Outpatient Hospital Services

Policy Number: BIP083.J
Effective Date: September 1, 2021

Instructions for Use

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Related Benefit Interpretation Policies

- Chemical Dependency/ Substance Abuse Detoxification
- Cosmetic, Reconstructive, or Plastic Surgery
- Dental Care and Oral Surgery
- Diagnostic and Therapeutic Radiology Services
- Experimental and Investigational Services
- Inpatient and Outpatient Mental Health
- Rehabilitation Services (Physical, Occupational, and Speech Therapy)
- Services/Complications Related to Non-Covered Services
- Blood and Blood Products

Federal/State Mandated Regulations

California

https://govt.westlaw.com/calregs/Document/IC8C4B7D0D44911DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Director may approve:

(c) Ambulatory care services, (outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Such services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's Evidence of Coverage (EOC)/ Schedule of Benefits (SOB) to determine coverage eligibility.

- Medically Necessary outpatient services and supplies, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital provided by the member's Primary Care Physician, or authorized by the Network Medical Group or UnitedHealthcare.
  Examples include, but are not limited to:
  - Diagnostic testing, including laboratory and radiological services (refer to the Benefit Interpretation Policy titled Diagnostic and Therapeutic Radiology Services)
  - Therapeutic radiological services (X-rays) (refer to the Benefit Interpretation Policy titled Diagnostic and Therapeutic Radiology Services)
  - Treatment services for the provision of basic health services
  - Prior authorized outpatient surgery
- Mental health outpatient services (refer to the Benefit Interpretation Policy titled Inpatient and Outpatient Mental Health)
- Detoxification and chemical dependency outpatient services (refer to the Benefit Interpretation Policy titled Chemical Dependency/ Substance Abuse Detoxification)
- Outpatient rehabilitative services, including physical, speech and occupational therapies (refer to the Benefit Interpretation Policy titled Rehabilitation Services (Physical, Occupational, and Speech Therapy)
- 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 member requires dental procedures that ordinarily would not require general anesthesia to be rendered in a contracted hospital or surgery center setting. (refer to the Benefit Interpretation Policy titled Dental Care and Oral Surgery)
- Complications of non-covered services requiring medically necessary treatment.

Not Covered

Examples of non-covered outpatient services include, but are not limited to:
- Cosmetic surgery (refer to the Benefit Interpretation Policy titled Cosmetic, Reconstructive, or Plastic Surgery)
- Non-medically necessary and/or non-authorized outpatient surgeries and/or procedures
- Experimental/investigational treatment on an outpatient basis
- Physical rehabilitation day treatment programs

Definitions

Hospital Services: Services and supplies performed or supplied by a licensed hospital on an inpatient or outpatient basis

Policy History/Revision Information

Date	Summary of Changes
09/01/2021	• Routine review; no change to benefit coverage guidelines • Archived previous policy version BIP083.I

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.