6, 2018)
- Medicare Learning Network (MLN) Matters, Number SE 1210. (Accessed August 6, 2018)

3. 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
b. Outpatient observation services that are provided only for the convenience of the member or his/her family or physician. (e.g., following an uncomplicated treatment or a procedure, physician busy when patient is physically ready for discharge, patient awaiting placement in a long term care facility). See the Medicare Claims Processing Manual, Chapter 4, §240 - Inpatient Part B Hospital Services. (Accessed August 6, 2018)

c. 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 Benefit Policy Manual, Chapter 6, §20 - Outpatient Hospital Services. (Accessed August 6, 2018)

d. Standing orders for observation following outpatient surgery. See the Medicare Claims Processing Manual, Chapter 4, §290.2.2 - Reporting Hours of Observation. (Accessed August 6, 2018)

II. DEFINITIONS

Observation Care: 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 status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Medicare Benefit Policy Manual, Chapter 6, §20.6 - Outpatient Observation Services. (Accessed August 6, 2018)

III. REFERENCES

See above

IV. REVISION HISTORY

04/01/2019 Updated policy introduction; added language to clarify:
- There are instances where [the Coverage Summary] 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)

08/21/2018 Annual review with the following updates:

Guideline 1 (Coverage of Outpatient Observation Services)
- Added the section title “Coverage of Outpatient Observation Services”
• Deleted the following:

  Outpatient observation services are covered for up to 48 hours and may include:
a. Use of a bed within a hospital for the purpose of observing the member’s
c  condition

b. Periodic monitoring by the hospital’s staff to evaluate an outpatient’s
d  condition and/or determine the need for a possible admission to the hospital

  as an inpatient

  Outpatient observation services should not be used for routine diagnostic services
and outpatient surgery/procedures. Refer to Guidelines # 3.c.

  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.

• Added the following (from the Medicare Benefit Policy Manual Chapter 4, §20.6
- Outpatient Observation Service):

  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. All

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

  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.

• Changed “direct admission” to “direct referrals” on the following note (based
on MBPM Chapter 4, §20.6 - Outpatient Observation Service)

  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.

• Deleted the following billing information and added a note to refer to the
Medicare Claims Processing Manual for billing and coding guidelines:

  A patient admitted to observation and then admitted to inpatient status on the

same day is billed using inpatient admission codes only.

  A patient admitted to observation and then admitted to inpatient status on a
different day may be billed with both the initial observation codes and also

hospital admission codes on the subsequent day.

08/15/2017 Annual review; no updates.
08/16/2016 Annual review; no updates.
09/15/2015 Annual review without updates.
09/16/2014 Annual review with the following updates:
Guideline #1 (Inpatient Hospital Services) - added a reference link to the CMS FAQ for the Two-Midnight rule specific to Medicare Advantage Plans.

Guideline #3 (Examples when observation care services may be medically necessary) - removed guideline; reference LCD for Acute Inpatient Services versus Observation (Outpatient) Services (L32222) was retired.

Definitions – updated definition of Observation Care to include the reference link to the Medicare Benefit Manual, Chapter 6, §20.6 Outpatient Observation Services.


04/29/2013 Added billing guidelines when an inpatient admission is changed to outpatient. Added examples when observation care services may be medically necessary.

10/31/2012 Annual review; no updates.

10/13/2011 Annual review; no updates.

09/07/2010 Policy updated to further clarify the benefit coverage for hospital observation services.